APPENDIX 1 TO THE INTERNATIONAL MEDICAL INSURANCE CERTIFICATE

International Medical Insurance Policy

This International Medical Insurance Policy (hereafter referred to as the "**Policy**") specifies general conditions of International Medical Insurance Certificate concluded between the Insurer (as represented by the Coverholder) and the Policyholder. This Policy constitutes Appendix 1 to the International Medical Insurance Certificate (hereafter may be referred to as the "**Certificate**", "**Insurance Certificate**", "**Contract**" or "**Insurance Contract**").

Special conditions of insurance cover to be applicable in respect of a particular Insured Person are established in the main body of the respective Certificate, as well as in its other attachments or appendixes (except for this Policy), including the following: the Schedule of Benefits, the List of Insured Persons and Insurance Premiums, and a Special Individual Certificate (if issued). Should there be a discrepancy between this Policy and provisions of the main body of the Certificate or its other attachments/appendixes, provisions of the main body of the Certificate / of its attachments /appendixes shall prevail.

The Policyholder's application for this insurance (including medical condition and prior international medical insurance history related documentation), as well as other information and documentation provided by the parties to each other for the purpose of concluding the Contract shall make up an inseparable part of the Contract.

Special terminology used in this Policy and elsewhere in the Contract is expressly explained below in **Article 1 "Definitions"** of the Policy. If a definition of any term is not provided for in this Policy and cannot be explained based on applicable legislation, then such term shall be interpreted in accordance with its usual lexical meaning.

Whenever within this Policy or elsewhere in the Contract a referral to "**this insurance**" is being made, the international medical insurance under the specific Contract (in accordance with all terms and conditions as set therein) shall be meant.

The Coverholder is acting on behalf of the Insurer, when executing all its rights and obligations as set in this Policy and elsewhere in the Contract.

Information about the Coverholder:

Company name:	dhig GmbH
Registered at:	Fleischmarkt 9/16, 1010, Vienna, Austria
Registration number:	FN 515759 w
Licensing:	Insurance intermediary license issued by the Magistrat of the city of Vienna, the Republic of Austria, under the number (GISA-Zahl): 31857536
Postal address:	Fleischmarkt 9/16, 1010, Vienna, Austria
E-mail:	contact@dhig.net
Website:	https://dhig.net

1. DEFINITIONS

The following terminology shall be used in this Policy and elsewhere in the Contract:

Accident is an external, sudden, short-term, unintentional, not being a result of a disease or its Treatment, unforeseen concourse of circumstances, which occurred during the Insurance Period, where against the will of an Insured Person his/her health is damaged or he/she dies. Accidents among other things include but are not limited to the following: illegal actions of third parties (including Terrorist Attack), an attempt of rescue of people or freight in peril; inhalation of gas or vapor, as well as absorption of poisoning or aggressive substances; disruptions and damage of muscles caused by a spurt; frostbite; drowning.

Actively-at-Work means a natural person's status of actively and competently performing all the essential duties of his/her usual job, without restriction for all or most of his/her regularly scheduled working hours. The following employees shall be recognized as being Actively-at-Work: those on maternity leave; those on compassionate leave; those on annual leave; those on study leave for no longer than 1 month per year.

Adult Health Screening (Check-up) includes a routine physical examination by a General Practitioner, routine blood tests, and urinalysis for persons aged 18 or older. Further tests and consultations by Specialists are recommended by the General Practitioner depending on the Insured Person's age and gender, his/her general health condition and occupational hazards, and may include:

- Mammograms for breast cancer screening or diagnostic purposes:
  - one baseline mammogram for asymptomatic women aged 35–39;
  - a mammogram for asymptomatic women aged 40–49 every 2 years;
  - a mammogram every year for women aged 50 or older.
- Pap smear: one annual Papanicolaou screening for Insured females.
- Prostate cancer screening (PSA-test): one annual prostate cancer screening for Insured men aged 50 or older or any age, when prescribed by a Doctor.
- Bowel cancer screening: an annual bowel cancer screening for Insured Person aged 55 or older.
- Bone densitometry: one annual scan to determine the density of the Insured Person's bones.

Aggregate Limit per event means the combined limit of the Insurer's liability under the Contract if a relevant event occurs, irrespective of number of Insured Persons affected by this event, their individual Sums Insured and Schedules of Benefits envisaged by the Contract. **Individual limit per event** means the limit of the Insurer's liability in respect of one Insured Person, if a relevant event occurs.

Alternative/Complementary Medical Practices (**Alternative/Complementary Medicine**) means practices and products that are not recognized world-wide as methods and standards of Medical Treatment and healthcare practices. Alternative medicine includes acupuncture, needle therapy, aromatherapy, hydrotherapy, chiropractic, homeopathic, naturopathic and osteopathic medicine, and Ayurvedic and traditional Chinese medicine.

Anniversary Date means the annual anniversary of the Insurance Start Date indicated in the first Certificate.

Assistance Service is a legal entity appointed by the Coverholder for organization of medical services and payment of relevant expenses covered by the Contract. The Insured Person must contact the Assistance Service to obtain pre-authorization of any Treatment for Benefits where this is obligatory as expressly indicated in paragraph 5.4 of this Policy and elsewhere in the Contract. The Assistance Service is operational 24 hours a day, 365 days a year. The specific contact details of the Assistance Service shall be indicated in the main body of the Certificate.

Benefit means a Medical Treatment, good and services executed/incurred/provided to the Insured Person solely within Hospitals belonging to the ACIBADEM chain in Turkey, which the Insurer agrees to pay for/compensate for (subject to terms, limitations, Specific Exclusions and exclusions, other general and special conditions as set in the Contract) and that are indicated in the Schedule of Benefits as covered under the Contract. This Policy (including its Article 1 "Definitions") and other wording of the Contract may contain provisions explaining and otherwise referring to certain benefits. However, for the avoidance of

any doubts, any benefit that is not expressly indicated in the Schedule of Benefits as covered by the Contract shall not be covered.

> **Schedule of Benefits** means the Schedule of Benefits, which is attached to the Certificate and specifies the Benefits covered by the specific Insurance Contract. The Schedule of Benefits makes up an inseparable part of the Certificate.

Chronic condition or a Chronic disease means a disease, a consequence of Injury or medical condition that causes irreversible pathological changes, which has 2 or more of the following characteristics:

a. it has no known recognized cure, or after a course of Treatment it comes back or is likely to come back;
b. it is permanent (continues indefinitely);
c. it requires long-term monitoring, consultations, check-ups, examinations or tests, or taking drugs regularly;
d. the Insured Person needs to be rehabilitated or specially trained to cope with it;

however, **tumor, congenital, and hereditary conditions are excluded from the definition of Chronic condition.**

The Treatment of a Chronic disease or of a Chronic condition is covered if expressly indicated so in the applicable Schedule of Benefits/elsewhere in the Certificate.

Claim means a request for reimbursement of expenses for (cost of) Medical Treatment/good or service, submitted to the Coverholder by the Insured Person, the Policyholder or by a Provider of the said Treatment/good or service. **Claim payment** means positive settlement of the Claim, where the Claim can be eligible for payment in full or in part.

Compassionate Trip Home means the cost of a return economy air ticket to the Insured Person's Home Country if his/her close family member dies during the Insurance Period. A close family member means Insured Person's Spouse/partner, parent, mother-in-law, father-in-law, brother, sister, child (including (un)married child, stepchild, foster child and legally adopted child), grand-child, or grandparent.

Complicated Pregnancy and Childbirth means any of the following medical conditions:

- miscarriage requiring immediate Surgery, or fetus death if it remains in the mother's uterus with placenta;
- stillbirth;
- abnormal cell growth in the uterus (hydatidiform mole);
- ectopic Pregnancy;
- severe hemorrhage for several hours or days immediately after birth (post-partum hemorrhage);
- remnants of afterbirth parts in the uterus (parts of placenta or membranes) after baby birth;
- low insertion of placenta;
- nephropathy;
- preeclampsia (condition with a number of symptoms including hypertension and fluid retention);
- eclampsia (late toxicosis, characterized by convulsive attacks followed by coma-like state);
- gestational diabetes;
- full cessation of labor activity;
- therapeutic abortion;
- uterine laceration;
- amniotic fluid embolism;
- complications following above stated conditions.

Complicated Pregnancy and Childbirth benefit means reimbursement of costs relating to prenatal and post-natal care and childbirth, of the insured mother and her Newborn child in the first 14 days of his/her life, where the Doctor has certified any of the medical conditions envisaged under the Complicated Pregnancy and Childbirth definition, or where a normal delivery would endanger the life of the mother and or child(ren). Besides tests and consultations indicated under a Normal Pregnancy and Childbirth benefit definition, the Complicated Pregnancy and Childbirth benefit includes other Medically Necessary

consultations, tests, and Treatments prescribed by the Doctor in connection with the Complicated Pregnancy and Childbirth, and also covers the associated expenses for Local Road Ambulance Services. However, if under insured mother's Certificate diabetes and diabetes-related diseases are expressly excluded, then no Treatment for diabetes during Pregnancy shall be covered by this insurance, and no associated expenses shall be reimbursed.

Congenital/hereditary diseases mean any hereditary disease, congenital disorder, physical abnormality and/or any deviation from normal development occurred since birth, or a medical condition acquired during fetal development, regardless of whether it was diagnosed at the time. For insurance purposes it does not matter whether Congenital disease is due to heredity or environment. If the **Congenital/hereditary diseases benefit is indicated as covered by the applicable Schedule of Benefits,** it is available if all of the following conditions are met:

- the mother was covered under her Contract for maternity:
- the child was born when such maternity cover was valid;
- within the first 30 days after the birth the child was also enrolled in the Contract; additional Insurance Premium quoted by the Coverholder was fully paid for his/her insurance under the Contract.

Controller means the natural or legal person, public authority, agency or other body which, alone or jointly with others, determines the purposes ("why?") and means ("How?") of the processing of Personal data.

Cooling off period means the first 30 calendar days from the Insurance Start Date, during which the Policyholder is entitled to terminate the Contract and to claim back the Insurance Premium paid, provided that no Insured Person received any Medical Treatment or assistance covered by this Contract during the above-mentioned period of time. The Cooling off period is not applied in respect of prolongation/renewal of the Contract.

Co-payment means a percentage of the cost of a Medical Treatment/good/service insured under the Contract, which the Insured Person must pay himself/herself (and for which the Insurer is not liable).

Country of residence means the country declared in the application for insurance as the country that will be the Insured Person's primary residence for the whole duration the Insurance Period; this information is shown on the relevant Certificate (in its main body). The Policyholder and the Insured Person are obliged to inform the Coverholder about any long-term (for more than 3 months) or permanent moving out of the Insured Person from the Country of residence, following the procedure as set further in this Policy.

Coverholder means the company **dhig GmbH** (contact details as indicated in the introduction of this Policy), which has been duly appointed by the Insurer to conclude and implement all the Contracts for and on behalf of the Insurer, including (but not limiting to) the following: collection of applications for insurance, Underwriting, issue of offers for insurance, issue and signing of Certificates, Special Individual Certificates and other documentation of the Contract, Insurance Premiums collection, subsequent Contract administration and Claims handling.

Dangerous Sports include windsurfing; surfing; diving (at depth up to 20 m); water skiing, riding scooters, motor bikes and motorcycles; jet skiing (aqua bikes); riding quadracycles, snowmobiles; parasailing; yachting; track mountain skiing and snowboarding.

Day-Care Treatment (Day-Patient Treatment) means Treatment in a Hospital, for which the patient does not have to stay overnight.

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

Deductible means the first amount of every cost of a Treatment/good/service insured under the Contract, which the Insured Person must pay himself/herself (and for which the Insurer is not liable).

Dental Basic Restorative Treatment means the following manipulations, subject to limitations envisaged by the Contract: relief of pain, X-Rays, filling/tooth decay Treatment, including tooth decay implications

(pulpitis, periodontitis), extraction and root canal therapy, Surgery to remove a complicated, buried or impacted tooth, for example in the case of an impacted wisdom tooth, or to treat irreversible bone disease involving the jaw(s) that cannot be treated in any other way, but not if it is related to gum disease or tooth disease or damage.

Dental Major Restorative Treatment includes the following manipulations, subject to limitations envisaged by the Contract: Treatment of gums, restoration of the function of dental prostheses and the installation of new prostheses, crowns, bridges and pivot teeth, as well as related Surgeries and Treatments.

Dental Orthodontic Treatment is available for insured Dependents up to the age of 18 years.

Dental Preventive & Diagnostic Treatment means the following manipulations, subject to limitations envisaged by the Contract: oral exams, routine cleanings, X-Rays, fluoride application, sealants and space maintainers (nonorthodontic).

Dental Treatment following an Accident means the Treatment required to restore or replace the Insured Person's sound natural teeth lost or damaged in an Accident, which takes place within 90 days as of this Accident date. Damage to teeth caused by biting or chewing is excluded from this definition.

Dentist (Dental Surgeon) means a person officially qualified and licensed to practice dentistry in the country where the Treatment is received.

Dependent means a Spouse or a partner of a Primary Insured Person, and also the latter's (un)married child (including stepchild, foster child, and legally adopted child) provided that the child is not more than 18 years old as on the date of entry into force of his/her insurance cover under the Contract or Anniversary Date (or up to age 24 if there is proof that the child is continuing in full-time education).

Disability means as partial or full loss of ability to work or to live normally, as confirmed by a qualified expert or by a specialized organization in relevant country, as a consequence of body Injury or health disorder, caused by an Accident or an Illness.

Doctor (Physician, Therapist) means a person, who graduated from a medical school, passed state attestation and who is legally practicing in the Hospital. Medical Treatment/goods/service (including but not limited to Hospitalization and Out-patient Care) are eligible (i.e. covered by this insurance) only if they are executed/provided at/by Doctors/Specialists in the Hospitals.

Experimental Treatment means a Medical Treatment, procedure, therapeutic course, equipment, medical device or a pharmaceutical product for medical or surgical use, which are at the study, trial, testing stage, or at any stage of experimental works under clinical conditions, and/or are not recognized yet by various scientific organizations or by the international medical society or by competent authorities, as duly tested, sufficiently safe, efficient, or suitable for Treatment of diseases or Injuries.

Extreme Sports mean activities that are commonly recognized as highly dangerous for life and health and include (but are not limited to), for example, sky jumping, gliding, mountain skiing, or snowboarding outside special tracks, speleology and rope jumping, sandboarding; diving at depth more than 20 m; wakeboarding; flyboarding; hang-gliding; para-gliding; kite-surfing; kayaking (rafting in a small one-seat vessel, i.e. a kayak); canyoning; zorbing; bucking; base-jumping; skateboarding; mountain bike (mountain descent on a special bike); Bison-Track-Show (tractor race); rope jumping (using a special safety rope from high objects); roofing (ascend to hard-to-reach and dangerous roofs and spires of high buildings without safety arrangements); mountaineering; stunt riding; trial; train surfing; free boarding; rollerblading; stunting or crossing using special bikes; participation in regattas; motor racing, automobile racing or any other racing.

Family Doctor or GP (General Practitioner) means a Doctor providing Medical Treatment not requiring a Specialist's training.

Grace Period means the number of days, starting from the date when the Insurance Premium or any installment thereof (should the Insurance Premium be agreed to pay on semi-annual, quarterly or monthly

basis) becomes due from the Policyholder, during which the Policyholder must pay the Insurance Premium. The Grace Period (if applicable) shall be indicated in the main body of the Certificate or in the Special Individual Certificate. Should the Policyholder be late to pay the Insurance Premium or any part thereof, the Coverholder reserves the right to postpone settlement of Claims under the Contract until the Policyholder pays all the amount due, and/or to terminate the Contract as expanded on further in this Policy.

HIV/AIDS benefit means the cost of Treatment arising from, or related to, Human Immunodeficiency Virus (HIV and/ or HIV-related Illness), including Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC). If the Insured Person is HIV positive, then the benefit limit established by the Schedule of Benefits for HIV/AIDS shall also apply (on a combined basis) to the Treatment of the following conditions: candidiasis (thrush), cervical cancer, CMN (cytomegalovirus), cryptococcal meningitis, cryptosporidiosis, HIV-associated brain impairment, Kaposi's sarcoma, lymphoma, mycobacterium avium intracellular, pneumonia including PCP (pneumocystis pneumonia), thrombocytopenia, toxoplasmosis, and tuberculosis.

Home Country means the country for which the Insured Person holds a current passport. Where the Insured Person holds more than one passport, the Home Country will be taken to mean the nationality that has been declared in the insurance application. For the purposes of the Contract, the Dependents will be deemed to have the same Home Country as the Primary Insured Person, irrespective of their nationality.

Hormone Replacement Therapy means consultations and Prescription Drugs, patches or implants for the sole purpose of treating a hormone imbalance medical condition, except the symptoms of menopause.

Hospital (In-patient Clinic) means a medical facility, which is legally allowed to carry out Medical Treatment of diseases or bodily Injuries, has necessary equipment, material/technological means, and professional employees to establish diagnosis and perform surgeries, give patients continuous Treatment, monitoring and care, and where Doctors and medical personnel stay for 24 hours a day, and which belongs to the ACIBADEM chain in Turkey. For the avoidance of doubts, any in-patient facilities and wards, whose main activities are those of a spa, hydro clinic, sanatorium, nursing home, home for the aged or places where alcoholism and drugs dependence is treated, shall be excluded from this definition of the Hospital and the Insured Person's stay and Treatment therein shall not be covered by this insurance.

Hospitalization (In-patient Treatment) means admission of an Insured Person to a Hospital for Treatment to stay overnight or longer due to therapeutic conditions.

Hospitalization Daily Allowance is a cash benefit payable to the Insured Person as an alternative to reimbursement of Hospitalization costs. The benefit of Hospitalization Daily Allowance (if indicated as covered by the Schedule of Benefits) is available if In-patient accommodation and Treatment are provided by a Hospital at no charge for both the Insured Person and for the Assistance Service, the Coverholder, or the Insurer.

Illness (sickness, disease) means any disorder of the normal well-being of an organism due to functional and/or morphological changes diagnosed and confirmed by a Doctor. Illness shall include all Injuries and consequences associated with one diagnosis, as well as all diseases due to one cause or associated causes. If a disease is due to the same cause, which led to the previous disease or a cause associated therewith, then such Illness is regarded to be the progression of the previous disease, not a separate disease.

Infertility Treatment means the Treatment of infertility, surgical or in vitro fertilization (IVF) procedures and all investigative procedures necessary to establish the cause(s) of infertility (e.g. hysterosalpingography, laparoscopy, hysteroscopy).

Injury means bodily Injury caused by an Accident.

Insurance Expiry Date means the day when the insurance cover under the Contract ends. Insurance Expiry Date shall be indicated in the main body of the Certificate. Should at any time during the Insurance Period

an Insured Person be excluded from the coverage under the Contract, then the insurance cover in respect of such excluded Insured Person will end on the date as agreed between the parties thereto.

Insurance Period is a period of time shown in the main body of the Certificate between the Insurance Start Date and Insurance Expiry Date, when the insurance cover is in force, unless it is cancelled by the Policyholder or by the Coverholder prior to the Insurance Expiry Date. Benefits occurred/received out of the Insurance Period are not covered by the insurance under the Contract. Should at any time during the Insurance Period as set in the main body of the Certificate (after the Insurance Start Date as indicated in the main body of the Certificate) a new Insured Person(s) be included into the coverage under the Contract, then the Insurance Period in respect of such newly included Insured Person will start from the date of the beginning of the coverage of this person under the Contract (as indicated in respective Special Individual Certificate) and will end at the Insurance Expiry Date as set in the Certificate, based on which the said Special Individual Certificate was issued.

Insurance Premium means a payment for insurance under the Contract due to be made by the Policyholder in the manner and within the time period as set in the Contract. Under group insurance Contracts, Insurance Premium rates may be established.

Insurance Start Date means the day as specified in the main body of the first Certificate, when the insurance cover under the Contract goes into effect (subject to general and special conditions as set herein and elsewhere in the Contract).

Insured Person means a natural person for the benefit of whom the Policyholder entered into the Contract. When a natural person enters into a Contract for own benefit, he/she acquires the rights and obligations of the Policyholder and those of the Insured Person.

Insurer means duly licensed insurance organization indicated in the main body of the Certificate, who ultimately carries the insurance risk under the Contract.

Intensive Care Unit means a section or ward within a Hospital that is designated as an intensive care unit, is maintained on a 24-hour basis solely for the Treatment of patients in critical condition, and is equipped to provide special nursing and medical services not available elsewhere in the Hospital.

Kidney Dialysis (renal insufficiency) means absolute renal failure, represented by chronic irreversible renal insufficiency for both (or single) kidneys, thus, requiring hemodialysis. If the Kidney Dialysis benefit is covered by the special conditions to the Certificate, it means that the expenses for the hemodialysis shall be reimbursed under the Contract, if it is carried out in a Hospital. No accommodation outside a Provider and transportation costs shall be reimbursed.

Lifetime Limit means the limit that applies for the full period when a person remained insured under the Contract, irrespective of the number of times the Contract is extended/renewed.

Local national means a natural person, whose Country of residence is the same as his/her Home Country.

Local Road Ambulance Service means the costs for medically required first aid to the Insured Person given by the doctor of the Local Road Ambulance Service, and the Insured Person's transportation to the Hospital for Medical Emergency or in-patient care, if necessary Medical Treatment by opinion of the Local Road Ambulance Service doctor can be secured only in a Hospital.

Medical Consultant means a doctor appointed by the Coverholder to evaluate the state of health of the Insured Person or of the person submitted for insurance.

Medical Emergency means a sudden or unexpected onset of a condition requiring medical or surgical care, which the Insured Person receives after the onset of such condition (or as soon thereafter as care can be made available, but in any case, not later than 24 hours after the onset), if in the absence of said care a person would die or be expected to suffer serious bodily Injury or major health deterioration.

Medical History Disregarded (MHD) means the Coverholder's acceptance to insure a person without requesting him/her to disclose previous medical history and Pre-Existing Medical Conditions, and without

any moratorium on covering Pre-Existing Medical Conditions. MHD is only available for groups contacting at least 20 Primary Insured Persons, unless otherwise expressly agreed upon between the Coverholder and the Policyholder.

Medically Necessary means medical service, medication, products, and means of medical aid rendering that meet all the criteria below:

a. according to the prevailing opinion, stated in the medical literature, are safe and effective to treat or diagnose a condition or a disease under consideration, in respect of which those are suggested to be rendered/used, or the safest (or having minimum side effects) in the case of Treatment of a life-threatening condition or a disease in clinical and experimental conditions;
b. in terms of type, regularity and duration of Treatment, consistent with scientifically justified norms and regulations of medical organizations, research organizations or health care organizations or state institutions, and
c. most acceptable from the medical point of view of circumstances for rendering such medical services, considering also service cost and quality, and
d. required due to the reasons other than to enrich the Insured Person or to bring any benefit to his/her Doctor.

Medical Treatment (Treatment) means a set of Medically Necessary manipulations undertaken by a Doctor, including medical services, organizational and technical measures, provision of medication and medical products, aimed at satisfying the Insured Person's need to recover from a disease or an Injury, or to establish a diagnosis, or to maintain his/her state of health. The Treatment also includes Medically Necessary manipulations, services, measures, medication and products undertaken/delivered in connection with maternity and delivery.

Midwifery means a Treatment provided by a legally licensed midwife. **A midwife** is a person who, having been regularly admitted to a Midwifery educational program that is duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in Midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice Midwifery.

Newborn means a baby who is within the first 30 calendar days of his/her life following birth.

Newborn Care means Medical Treatment received by a Newborn within the first 14 days from the date of birth. The relevant expenses shall be reimbursed from his/her Insured mother's Contract, provided that her Pregnancy is covered by the Contract.

Normal Pregnancy and Childbirth benefit means reimbursement of expenses for Treatment costs relating to prenatal and post-natal care and childbirth of the Insured mother and her Newborn in the first 14 days of his/her life, where no special obstetric procedure is required. Prenatal care includes triple/quad test, amniocentesis, DNA analysis for women age 35 and above, no more than 3 routine prenatal ultra-sound unless medically required, no more than 12 routine prenatal check-ups (covering for example nuchal translucency test, dating scan and blood tests, scans for abnormalities, medication to prevent complications of Pregnancy, for example blood thinning, anti-D injections) unless Medically Necessary, and consultations with a midwife. Costs of antenatal classes, parenting or other teaching classes, 4D or 5D scans, and mother massages are not covered by this insurance.

Nuclear, Chemical, Biological Terrorism means the use of any nuclear weapon or device or the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous Chemical agent and/or Biological agent during the period of this insurance by any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious or ideological purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.

> **Chemical agent** shall mean any compound which, when suitably disseminated, produces incapacitating, damaging or lethal effects on people, animals, plants, or material property.

Biological agent shall mean any pathogenic (disease producing) microorganism(s) and/or biologically produced toxin(s) (including genetically modified organisms and chemically synthesized toxins) that cause Illness and/or death in humans, animals, or plants.

Nursing at Home means medical services of a duly qualified nurse in the Insured Person's home (excluding home help) when prescribed by his/her Doctor and related directly to an Illness, Injury, or medical condition for which the Insured Person has received and is receiving Treatment immediately after or instead of In-patient or day-care Treatment. This benefit may be available only if pre-authorized by the Assistance Service.

Oncological disease (oncology) means a cancer or a malignant tumor of any nature, including Hodgkin disease and includes also a non-invasive cancer (in situ).

Out-patient Care (Out-patient Treatment) means Medical Treatment provided to the Insured Person by the Hospital, when he/she is not a registered in this Hospital, and includes services provided by or ordered by a Doctor who is licensed as a General Practitioner, a Specialist, or a Medical Consultant, laboratory testing, and radiographic and nuclear medicine procedures used to diagnose and treat medical conditions.

Out-patient Surgery means a Surgery carried out as Out-patient Treatment or at a Surgery room within one day, and the patient is discharged from the Hospital on the same day without the need to stay overnight.

Palliative Treatment of terminal Illness & hospice care means costs of accommodation, nursing care by a qualified nurse and Prescription Drugs and dressings provided to in a registered hospice or Hospital in case of a terminal prognosis, given on the advice of a Doctor for the purpose of offering temporary relief of symptoms.

Personal data means any information relating to an identified or identifiable natural person ("**data subject**"); an identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier, or one or more factors specific to the physical, physiological, genetic, mental, economic, cultural, or social identity of that natural person.

Physiotherapy means a Treatment provided by a licensed physiotherapist in the Hospital and ordered by the treating Doctor.

Policyholder means a natural person who, or a legal entity that entered into a Contract on the terms and conditions provided for herein and elsewhere in the Contract. Legal entities registered in Bermuda or natural persons residing in Bermuda cannot conclude Contracts with the Insurer and cannot become Policyholders under this Policy.

Pre-Existing Medical Conditions mean any known medical condition (or related condition) of the Insured Person that, within a 2-year period immediately prior to the Insurance Start Date/start of the initial cover of this Insured Person under the Contract (when the very first insurance cover under the Contract in respect of the Insured Persons begins after the Insurance Start Date), had/has had one or more of the following characteristics:

- it has been diagnosed;
- it has needed Medical Treatment (including drugs that can be purchased without a prescription, special diets, injections, or other procedures or investigations);
- medical advice has been sought including routine medical examinations and check-ups;
- medical advice should have been sought if recognized clinical advice had been followed;
- it has undiagnosed symptoms, whether recognized or not.

Pregnancy means a period of time from the date of conception until delivery.

Prescription Drugs (Drugs) mean medicines necessary to treat a confirmed medical diagnosis or medical condition as prescribed by a Doctor, except for "over-the-counter" medicines like Aspirin, vitamins, cold

remedies (for nose relief, cold and flu), homeopathic drugs and herbs, lifestyle products, vitamins, food additives, dietary products, and any experimental drugs, even if prescribed by a Doctor.

A Doctor's prescription (recipes) for a Drug should contain the following details:

- Doctor's First and Family Name or Out-Patient Clinic name, address and phone number;
- Prescription date;
- Patient's full name, age;
- Drug name or instruction for its production (finished pharmaceutical product or indication to pharmacy to make it extemporaneously);
- Prescription deadline (indicated by the Doctor). If the prescription deadline is not specified or not established by applicable local regulations, then it will be deemed that the prescription is valid for 1 month from the prescription date;
- Doctor's signature;
- Personal Doctor seal (if available);
- Pharmacy/Drug Provider seal (if available).

Preventive Care means Well Child Care, Adult Health Screening (Check-up), and Vaccination as these terms are defined herein.

Primary Insured Person means the following, depending on who is the Policyholder:

- if a legal entity is the Policyholder and it insures its employee and his/her Dependents (if insured), then the employee is the Primary Insured Person;
- if an association of individuals insures its member and his/her Dependents (if insured), then the member of the association is the Primary Insured Person;
- if a natural person insures himself/herself, then he/she is the Primary Insured Person;
- if a natural person insures his/her relatives or family members but not himself, then he/she may select an adult (18 years old or older person) who will be the Primary Insured Person.

Processing means any operation or set of operations performed on Personal data or on sets of Personal data, whether or not by automated means, such as collection, recording, organization, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure, or destruction.

Processor means a natural or legal person, public authority, agency or other body which processes Personal data on behalf of the Controller.

Professional Sports means any sports activities (except for chess and checkers), if aimed at receiving remuneration or salary, or achievement of officially recognized sports results as a rank, rating, title, etc., at official national sport contests or official international sports contests. This includes preparations for sport contests and relevant sports training. Professional Sports also include any kind of competition with motor vehicles.

Prosthetic Device (Prosthesis) means a device replacing the whole organ or a part thereof, or replacing fully or partially an invalid or poorly functioning part of a body.

> **Internal Prosthetic Devices and aids** include implanted internal Prosthesis (such as pacemakers and hip joints, breast Prosthesis for cancer patients), and internally implanted devices and aids (such as surgical mesh, stents, bone cement, implanted nuts, bolts, screws, and rods). For Internal Prosthetic Devices and aids to be covered by this insurance, they must be prescribed by a Physician, pre-authorized by the Assistance Service, and inserted during the Surgery, which is covered by this insurance. Prosthetic Devices and aids related to sexual dysfunction are not covered by this insurance.
>
> **External Prosthetic Devices and aids** include those used or installed as a necessary part of Treatment immediately after Surgery, as well as a part of the recovery process. The External Prosthetic Devices and aids benefit (if indicated as covered by the Schedule of Benefits) includes

all the costs associated with the procedure, including any therapy related to the usage of the new limb. Special high-performance Prosthesis for sports or improvement of sports performance will not be covered by this insurance.

Provider means a Doctor duly licensed for Out-patient Medical Treatments and consultations in the Hospital, or a Hospital, or an establishment providing transportation services, a funeral bureau, a translation bureau, or another service Provider, which (acting in compliance with the local legislation) provides other services for the Insured Person, or which is appointed by the Coverholder or by its contractors/subcontractors for the purpose of organizing Treatment and other services or reimbursement of relevant expenses, with due regard of the Schedule of Benefits envisaged by the Certificate.

Psychiatric Illness means a mental or nervous disorder that meets the criteria for classification under an international classification system such as **Diagnostic and Statistical Manual of Mental Disorders (DSM)** or **the International Classification of Diseases (ICD)**. The disorder must be associated with present distress, or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The aforementioned condition must be clinically significant and not merely an expected response to a particular event such as bereavement, relationship or academic problems, or acculturation.

Reconstructive Surgery means a surgical procedure(s) which is required to restore appearance/function of the Insured Person's body following an Accident or Illness/Injury. For the Reconstructive Surgery to be covered by this insurance, all the following conditions should be met:

a) the original Accident or Illness/Injury must occur after the Insurance Start Date (and in case when the insurance cover of an Insured Person enters into effect after the Insurance Start Date, then the original Accident/Illness/Injury of such Insured Person must occur after such date of entry into force of the cover of this Insured Person) and be covered by this insurance, and

b) the Reconstructive Surgery itself must take place within 24 months since the original Accident or Illness/Injury, and

c) the date of Reconstructive Surgery must be within the Insurance Period.

Rehabilitation means an In-patient or Out-patient Treatment as prescribed by a Physiotherapist with the purpose to restore health and mobility after an Accident, Injury, or Illness to a state in which the patient can be self-sufficient.

Reinsurer means a duly licensed insurance or reinsurance organization, with which the Insurer has concluded an agreement on reinsurance of risks under the Contract.

Related (Incidental) Medical Condition means any disease, bodily Injury, or health deterioration, including psychic disorder caused by a Pre-Existing Medical Condition or occurring due to the same underlying cause as the Pre-Existing Medical Condition.

Renewal offer means the offer made by the Coverholder to the Policyholder prior to the Insurance Expiry Date regarding the Schedule of Benefits and other general and special conditions available to the Policyholder if the latter wishes to continue insurance coverage.

Repatriation or Burial locally benefit means that if the Insured Person dies out of his/her Home Country or the Country of residence, his/her legal representative has the right to request either the Insured Person's dead body to be transported to his/her Home Country or the Country of residence, or to be buried locally or cremated, and all relevant arrangements and expenses shall be paid under the Contract.

This benefit is not available to persons who were aged 65 or over as on the Insurance Start Date/the start date of their initial cover under the Contract (when the very first insurance cover under the Contract in respect of them begins after the Insurance Start Date).

Restorative speech therapy benefit means that the expenses for out-patient consultations, sessions and lessons by a speech Therapist to restore speech skills lost as a result of an Accident or a disease, can be claimed for reimbursement under the Contract, if a Treatment of the Accident-related Injury or the related

disease is covered by the Contract and the appointment of the speech Therapist is prescribed by the Insured Person's treating Doctor.

Semi-private Room means the room in a Hospital that is made for dual occupancy accommodation with corresponding Treatment rates and charges.

Simplified Underwriting means a situation when the Insured Person is released from obligation to disclose to the Insurer any Pre-Existing Medical Condition, and the Insurer respectively is released from obligation to pay any Claim caused or anyhow related to any Pre-Existing Medical Condition.

Special Individual Certificate is a document issued by the Coverholder for an Insured Person, in confirmation or clarification of this Insured Person's insurance conditions under the Certificate providing insurance to a group of individuals (for example, employees of a company, where the employer is the Policyholder, or members of an association, where the association is the Policyholder, etc.). The Special Individual Certificate should be read in conjunction with the Certificate. The Special Individual Certificate constitutes an inseparable part of the Certificate, however, it may also foresee special insurance conditions to be applicable in respect of the Insured Person indicated in such Special Individual Certificate, that are different to insurance conditions of other persons insured under the Certificate.

Specialist means a Doctor having a specialized qualification in the field of, or expertise in, the Treatment of Illness or Injury being treated.

Spouse means a person recognized as a Spouse by applicable law.

Standard-private Room means the lowest rate (regular) private room with one bed available in a Hospital.

Sum Insured means the combined limit of Benefit amounts, which can be claimed under the Contract from the Insurer within one Insurance Period in connection with a single Insured Person, unless an Aggregate or Individual Limit per event is applicable.

Surgery means a set of exposure on human tissues or organs an Insured Person undergoes due to therapeutic indications and carried out by a qualified Doctor in accordance with the generally accepted standards in the Surgery Unit (Surgery Room) of a Hospital, in order to treat, diagnose, improve organism's functions, using various methods of tissue separation, removal, and adnation.

Terrorist Attack means use of force or violence and/or a threat of such use by any person or groups (group) of persons acting independently or on behalf of any organization (organizations) or governments (government) or in connection therewith, pursuing political, religious, ideological or similar purposes, including an intention to influence government and/or frighten population or a part thereof; or use of biological, chemical, radioactive or nuclear substance, material, means, or weapon.

Transplantation of kidney, heart, heart-lung, liver, bone marrow, and stem cell Treatment (both autologous and donor-provided) means transplantation Surgery where the Insured Person is the recipient. Expenses relating to the acquisition of transplant materials and donor's expenses are not covered by this insurance. Transplantation/stem cell Treatment must be carried out in internationally accredited institutions by duly qualified surgeons and the organ acquisition to be made in accordance with WHO guidelines.

Transportation For Treatment Assistance If Medically Necessary benefit means that in medical conditions when a Doctor decides that it is Medically Necessary for the Insured Person to be accompanied by a doctor or by a nurse during his/her trip from the Country of Residence to the ACIBADEM chain Hospital for a Treatment or back home to the Country of Residence from a Treatment, the costs of such medical escort as well as regular flight ticket and local road ambulance shall be covered by the insurance, up to the limit indicated in the respective Schedule of Benefits. This Transportation For Treatment Assistance If Medically Necessary benefit is subject to pre-authorization in accordance with paragraph 5.4 of this Policy.

Underwriter means a duly qualified or licensed individual or a legal entity, engaged by the Coverholder to execute medical and financial Underwriting of an application for this insurance.

Underwriting means the process of evaluating medical and financial risk related to providing insurance in respect of specific persons applying for insurance (persons to be insured), deciding on the acceptance or refusal to accept these risks, deciding on specific coverage to be provided to persons to be insured, and deciding on Insurance Premium due and on other insurance conditions.

Usual, Customary, and Reasonable (UCR) expenses or charges mean expenses for consulting a Doctor, medical manipulations, services, Drugs, products and medical service, which are most likely to be incurred if medical services of similar complexity is demanded from other Doctors, Hospitals, or Out-patient medical facilities of the same category (class) in the same or adjacent region or throughout the country, also with due regard of generally accepted or recommended by authorized bodies/organizations methods, plans, or Treatment of relevant disease, Surgery, or procedure, as well as average prices if available in relevant countries. In countries with recommended medical services price lists or where publicly available statistics of medical services cost is kept, the term "**Usual, Customary, and Reasonable**" expenses assumes consideration of price lists data and statistical data. If a usual, customary, and reasonable level cannot be determined because of the unusual nature of the service or supply, the Assistance Service will on behalf of the Coverholder determine to what extent the charge is reasonable, taking into account the complexity involved, the degree of professional skill required, and all other pertinent factors.

Vaccination means Medically Necessary Vaccination according to medical indications and recommendations of a Physician, or under mandatory state vaccination standards in the Country of residence or voluntarily, including when Vaccination is carried out to obtain a permission to enter another country (from official authorities of such country). Child Vaccination includes: Diphtheria, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella, Hemophilus Influenza B, and Hepatitis, as well as other Medically Necessary Pediatric Vaccinations.

Waiting Period means the period during which no Treatment, goods and services shall be paid for, and no reimbursement shall be made under Benefits, as specified in the Schedule of Benefits and/or elsewhere in the Certificate. If the Waiting Period remained unexpired at the Contract renewal date, then only the unexpired part of the Waiting Period is applicable to the new Insurance Period.

Well Child Care includes medical checks and tests established by the applicable national standards for children from birth to the age of 18, for the monitoring and evaluation of normal physical and mental development. Among other things, these checks and tests may include blood tests, height and weight measurements, urinalysis, check of senses, neurologist examination, detection of hereditary and metabolic diseases, urinalysis, tuberculin samples, determination of hematocrit, hemoglobin and other blood tests, including tests for hereditary forms of hemoglobinopathies.

2. ENTERING INTO THE INSURANCE CONTRACT

2.1. This insurance is designed for natural persons who would like secure access to the Medical Treatment and other services within Hospitals belonging to the ACIBADEM chain in Turkey, in case of Illness or body Injury.

2.2. This insurance is not available:

a) for the USA and Caribbean nationals who are residents in their Home Countries, unless otherwise is expressly accepted by the Coverholder;

b) for persons or in countries where it would breach any sanction, prohibition, or restriction imposed by law or regulation;

c) for certain occupations listed in paragraph 7.4 "Excluded Occupations".

2.3. Unless otherwise expressly accepted by the Coverholder, the maximum age for a person to be insured under a Contract for the first time in his/her life is **60**. Then the insurance can be renewed for life — via concluding 1-year term Contracts with no break between their terms.

2.4. A natural person may apply for this insurance to cover himself/herself and/or his/her Dependents.

2.5. An employer or a legal entity can apply for this insurance to cover its employees/members and their Dependents. A Policyholder's employee can be insured, if he/she is Actively-at-Work as of the day of the Policyholder's request or application for insurance is received by the Coverholder, unless this condition is expressly waived in the Certificate / Special Individual Certificate.

2.6. Children are eligible for cover under this insurance not earlier than upon expiry of the first 90 calendar days of the child's life.

2.7. If the applicant or a person to be insured is recognized by law as a public person/politically exposed person, he/she must declare this during application for insurance and may be requested to complete a special declaration (form).

2.8. Applications for this insurance can be made online using the Coverholder's internet site.

2.9. Persons eligible for this insurance are subject to Simplified underwriting, however, the Coverholder reserves the right to request completion of its application forms / questionnaires by the applicants (Policyholders) and/or by the persons submitted for insurance (persons to be insured). Based on received information, the Coverholder makes Underwriting, issues a proposal for the insurance, etc.

2.10. The Policyholder is not obliged to inform the Coverholder about Pre-Existing Medical Condition of an Insured Person, however, **persons, who at the moment of applying for this insurance, are having or had previously ever suffered any Pre-Existing Medical Condition mentioned below, cannot be covered under this insurance**:

a. Oncological disease, diagnosed at the time of application for insurance or suffered within 5 years immediately preceding that time;
b. any kind of brain tumor or cerebral cyst and other intracranial structures, skull bones, sinuses, or spinal cord cist;
c. diagnosed leukemia or any blood disease (e. g. anemia, lymphoma, myeloma, coagulation failure, hemophilia, or blood vessel disorder;
d. diagnosed at the time of application for insurance or suffered within 5 years immediately preceding that time heart diseases (for instance stenocardia), cardiosclerosis, cardiomyopathy, myocardial infarction or other heart attack, heart valves diseases (including cardiac defects), heart murmur, or rheumatism;
e. diseases classified as congenital abnormalities, deformations and chromosome disorders, and (or) complications associated thereto;
f. systemic damage of the connective tissue, including all non-differentiated collagen diseases;
g. diseases associated with chronic renal or liver insufficiency and requiring chronic hemodialysis;
h. state of obesity with body mass index above 37.0, or state of body mass deficit with body mass index below 18.5 (body mass index is calculated as a ratio between body weight (in kilograms) and the square of body height (in meters);
i. stroke or cerebral hemorrhage;
j. any diabetes form;
k. psychiatric Illness or behavior disorder;
l. tuberculosis;
m. chronic Hepatitis of B, C, E, F, or G forms;
n. disability;
o. AIDS/HIV;
p. amyotrophic lateral sclerosis (Charcot disease);
q. Alzheimer's disease;
r. aneurysm of any vessel;
s. ankylosing spondylitis;

t. autism;
u. cerebral paralysis;
v. cirrhosis of the liver;
w. fibrosis of the bladder;
x. Down's syndrome;
y. any disease of decompensated form (uncontrollable);
z. disorders associated with eating;
aa. hemochromatosis;
bb. any type of hemophilia;
cc. systemic lupus erythematosus;
dd. systemic atherosclerosis;
ee. myasthenia gravis;
ff. state after organ transplantation;
gg. Parkinson's disease;
hh. common polycystic kidney disease;
ii. polymyositis;
jj. Reiter's syndrome;
kk. sarcoidosis;
ll. schizophrenia;
mm. Von Willebrand disease;
nn. Wilson's disease.

2.11. The condition of paragraph 2.10 is essential for the purpose of Underwriting by the Coverholder. If after Insurance Start Date it is revealed that the Insured Person at the moment of applying for this insurance suffered, or had previously ever suffered from any Pre-Existing Medical Condition mentioned in paragraph 2.10, then the Insurance Contract in respect of this person is considered null and void, and the Coverholder shall refund the insurance premium in full.

2.12. Besides this Policy, the Certificate shall include:

a. Names of the Insurer, the Coverholder, and the Policyholder;
b. Reference to this Policy;
c. Country of residence;
d. the Schedule of Benefits and the List of Insured Persons;
e. Assistance Service and/or reference to the network of Providers (if applicable);
f. contact details (website, e-mails, etc.) for presenting the Claims and complaints (if presented directly to the Insurer);
g. Special conditions of insurance, if they are offered as a result of an assessment of the Insured Person health condition and other factors affecting the insurance risk;
h. the Insurance Premium, its payment currency and other payment related conditions;
i. the Insurance Start Date and the Insurance Expiry Date;
j. Applicable law and jurisdiction for handling disputes;
k. other conditions as agreed between the parties thereto.

2.13. The Contracts, attachments and addendums thereto, amendment or early termination thereof shall be made in writing or per e-mail and signed by the Policyholder/authorized representatives of the Policyholder and/or the Coverholder. If a Contract is issued via the internet, the Policyholder accepts that the image of the signature of the Coverholder’s authorized representative shall be recognized as if it was made in person.

2.14. The content of the Special Individual Certificate issued in connection with group insurance Certificates shall be agreed upon between the Policyholder and the Coverholder, and such Special Individual Certificate shall be signed by the Coverholder as follows: by the Coverholder’s authorized representative personally or by using the image of a signature of the Coverholder’s authorized representative.

2.15. All data provided by the person applying for insurance/Policyholder in writing / per e-mail / verbally with respect to the Contract shall be regarded as material for the purposes of Underwriting and execution of the Contract.

2.16. Upon signing of the Contract, the Coverholder's liability in respect of the Insured Person to settle Claims shall start from entry into force of the insurance cover under the Contract of this person, but not earlier than the day in which the Insurance Premium due is received at the Coverholder's bank account, unless otherwise is established in the Contract.

3. INSURANCE PREMIUM

3.1. The Coverholder shall determine the size of the Insurance Premium due, taking into account the following:

a. demanded Schedule of Benefits, Sums Insured, Individual and Aggregate Limits per event, Deductibles, Co-payments, Specific Exclusions, and other special insurance conditions, as well as expected level of the insurance risk (risk of utilization of the Benefits);

b. state of health of persons to be insured, based on the results of medical questionnaires and, if necessary, medical examination;

c. insurance intermediary's commission, if applicable;

d. total number of persons to be insured under the Contract, and their age, gender, occupation, Country of residence;

e. previous voluntary medical insurance claims experience, if available;

f. price level of the applicable network of Providers, if applicable, and their geography.

The Coverholder shall also have the right to establish the minimal and maximal amounts of the Insurance Premium.

3.2. To determine the Insurance Premium adequate to the expected insurance risk, the Coverholder shall have the right to rely on the opinion of Medical Consultants, the Assistance Service, Underwriters, or the Reinsurer(s).

3.3. Insurance Premium can be paid annually, semi-annually, quarterly, or monthly if agreed by the Coverholder. The specific amount, payment frequency and currency of the Insurance Premium shall be established in the main body of the Certificate. Insurance Premium shall be paid via wire transfers or by credit/debit card (Visa/MasterCard/American Express).

3.4. Unless otherwise is agreed between the parties to the Contract, the Grace Period of 30 calendar days shall apply, however, under a Contract where the Policyholder is a natural person or an individual entrepreneur, the Grace Period is nil for a single Insurance Premium or for the first installment of the Insurance Premium.

3.5. It is the Policyholder's liability under the Contract to ensure that the Insurance Premium is paid in full and in a timely manner complying with the terms determined by the Contract. Unless otherwise is specified in the Certificate or elsewhere in the Contract, the Policyholder's liability for payment of a due Insurance Premium shall be regarded as fulfilled, if the full amount due is received by the Coverholder. If not otherwise agreed between the parties in the Contract, bank transfer fees shall be borne by the payer.

3.6. If an Insurance Premium payment transaction is declined by the Policyholder’s card provider, the Coverholder will advise the Policyholder thereof in writing, by e-mail, or by telephone. The Policyholder must promptly contact his/her card provider to resolve the issue or provide another method of payment.

3.7. If the Insured Person’s Country of residence falls within an area where the Coverholder is required to collect Insurance Premium Tax (IPT) or local government tax, this will be charged in addition to the Insurance Premium due under the Contract. The Coverholder shall inform the Policyholder if the latter is required to pay Insurance Premium Tax prior to the first Insurance Premium payment due date.

3.8. Each time after expiry of the Insurance Period the Coverholder may change the way of calculation/determination of the Insurance Premium due, as well as the method of its payment. If so, the Policyholder shall be informed about this accordingly in accordance with provisions of Article 10 of this Policy.

4. SUMS INSURED AND LIMITS OF BENEFITS

4.1. The Contract shall be deemed to have been executed in full or fully executed in respect of a Benefit, when the sum of the expenses incurred for Treatment and related goods/service provided to the Insured Person during the Insurance Period reaches the relevant Sum Insured or the limit of Benefit indicated in the applicable Schedule of Benefits.

4.2. In addition to liability limitations foreseen in this Policy and elsewhere in the Contract, a Certificate may also contain Benefit limits with respect to a single Claim of a certain type or to all Claims of a certain type, over the whole Insurance Period or over a part of that term. Furthermore, the limit of the Insurer's liability may be provided by the Contract in a view of possible prolongation of the Contract (renewals) in respect to the Insured Person.

5. INSURED PERSONS' RIGHTS & DUTIES

5.1. The Insured Person must notify the Assistance Service by post, e-mail, or telephone about a Claim as soon as practicably possible after the start of the Treatment, even when the supporting documentation is not yet available. Furthermore, all the Claims under the Contract must be presented via e-mail and/or via internet portal as indicated in the Certificate.

5.2. If the Insured Person wants to apply for reimbursement of incurred expenses, he/she must provide a separate fully completed Claim form adopted by the Coverholder for each medical condition that has been signed by the treating Physician of the Hospital, and attach the full supporting documentation, original invoices, and receipts as soon as practicably possible. The Assistance Service/Coverholder reserves the right to reject reimbursement of any invoices/receipts received from the claimant that are more than 90 days old.

5.3. When the Insured Person receives a Treatment for a condition/Benefit covered by the Contract, he/she is eligible to Claim reimbursement of expenses/costs that fall in a period starting from the beginning of this Treatment until the Treatment ends, or until the expiry/termination of his/her Contract, whichever comes first.

5.4. Reimbursement of certain expenses incurred in certain circumstances can be claimed only if relevant Treatment or service has been pre-authorized by the Assistance Service. The Insured Person, his/her Doctor or the Insured Person's legal representative shall always be obliged to obtain **preliminary authorization** by the Assistance Service in any of the following situations:

a. Transportation For Treatment Assistance If Medically Necessary;
b. Hospitalization or Day-Care Treatment, or the undergoing of Day-Surgery;
c. any medical procedure, involving general anesthesia;
d. preoperative examination of the Insured Person;
e. Out-patient Treatment, if its cost will likely exceed the equivalent of 5 hundred EUR;
f. any medical condition for which Treatment cost will likely exceed the equivalent of 5 thousand EUR;
g. Treatment of an Oncological Disease;
h. Repatriation or Burial.

5.4.1. The Insured Person, his/her Doctor or legal representative shall complete Preliminary Authorization Form available from the Assistance Service, and do so at least 5 calendar days prior to the expected date of the applicable event requiring pre-authorization, except for cases of Medical Emergency admission to a Hospital. The Preliminary Authorization Form or the equivalent notice shall contain the following information:

a. diagnosis;
b. description of required Treatment;

c. name and address of the Hospital where the Insured Person is recommended by his/her Doctor to undergo the Treatment;
d. expected duration of Hospital stay;
e. expected costs of the Treatment.

5.4.2. If the above pre-authorization requirement is not fulfilled, the Assistance Service reserves the right to reduce the Benefit to the amount of Usual, Customary, and Reasonable expenses and charges for Treatment and assistance in normal circumstances, but not by more than 25 percent. However, if un-pre-authorized Treatment or service appears not Medically Necessary, then no reimbursement of relevant expenses can be claimed.

5.4.3. In case of Hospitalization in a situation of Medical Emergency, pre-authorization requirement can be replaced by post-authorization requirement, meaning that the Insured Person or Policyholder or their authorized representatives must inform the Assistance Service of such event (by phone, e-mail, or post with the notice of delivery) as soon as possible in given circumstances, but not later than 48 hours after the Insured Person's admission to the Hospital.

5.4.4. The Assistance Service may need to contact the Insured Person or his/her Doctor to obtain additional medical information as necessary to decide on pre-authorization. Should the Assistance Service decide to pre-authorize the requested Treatment/ provision of goods and/or services to the Insured Person, it will send to the Insured Person, or to the Doctor or the relevant Provider (as the case may be), a confirmation that the required Treatment/goods/services is (are) covered by the Contract. If necessary, the Assistance Service will issue a guarantee of payment to the Doctor/Provider; then, the latter will send the medical bills directly to the Assistance Service (with due regard of any Deductible or Co-payment, if applicable).

5.4.5. When contacting the Doctors/in case of direct settlements with the Doctors/Providers, the Assistance Service/the Coverholder would need to receive Personal data (including health-related Personal data) of the Insured Person directly from these Doctors/Providers. Therefore, this may only be done subject to explicit consent of the Insured Person/his (her) legal representative, unless applicable laws allow otherwise. In case of absence of such consent, the Assistance Service might not be able to get all the necessary information in order to decide on the requested direct settlement. Thus, the Assistance Service shall not be liable for the consequences related thereto. Should (due to the lack of the mentioned above consent) the Assistance Service be not able to settle directly, then the Insured Person shall execute payments directly and the Assistance Service will reimburse such incurred expenses subject to limitations, exclusions, Specific Exclusions, and other conditions as set in the Contract.

5.5. In circumstances not requiring pre-authorization, the Insured Person shall contact a Doctor / Hospital of the ACIBADEM chain for an appointment directly.

5.6. If the Insured Person has no indication whether possible costs of a desirable Out-patient Treatment or service might exceed the limit requiring pre-authorization, the Insured Person may apply to the Assistance Service with a request to issue a guarantee of payment, under which a Doctor or a Provider will receive payment for their services directly from the Assistance Service. In this case, it is preferable that the Insured Person's request is received at least 5 business days prior to the planned visit to a Doctor/admission to a Provider.

5.7. The Insured Person is also obliged:

a. to strictly follow the advice given by the ambulance team, procedures of In-patient or Day-patient Medical Treatment/Day-Surgery and to follow internal rules established by a relevant medical facility;

b. not to hand out his/her insurance card or Special Individual Certificate to other people who are not insured under the relevant Contract;

c. to cancel immediately (or as soon as possible in given circumstances) a Doctor's appointment or ambulance call if the Insured Person recognizes that it is no longer possible or necessary or desirable for him/her to use medical services from this relevant Doctor, Provider, or ambulance team;

d. to follow the Doctor's recommendations given during any kind of Out-patient Medical Treatment, health examination, or consultation;

e. to inform the Coverholder/the Assistance Service immediately (or as soon as possible in given circumstances) about being diagnosed of any Illness or being given any status from those indicated in paragraph 2.10 of this Policy;

f. to undergo additional medical examination and/or provide additional medical information, whatever is required by the Coverholder/Assistance Service, in the case that an Illness or a status indicated in paragraph 2.10 of this Policy is diagnosed/given to the Insured Person;

g. to timely pay amounts corresponding to the Deductibles and Co-payment, if any is envisaged by the Contract;

h. to timely advise the Policyholder and the Coverholder about a change of surname or address details;

i. duly execute other obligations as established elsewhere in the Contract.

5.8. If a Provider does not accept payments corresponding to the amounts of Co-payment or Deductible envisaged by the Insurance Contract, directly from the Insured Person, then the relevant amount can be paid to the Provider by the Coverholder, under condition that the Insured Person or the Policyholder shall be obliged to reimburse the Coverholder for such payment to the full extent (including but not limiting to the amounts transferred, as well as transfer costs and currency exchange related costs). The above reimbursement shall be due within 30 days since relevant payment request is sent by Coverholder (by post or by e-mail) to the Insured Person. In case of the Insured Person's failure to reimburse the above-mentioned expenses, the Coverholder shall invoice Policyholder accordingly. **The Policyholder shall be liable to pay all the debts of Insured Persons and Dependents (as covered by the Contract that the Policyholder is part to) in respect of the Coverholder**.

6. REIMBURSEMENTS TO INSURED PERSONS AND DIRECTS SETTLEMENTS TO PROVIDERS

6.1. The Insured Person's expenses, which can be claimed for reimbursement under the Contract, and the amounts that can be paid in respect of the Insured Person to the Providers, as well as the scope of services that can be requested under the Contract, shall not exceed those indicated in the Schedule of Benefits, and are subject to provisions, Specific Exclusions and general exclusions and special conditions established by the Contract.

6.2. The Coverholder can delegate processing, adjudication, and payment of Claims to the Assistance Service; therefore, solely for the purpose of Article 6 of the Policy, the Coverholder does also mean the Assistance Service.

6.3. Any reimbursement due from the Insurer under the Contract (including but not limiting to reimbursement of costs/expenses of Treatment/Surgery/consultation/monitoring (irrespective of the fact whether organized by the Assistance Service or the Insured Person his/herself)) shall not exceed the level of Usual, Customary, and Reasonable expenses and charges as defined in Article 1 "Definitions" of this Policy.

6.4. For the Coverholder to make a decision on reimbursement of expenses to the Insured Person/Provider, the Insured Person shall submit the following documents to the Coverholder (and

shall do so within **90 calendar days** since receipt of the Medical Treatment or since becoming physically able to submit the Claim):

a. completed Claim form provided by the Coverholder, including the consent to disclose the health-related Personal data of the Insured Person to the Coverholder, Assistance Service, Medical Consultant, Insurer, Reinsurer(s), and third parties appointed by the Coverholder to adjudicate and settle the Claim, for the purposes (and to the extent it is necessary for these purposes) related to the handling and settlement of the Claim, and to provide necessary assistance to the Insured Person as foreseen under the Contract. Failure to provide such consent shall prevent the Coverholder and parties mentioned in the previous sentence from being able to process health-related Personal data of the Insured Person; which, consequently, will preclude them from being able to provide necessary assistance and duly handle and settle the Claim. Therefore, should the Insured Person refuse to provide the herein discussed consent or should such consent be revoked, the Coverholder will be entitled to reject the Claim;

b. the Doctor's prescription for Medical Treatment as well as all pieces documenting the delivery of services to the Insured Person (an extract from the medical history, discharge summary, medical prescription, and other related documentation);

c. originals of paid invoices clearly indicating the Provider's name and address, the detailed list of services/goods provided, and their costs. In some jurisdictions, documents proving the legal ground for organization of relevant services for the Insured Person (e. g. service contracts) are required as well;

d. when a Benefit is associated with reimbursement of expenses incurred by the Insured Person for purchase of Prescribed Drugs and/or medical products that are covered under the Contract: a Doctor's prescription, as well as the original receipts of payment for these Prescribed Drugs and/or medical products.

e. when a Benefit is associated with reimbursement of expenses incurred by the Insured Person for Preventive Care: the documents confirming those examination being prescribed by the Family Doctor and/or Specialist's prescription;

f. in the case that the Insured Person's Medical Treatment is related to an Accidental body Injury, the Coverholder reserves the right to demand that the Insured Person provides detailed description of all the relevant circumstances of the Accident (including but not limiting to the date, place, persons involved, witnesses, persons possibly liable, etc.), and if registered by the police or other competent authorities, to demand a copy of their report.

6.4.1. The Insured Person shall be liable to retain all the originals of the Claim supporting documentation. The Coverholder reserves the right to request original supporting documentation (including receipts) of the Claim within up to 12 calendar months after settlement of this Claim, for auditing purposes. Should the Coverholder be liable to reimburse expenses paid directly by the Insured Person, the Coverholder reserves the right to request a proof of payment (e.g. bank statement, etc.) of claimed expenses.

6.4.2. Documents submitted in foreign language will be accepted by the Coverholder without translation. In the case of the submission of documents that cannot be read because of the handwriting or due to a damage of the document (torn, bent, erased, etc.), the Coverholder shall have the right to postpone making decision on this case until documents of proper quality have been submitted.

6.5. The Coverholder reserves the right to request information related to the received Claim from competent authorities and/or from third parties, which normally have or must have such information. The Coverholder shall also be entitled to consult Medical Consultants and Providers regarding the Claim. Furthermore, the Coverholder shall have the right to postpone settlement of the received Claim until it has received all the requested documents/information and/or an expertise.

6.6. The Coverholder may decide to settle the Claim without full delivery of the documents/information referred to in paragraphs 6.4 and 6.5 of this Policy, or to accept the copies of certain documents, if submitted (copies of) documents are clear and sufficient to understand the circumstances of the Claim and to eliminate any doubts regarding the Claim being eligible for reimbursement under the Contract.

6.7. Whenever deemed necessary for the assessment of a Claim, the Coverholder is allowed to request a medical examination of the Insured Person, performed by a Medical Consultant appointed by the Coverholder, at the Coverholder's expense. The Insured Person can ask for his/her own Doctor to be present at this examination (the costs for the Insured Person's own Doctor shall be borne by the Insured Person). The Coverholder shall have the right to postpone making decision on settlement of a Claim until results of the above-mentioned medical examination become available. Failure by the Insured Person to undergo the above medical examination allows the Coverholder to reject the Claim.

6.8. Within 10 business days from the date of receipt of all the documents and information as discussed in paragraphs 6.4 – 6.7 of this Policy, the Coverholder shall make a decision and pay the Claim (in part or in full, as the case may be) or send (in writing or per e-mail) a letter of rejection containing explanation/reasons for refusal. When an audit of invoices is carried out by the Insurer or by competent authorities to confirm their relevance to the Claim, the term of payment thereof may be increased to 90 calendar days, and the Coverholder shall notify the Insured Person about the invoice audit and a new term of settlement.

6.9. If a reimbursement is claimed for a Treatment received, and then another reimbursement is claimed for a new course of a Treatment, which is not in any way connected with the former Treatment, the subsequent Claim will be regarded as a new Claim.

6.10. Claims can be settled in any currency that the claimant chooses (providing that such currency can be freely purchased by the bank of the Coverholder or the Assistance Service) and not necessarily in the currency of the bills submitted or the currency of the Schedule of Benefits. On submission of a Claim, the claimant must provide full bank account details (including IBAN and SWIFT/BIC where required).

6.11. The Coverholder shall keep records of Claims paid in both the nominal currency of each claimed amount and of its equivalent in the currency of the Schedule of Benefits. Depending on the applicable law or customary business practice in the jurisdictions of the Providers and the Assistance Services, engaged in Claims' settlement, the applicable exchange rates are those valid on the dates of Claims processing, and include those available at www.oanda.com and/or those established by competent/regulatory authorities (e.g. Central Banks) and/or by the banks effecting payments.

6.12. For the purpose of recording of Benefits utilization and accounting under the Contract, the paid Claim value, besides the amount that the claimant (Provider or Insured Person or his/her legal representative) becomes eligible for, subject to respective Coverholder's decision made in accordance with the Contract, shall also include the following costs incurred by the Coverholder, provided that such costs are directly linked to and limited to the above amount:

a. wire transfer fees associated with the remittances, if taken by the bank;

b. exchange rate costs, associated with conversion of the equivalent of Benefit amount from the currency as set in the Schedule of Benefits into the currency of the bank account where the Benefit amount shall be paid in accordance with the claimant's instruction;

c. local intermediary fees and charges if, due to the peculiarities of local regulations, settlement of the Claim is only possible via engagement of a local intermediary.

6.13. The Insured Person has the right to request from the Assistance Service an explanation on handling/settlement of his/her Claim.

6.14. The Coverholder shall have the right to refuse arrangement of a Medical Treatment or a service/provision of goods and to refuse payment of invoices issued by Providers, and/or to refuse payment of Claims submitted by the Insured Person, if any of the following takes place:

a. the claimed Medical Treatment is subsequently proven to be not Medically Necessary; or

b. services rendered /goods provided to the Insured Person are not covered by the Contract; or

c. the aggregate (during the whole Insurance Period) amount of expenses paid by the Coverholder has reached the Sum Insured or the applicable limit specified in the Contract; or

d. the Insured Person applied for a Medical Treatment other goods/services covered by the Contract after expiration of the Insurance Period or before the Insurance Period commencement date; or

e. the Policyholder's obligation to pay Insurance Premium (or any installment thereof) remains unfulfilled by the end of the Grace Period; or

f. in the occurrence of any kind of fraud on the side of the Insured Person/Policyholder/their representatives; or

g. in other specific cases as set elsewhere in the Contract.

7. GENERAL EXCLUSIONS

7.1. If not otherwise expressly indicated in the Certificate, the following is not covered by this insurance and thus no Claim shall be paid by the Coverholder in connection with any of the following:

7.1.1. Medical Treatment, goods and services granted / provided to the Insured Person elsewhere but the Hospital belonging to the ACIBADEM chain in Turkey.

7.1.2. Medical Treatment, goods and services that are not indicated as covered in the Schedule of Benefits;

7.1.3. Medical Treatment, goods and services that are not Medically Necessary;

7.1.4. Any Pre-Existing Medical Condition;

Any Chronic Condition, even if first diagnosed after Insurance Start Date.

7.1.5. Active participation in war, riots, strikes, lockouts, civil commotion, rebellion, revolution, insurrection, terrorism, military coup (coup d'etat), or any illegal act, including resultant imprisonment;

7.1.6. Release of weapon(s) of mass destruction (nuclear, chemical, or biological) whether they involve(s) an explosive sequence(s) or not; epidemic or pandemic;

7.1.7. Injury or Illness while serving as a member of a police or military force or unit;

7.1.8. ionizing radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel;

7.1.9. the radioactive, toxic, explosive, or other hazardous properties of any explosive nuclear assembly or nuclear component thereof, radiation or radioactive contamination, chemical contamination;

7.1.10. military maneuvers, exercises, or weapon tests;

7.1.11. consciously exposing oneself to danger, voluntarily entering zones of risk announced by official authorities; or conscious failure to take available measures to ensure personal safety;

7.1.12. voluntary or intentional act or a deliberate crime committed by the Insured Person that led to his/her body Injury or Illness;

7.1.13. participation in a brawl, fight, or any kind of disturbance, and measures taken to combat them, except in the case of self-defense or if the Insured Person falls victim to the above-mentioned disturbances;

7.1.14. preparation of or participation in crimes or misdemeanors;

7.1.15. diagnostics or Treatment or Rehabilitation related to alcoholism, drug addiction, chemical abuse or intoxication as a result of taking alcohol or psychotropic, narcotic, or psychedelic substances, and all associated medical conditions;

7.1.16. health check-ups, inoculations, visits, and tests necessary for administrative purposes (e.g., determining employment, school- or sport-related physical examinations, etc.);

7.1.17. sleep studies and other Treatments relating to sleep apnea;

7.1.18. smoking cessation Treatments whether or not recommended by a Doctor;

7.1.19. weight reduction course and the cost of all relevant Treatments, supplies, services or drugs for weight reduction or weight reduction programs, medical fasting diets, weight loss programs, and educational dietary counseling related to weight loss efforts;

7.1.20. health care services and associated expenses related to or associated with Treatment of morbid or non-morbid obesity, including, but not limited to, gastric bypass, gastric balloons, gastric stapling, jejunal ileal bypass, and any other procedures or complications arising there from;

7.1.21. taking "Viagra" or other sexual enhancement drugs and their respective generic equivalents;

7.1.22. vitamins, minerals and other supplements, including homeopathic remedies, irrespective of whether these have been prescribed or not;

7.1.23. attending maternity/delivery preparation classes;

7.1.24. circumcision, unless Medically Necessary, and pre-authorized;

7.1.25. genetic counseling, screening, and testing;

7.1.26. narcotic, toxic inebriation, or life-threatening alcohol intoxication (when level of alcohol in blood is 2.5 ppm (two point five per mille) or higher);

7.1.27. car Accident, if the Insured Person was a driver and the alcohol level in his/her blood and urine was higher than that acceptable for driving in the country where the car Accident occurred;

7.1.28. body Injury or disease caused as a result of a bet or gambling;

7.1.29. being engaged in any Professional Sport; or doing Extreme Sports;

7.1.30. doing Dangerous Sports, unless specific kind of sport was explicitly stipulated in the application for insurance or in the Certificate;

7.1.31. Medical Treatments without Doctor's prescription;

7.1.32. complementary (and/or alternative) and or Experimental Treatment;

7.1.33. rejuvenation and spa treatments, cosmetic treatments, diet resorts, and convalescent rest;

7.1.34. medical Rehabilitation, except when it is recommended by a Doctor after carrying out Treatment covered by the Contract and pre-authorized, and except admission following a Hospitalization within 5 days;

7.1.35. being at facilities for the aged, primarily giving custodial, educational and rehabilitative care, not medical service;

7.1.36. maternity and childbirth during the Waiting Period;

7.1.37. elective caesarean;

7.1.38. sterilization and Infertility Treatment;

7.1.39. taking contraceptive medicine and methods;

7.1.40. abortion, except in case of Medical Necessity to save mother's life;

7.1.41. cosmetic/aesthetic Treatments, except for medical Rehabilitation after an Accident;

7.1.42. undergoing corrective eye Surgery (keratectomy and keratotomy, including LASIK and LASEK methods), except for cases of refractive cornea disease (where Surgery is covered in a way similar to other surgical operations);

7.1.43. undergoing remedial teaching course;

7.1.44. undergoing sex change Surgery and all related Treatments;

7.1.45. alopecia, selection, and production of a wig and/or hair transplantation and all types of hair loss therapy;

7.1.46. Treatment of the Insured Person by his/her family member, even if such person is a Doctor.

7.1.47. Maternity, Childbirth and Newborn Care;

7.1.48. medical service rendered before the start of the Insurance Period or after the Insurance Expiry Date;

7.1.49. disease/Injury diagnosed or treated by a Doctor without necessary qualification;

7.1.50. health disorder directly or indirectly related to a sexually transmitted disease or to HIV/AIDS infection;

7.1.51. health disorder or Injury related to conditions or circumstances of execution of a court act and (or) during staying at places of confinement or in custody, or during carrying out investigative activities;

7.1.52. all costs relating to orthotics for example insoles;

7.1.53. Kidney Dialysis (renal insufficiency);

7.1.54. The costs associated with locating a replacement organ or any costs incurred for the removal or the organ from the donor, transportation costs of the organ, and all associated administration costs. All costs associated with organs not specified within the meaning of words of organ transplant;

7.1.55. Rehabilitation unless it forms an integral part of Medical Treatment received as an In-patient and is under the control or supervision of a Specialist and is undertaken in a recognized Rehabilitation unit;

7.1.56. Any costs arising after the Insurance Expiry Date, unless the Contract has been renewed for subsequent 12 months. Any costs incurred after completion of the Insurance Period if the Insured Person reaches their 65th, respect. 75th birthday;

7.1.57. Expenses for Preventive Care, if not covered under the applicable Schedule of Benefits, as well as expenses for incurred taxes and the issue of medical documents.

7.1.58. Any Dental Treatment.

7.1.59. Palliative Treatment of terminal Illness & hospice care.

7.1.60. Rehabilitation.

7.1.61. External Prosthetic Devices and aids.

7.1.62. Cost of a wig/hairpiece if required following a course of cancer Treatment.

7.1.63. Hormone Replacement Therapy.

7.1.64. Physiotherapy Outpatient.

7.1.65. Alternative/Complementary Medical Practices: Acupuncture, needle therapy, aromatherapy, chiropractic, homeopathic, naturopathic and osteopathic medicine, Ayurvedic and traditional Chinese medicine, hirudotherapy.

7.1.66. Nursing at Home.

7.1.67. Psychiatric out-patient consultations and prescribed Drugs.

7.1.68. Restorative speech therapy.

7.1.69. HIV/AIDS.

7.1.70. Congenital / hereditary diseases.

7.1.71. Preventive Care: Well Child Care, Adult Health Screening (Check-up), Vaccination.

7.1.72. Compassionate Trip Home.

7.2. In no case shall this insurance cover loss, damage, liability, or expense directly or indirectly caused by or contributed to by, or arising from the use or operation of any computer, computer system, computer software program, malicious code, computer virus or process, or any other electronic system.

7.3. Sanctions Exclusion

Notwithstanding any other terms under the Contract, the Insurer shall not provide coverage nor will he make any Claim payments or provide any service or Benefit to any Policyholder, Insured Person, beneficiary, or third party who may have any rights under the Contract to the extent that such cover, payment, service, Benefit, or any business or activity would violate any applicable trade or economic sanctions law or regulation.

Claimant may be referred to as Policyholder, named insured, covered person, Insured Person or beneficiary, or as otherwise defined in the Contract, and shall mean the party, person or entity having defined rights under the Contract. These definitions may be found in various parts of the Contract and any applicable riders or endorsements.

7.4. This insurance is not available for the following occupations:

Occupation	Occupation Detail
Abattoir	Slaughterer
Abattoir	Slaughterhouse Worker
Agricultural	Cane Cutter
Agricultural	Harvester / Harvesting Contractor
Agricultural	Heavy Equipment Operator
Agricultural	Labourer / Manual Worker
Animal Breeding and Training	Breeder Other dangerous animals
Antenna Erector	Aerial Erector
All military forces	All occupations
Astronautics	Astronaut - NASA
Astronautics	Astronaut - Otherwise
Astronautics	Fuel Technicians
Astronautics	Gantry Workers / Launch Platform Workers
Aviation - Commercial	Advertising - banner towing, skywriting
Aviation - Commercial	Aerial Fire Fighting Air tankers
Aviation - Commercial	Aerial Fire Fighting Smoke jumpers
Aviation - Commercial	Agricultural Flying Cattle Mustering / Herding (usually helicopters), Game capture
Aviation - Commercial	Agricultural Flying Crop Spraying.
Aviation - Commercial	Air Displays
Aviation - Commercial	Commercial Pilot / Transport/General≥ 500 hours per annum
Aviation - Commercial	Helicopter pilot< 500 hours per annum
Aviation - Commercial	Helicopter pilot≥ 500 hours per annum
Aviation - Commercial	Airline Test Pilot
Aviation - Commercial	Construction - airlift of building materials

Occupation	Occupation Detail
Aviation - Commercial	Pipeline Inspection / Powerline Inspection
Aviation - Commercial	Police Pilot - All aircraft
Aviation - Commercial	Test Pilot Approved fixed wing aircraft
Aviation - Commercial	Test Pilot Approved rotorcraft
Aviation - Commercial	Test Pilot Experimental / prototype
Biology	Any occupation involving regular contacts or manipulations with hazardous biological or chemical materials, including but not limited to viruses and bacteria researches and vaccine development
Bookmaker	Professional Gambler
Brassfoundry	Furnaceman / Furnace Operator
Bullfighting	Banderillero
Bullfighting	Forcados
Bullfighting	Novillero
Bullfighting	Picador
Bullfighting	Recortador profesional
Bullfighting	Rejoneador
Bullfighting	Torero / Matador
Casino (licensed)	Security Staff
Cement Manufacture	Furnaceman / Kiln Worker
Chemical industry	Any occupation involving regular contacts or manipulations with hazardous chemical materials
Circus	Aerialist / Tightrope Walker / Trapeze Artist
Circus	Animal Handler / Animal Trainer Elephants, Horses, Monkeys
Circus	Animal Handler / Animal Trainer Lions, Tigers, Bears, etc
Circus	Carnival Fire Eater / Sword Swallower
Commercial Diving	Coastal water, docks and harbours - construction and ship maintenance / inspection< 5 years experience
Commercial Diving	Oil / natural gas rig maintenance and inspection Less than 5 years experience
Commercial Diving	Oil / natural gas rig maintenance and inspection Naval trained or ≥ 5 years experience
Commercial Diving	Pipeline and cable laying / maintenance / inspection, salvage, survey work or exploration< 5 years experience
Commercial Diving	Pipeline and cable laying / maintenance / inspection, salvage, survey work or exploration Naval trained or ≥ 5 years experience
Commercial Diving	Research, experimental depths
Commercial Diving	Professional instructors
Construction	Blaster / Explosives Handler
Construction	Dogman
Construction	Labourer / Manual Worker
Construction	Rigger
Construction	Roof Tiler / Slater
Construction	Roofer
Construction	Scaffolder
Construction	Spiderman
Construction	Steel Erector / Fixer
Construction	Steeplejack
Courier	Bicycle

Occupation	Occupation Detail
Courier	Motorcycle
Courier	Roller Blades / Inline Skater
Demolition Trade	Demolition Handling explosives
Demolition Trade	Demolition No explosives used
Demolition Trade	Wrecker Handling explosives
Demolition Trade	Wrecker No explosives
Diplomatic Service	Embassy Security
Dock Workers	Cargo Handler (not office based)
Dock Workers	Crane Operator / Crane Driver / Crane Slinger
Dock Workers	Docker
Dock Workers	Labourer / Manual Worker
Dock Workers	Loader Operator
Dock Workers	Stevedore
Doorman	Nightclub Doorman / Bouncer
Doorman	Public House Doorman / Bouncer
Drilling Industry	Offshore Drilling
Elevators / Lifts	Installers and repairers
Entertainers	Fire Eater
Entertainers	Wall of Death Rider
Entertainment Industry	Hostess / Dance Hostess / Bar Girl
Explosives Manufacture	Filler
Explosives Manufacture	Firework Manufacture - All Workers
Explosives Manufacture	Labourer / Manual Worker
Explosives Manufacture	Loader / Packer
Explosives Manufacture	Munition Worker
Explosives Manufacture	Process Worker
Explosives Manufacture	Tester
Film / Television	Cameraman War/disaster reporting
Fire Brigade	Bush Fireman
Fishing Industry - large vessels	Captain
Fishing Industry - large vessels	Cook
Fishing Industry - large vessels	Deckhand
Fishing Industry - large vessels	Fisherman - No details known.
Fishing Industry - large vessels	Master / Mate / Engineer
Fishing Industry - large vessels	Radio Operator
Fishing Industry - small vessels	Fisherman Deep sea
Fishing Industry - small vessels	Fisherman Local waters only
Forestry	Boomman
Forestry	Forester
Forestry	Log Haulier
Forestry	Logging Contractor
Forestry	Lumberjack
Forestry	Raftman
Forestry	Tree Feller
Forestry	Woodcutter
Invention	Inventor Otherwise, obtain full details
Journalism	War Correspondent / War Reporter
Metal Trades	Forger / Forge Hammerman / Forge Pressman
Metal Trades	Furnaceman / Furnace Operator
Metal Trades	Labourer / Manual Worker
Metal Trades	Riveter / Riveting Machine Operator

Occupation	Occupation Detail
Metal Trades	Sheet Metal Worker
Metal Trades	Welder Other
Mineral Industry	Crusher
Mining Industry	Miner Explosive Handling
Mining Industry	Miner Open Cast Mining
Mining Industry	Miner Underground
Mining Industry	Miner - Asbestos - All Sites and Trades
Nuclear Industry	Deactivation / Demolition Worker
Nuclear Industry	Nuclear equipment operation technicians
Oil and Gas - Offshore Workers	Cathead Man
Oil and Gas - Offshore Workers	Cementer
Oil and Gas - Offshore Workers	Crane Operator
Oil and Gas - Offshore Workers	Derrickman
Oil and Gas - Offshore Workers	Down Hold Logger
Oil and Gas - Offshore Workers	Driller
Oil and Gas - Offshore Workers	Fire fighter / Emergency response officer
Oil and Gas - Offshore Workers	Labourer / Manual Worker
Oil and Gas - Offshore Workers	Rigger
Oil and Gas - Offshore Workers	Roughneck
Oil and Gas - Offshore Workers	Roustabout
Oil and Gas - Offshore Workers	Secondman
Oil and Gas - Offshore Workers	Scaffolder
Oil and Gas - Offshore Workers	Topman
Oil and Gas - Offshore Workers	Watchstander
Oil and Gas - Offshore Workers	Welder (no diving)
Oil and Gas - Offshore Workers	Wireline Operator
Oil and Gas - Onshore - Exploration and Extraction	Labourer / Manual Worker
Oil and Gas - Onshore - Exploration and Extraction	Roughneck
Oil and Gas - Onshore - Exploration and Extraction	Roustabout
Oil and Gas - Onshore - Exploration and Extraction	Security Staff
Oil Refining	Security Staff
Overseas Aid Workers	Overseas Aid Worker Travel required
Pharma	Any occupation involving regular contacts or manipulations with hazardous biological or chemical materials, including but not limited to viruses and bacteria researches and vaccine development
Photographers	News Overseas / Hazardous Work
Photographers	War
Police Force, law enforcement or penitentiary	All occupations
Public Servant	Immigration or customs inspectors
Quarrying	Blaster
Quarrying	Crane Operator / Crane Driver
Quarrying	Crusherman / Crusher
Quarrying	Cutter
Quarrying	Driller
Quarrying	Driver - Heavy Vehicle

Occupation	Occupation Detail
Quarrying	Explosives Handler
Quarrying	Jackhammer Operator
Quarrying	Labourer / Manual Worker
Quarrying	Loader
Quarrying	Plant Operator
Quarrying	Pump Man
Quarrying	Shotfirer
Quarrying	Skilled Technician - No Explosives
Religious Roles	Missionary
Refractory materials	Repairers
Road Construction	Labourer / Manual Worker
Security	Bodyguard
Ship Building Trades	Flame Cutter
Ship Building Trades	Riveter
Ship Building Trades	Welder
Stables	Horse Breaker
Stables	Jockey - Flat
Stables	Jockey - Jumps
Stuntwork	Aviation
Stuntwork	Cars
Stuntwork	Fallers
Stuntwork	Fights
Stuntwork	General
Stuntwork	Horse Riding
Stuntwork	Motorcycles
Stuntwork	Underwater
Timber Industry	Sawyer
Transport	Driver - Explosive / Hazardous Materials
Tunnelling	Borer
Tunnelling	Compressor Operator
Tunnelling	Engineer
Tunnelling	Explosive Handler
Tunnelling	Heavy Plant Operator
Tunnelling	Labourer / Manual Worker
Tunnelling	Shotfirer
Tunnelling	Tunnel Miner
Tunnelling	Tunneller - No Details
Weapons	Weapons Dealer - International
Wood - Associated Trades	Sawyer

8. HOW TO INTRODUCE AMENDMENTS INTO THE CONTRACT

8.1. The **elements of the Schedule of Benefits** can be changed at an Anniversary Date only, by a respective written agreement between the Coverholder and the Policyholder. If the Policyholder wishes to introduce such changes, he/she/it has to notify the Coverholder thereof at least 10 working days prior to the Anniversary Date. Upon receipt of a respective request from the Policyholder, the Coverholder will provide the Policyholder with a revised renewal offer reflecting the requested changes, which are accepted to the Coverholder, and special conditions (if any) subject to which such changes are acceptable. If the Coverholder and the Policyholder agree on changes to the Schedule of Benefits, respective new Certificate or new Special Individual Certificate and amended Schedule of

Benefits shall be issued. If the Policyholder requests upgrading the Schedule of Benefits, the Coverholder reserves the right to introduce Waiting Periods and/or other special conditions starting from the date when the agreed changes come into force.

8.2. The Policyholder must notify the Coverholder about the Insured Person moving from his/her **Country of residence**. This notification shall be sent to the Coverholder in writing or by e-mail, or submitted via the Coverholder's online portal at least 30 days prior to such change. The notice must include the country where the Insured Person is planning to move to, the date of the beginning of residence in the new country, and the new contact details of the Insured Person.

8.2.1. Change of the Country of residence might request respective amendment of the Certificate. Such amendments shall be made upon respective written agreement between the Coverholder and the Policyholder by issuing the amended Certificate, Special Individual Certificate (if it was issued before), and/or issuing a new insurance card (if it was issued before).

8.2.2. There are countries where the Coverholder may not be able to provide coverage under the insurance for regulatory or insurance licensing reasons. Should the Insured Person move to such a country, then the Country of residence may not be changed and the Contract shall be terminated.

8.2.3. The Country of residence may not be changed and the insurance cover will automatically be cancelled for the USA and Caribbean nationals if they reside in their Home Country for more than 3 consecutive months.

8.3. The Policyholder must notify the Coverholder of any changes to the Policyholder's and the Insured Person's name, surname, and contact details as soon as practicably possible. The Coverholder will confirm receipt of the information on changes and update its records, and may need to issue a new Special Individual Certificate or a new insurance card.

8.4. No back-dated enrollments are allowed.

8.5. If the Policyholder would like to cancel the insurance cover for an Insured Person before the Insurance Expiry Date, the Policyholder must notify the Coverholder about it accordingly in writing or by e-mail. The Policyholder must also notify the Coverholder or the Assistance Service about the Insured Person's death as soon as practically possible in given circumstances. Article 9 "Contract Termination" of this Policy shall be applicable for cases mentioned in this paragraph of the Policy. Should the Repatriation or Burial locally benefit be indicated as covered by the applicable Schedule of Benefits, the Assistance Service will help with making these arrangements (in this case the Assistance Service should be provided with the circumstances of death and, if available, with the death certificate).

9. CONTRACT TERMINATION

9.1. The Contract terminates in the following cases:

9.1.1. expiration of the Insurance Period;

9.1.2. the Policyholder's failure to pay the second or any subsequent Insurance Premium installment within the Grace Period. In case described in this point, the Contract terminates from the date set forth in respective written notice of the Coverholder. However, the date of termination set forth in such written notice of the Coverholder should not be earlier than the date when the delayed Insurance Premium installment was due, or earlier than the date of sending the above notice; no Benefits shall be claimed or paid for and no Treatments/provision of good or services shall be arranged during the time when the Insurance Premium due (or any part thereof) is late.

9.1.3. the total amount of Claims settled by the Coverholder reaches Sum Insured. In the case described in this point, the Contract terminates from the date when the Sum Insured reaching happened. At the request of the Policyholder or the Insured Person, the Coverholder shall issue a complete Claims statement proving that the Coverholder's obligations under the Contract were fulfilled in full;

9.1.4. Policyholder's unilateral termination of the Contract. In case described in this point the Contract terminates from the date of the Coverholder's receipt of relevant request, or from the date set forth in such request if it falls later than the date of the Coverholder's receipt;

9.1.5. in the case of death of the Insured Person, the Contract terminates on the date of the Insured Person's death as said in the death certificate or the court decision according to which the Insured Person was declared deceased;

9.1.6. subject to mutual agreement between the Policyholder and the Coverholder. In this case the Contract terminates from the date of signing of respective termination agreement or from the date set forth in such an agreement;

9.1.7. at the initiative of the Coverholder in cases foreseen in this Contract and/or in applicable laws. In the case foreseen in this point, the Contract terminates from the date set forth in the written notice of the Coverholder but not earlier than the date of delivery of such a notice to the Policyholder;

9.1.8. the Insurer loses legal grounds to process Personal data of the Insured Person in accordance with the Contract. In the case foreseen in this point, the Contract shall terminate as of the date as set in respective notice of the Coverholder. No Insurance Premium refund can be arranged under the Contract terminated in this way;

9.1.9. when the Policyholder (an entrepreneur/legal entity) has arranged insuring of its employees/members under the Contract, then the Contract shall terminate in respect of the specific Insured Person should the relevant employment/membership relationship cease.

9.1.10. in other cases stipulated by the applicable law and/or the Contract.

9.2. The Contract may also be early terminated at the request of the Coverholder in case the Policyholder refuses to pay additional Insurance Premium due in accordance with the Contract.

9.3. In case of the Contract cancellation by the Policyholder prior to the Insurance Period commencement or within the Cooling off period, the Coverholder shall refund to the Policyholder 100 % of the paid Insurance Premium within 20 business days from the date when the Policyholder's cancellation notice was received by the Coverholder (save for the exceptions foreseen below in paragraph 9.4 and/or elsewhere in the Contract).

9.4. If the Certificate is cancelled by the Policyholder after the Insured Person received some Medical Treatment or assistance covered by the Contract, then:

9.4.1. no Insurance Premium refund is available under Contract, where less than 5 persons are insured at the Contract cancellation moment, unless otherwise agreed between the parties in the Contract;

9.4.2. if 5 or more persons are insured under the Contract at the moment when it is cancelled in respect of any number of Insured Persons, the Coverholder shall refund the Policyholder part of relevant Insurance Premium, that shall be determined according to the following formula (if not otherwise is established in the Certificate):

R = P x (100% - k) x U : I,

where

R — means Insurance Premium Refund Amount;

P — means Insurance Premium Amount received by the Coverholder for relevant period, as specified in the Certificate;

k — means a percentage of Insurance Premium reflecting the Insurer’s expenses associated with the Insurance Contract administration and termination. If not otherwise is established in the Contract, k equals 30%;

U — means the number of days between the actual Contract termination date and the end date of the period for which the Insurance Premium was received by the Coverholder;

I — means the number of days of the Insurance Period, for which the Insurance Premium was received by the Coverholder.

9.5. Subject to respective instructions of the Policyholder, transfer of the refundable Insurance Premium amounts can be postponed till expiry of the original Insurance Period or off-set against enrollment of new Insured Persons in the future.

10. RENEWAL PROCEDURE

10.1. The Contract can be renewed on each Anniversary Date of the Insurance Start Date, subject to the wording of the Policy and the Insurance Premium rates approved by the Insurer at the time of each Anniversary Date, which the Coverholder will inform the Policyholder about in writing prior to the Anniversary Date.

10.2. For the avoidance of any doubts, the Coverholder is entitled to apply revised Policy as of renewal of the Contract.

10.3. Prior to the Anniversary Date, the Coverholder will send to the Policyholder a renewal offer. The Insurance Premium due on the Anniversary Date will depend on the Insured Person's age on this Anniversary Date.

10.4. Should the Policyholder wish for any changes to be made to the Contract as of the Anniversary Date, the Coverholder must be notified thereof in writing or by e-mail at least 10 working days prior to respective Anniversary Date as foreseen in Article 8 of this Policy.

10.5. The Contract shall be recognized as renewed upon receipt by the Coverholder of relevant Insurance Premium in due time. It shall be deemed that by paying the Insurance Premium the Policyholder agrees to all the insurances conditions as indicated in the renewal offer.

10.6. Children can continue to be covered under the Contract as Dependents for appropriate rate up to their 18th birthday, or up to their 24th birthday if they are enrolled in full-time education (the proof of enrolment to full-time education must be submitted to the Coverholder).

10.7. If a child aged between 18 and 24 years is no longer a full-time student, he/she is no longer eligible for cover under the Contract as a Dependent; however, he/she can apply for this insurance in his/her own right by completing and signing an application form and paying the appropriate Insurance Premium. Providing that the Insurance Premium is paid on or before the Anniversary Date and there is no break in cover, the original Insurance Start Date shall be maintained.

11. DUTY OF DISCLOSURE

11.1. The Policyholder and the Insured Person must take proper care and concern when answering any questions asked by the Coverholder when entering into the Contract, at its renewals, etc., ensuring that any information provided is accurate and complete. The Policyholder and the Insured Person are liable to disclose to the Coverholder all circumstances known to them (including but not limited to the circumstances declared in the relevant insurance application form), which are significant for the assumption of the insurance risk under the Contract (i.e. all circumstances that are likely to have an influence on the Insurer's decision to accept the risk/on the conditions subject to which the risk may be accepted). When the Coverholder makes decision about terms and conditions on which a person could be insured under a Contract, it fully relies on the information provided by the Policyholder and the Insured Person.

11.2. If the Coverholder establishes that, when entering into the Contract, at its renewal etc., the Policyholder and/or the Insured Person deliberately or recklessly provided the Coverholder with untrue and/or misleading and/or incomplete information, the Coverholder will have the right to:

a. treat such Contract void from the start;

b. decline all Claims thereunder; and

c. retain the Insurance Premium received; and

d. demand reimbursement of all the Benefits as paid by the Coverholder under such Contract;

e. demand reimbursement of all other cost and damages as suffered by the Coverholder in relation thereto.

The Coverholder will notify the Policyholder about the above-mentioned accordingly in writing or by e-mail.

11.3. If the Coverholder establishes that (when entering into the Contract, at its renewal etc.) the Policyholder and/or the Insured Person has carelessly provided the Coverholder with untrue and/or misleading and/or incomplete information, and if no Claim has ever been reported to the Coverholder, the latter (at its sole discretion) will have the right to:

a. treat the Contract void from the start, refuse to pay any Claim thereunder and return the Insurance Premium received; or

b. propose changes to the conditions of the Contract with due regard to the accurate and complete information that has become available.

The Coverholder will notify the Policyholder in writing or by e-mail if (a) or (b) applies. If within 10 days as of receipt of the Coverholder's notice about applicability of point (b) the Policyholder does not accept the Coverholder's proposal, the Contract shall automatically lapse in line with point (a).

11.4. If the Coverholder establishes that (when entering into the Contract, at its renewal etc.) the Policyholder and/or the Insured Person has carelessly provided the Coverholder with untrue or misleading or incomplete information, and if a Claim has ever been reported to the Coverholder under such Contract, the latter shall (in writing or per e-mail) propose to the Policyholder changes to the conditions of the existing Contract to be made with due regard to accurate and complete information. If within 10 days since the Coverholder's respective notice the Policyholder does not accept the Coverholder's proposal, the Contract shall lapse automatically and the Coverholder will have the right to:

a. decline all Claims under such Contract;

b. retain the Insurance Premium received;

c. demand reimbursement of all the Benefits as paid by the Coverholder under such Contract;

d. demand reimbursement of all other cost/damages suffered by the Coverholder in relation thereto.

11.5. If the Policyholder, the Insured Person, or anyone acting on their behalf, makes a false, fraudulent, or intentionally exaggerated Claim, or if fraudulent means/devices have been used by the Insured Person/Dependent/anyone acting on their behalf to obtain a Benefit under the Contract (for example, a loss that is fraudulently caused and/or exaggerated and/or supported by a fraudulent statement or other device), the Coverholder:

a. will not be liable to pay such Claim; and

b. any amount paid by the Coverholder in respect of such Claim will become immediately due and owing to the Coverholder; and

c. should the Insured Person be insured by the Policyholder (as its employee, member or else), the Coverholder reserves the right to inform the Policyholder about such fraudulent acts of the Insured Person or his/her representatives;

d. may by notice to the Policyholder treat the Contract as having been terminated with effect from the time of the fraudulent act.

If the Coverholder exercises its right under point (d) above:

- it shall not be liable to the Policyholder or to the Insured Person in respect of a relevant event occurring after the time of the fraudulent act. A relevant event is whatever gives rise to the Coverholder's liability under the Contract (such as the occurrence of a loss, the making of a Claim, or the notification of a potential Claim); and
- it need not return any of the Insurance Premium paid.

12. DATA PRIVACY

12.1. For the purpose of entering into, implementing, and renewing the Contract, the Insurer and the Coverholder will need the Personal data of persons to be insured, Insured Persons, and Dependents. Any Personal data requested will be adequate, relevant and limited to what is necessary. If the person to be insured/Insured Person/Dependent does not wish to provide this to the Coverholder, the Coverholder will not be able to arrange entering into and implementation of the Contract request (e.g. tailoring offerings, preparing the Contract wording, handling Claims, etc.).

Processing of Personal data under the Contract shall be subject to relevant applicable laws on Personal data protection. When processing Personal data the Coverholder shall be subject to the Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the Processing of Personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation).

12.2. The following Personal data of data subjects may be processed based on the Contract:

a. full name;

b. age/date/place of birth;

c. gender;

d. address and other contact details (Country of residence, data related to planning on moving out of the Country of residence, Home County, e-mail address, telephone numbers);

e. identification data — identification document number (i.e. passport number), identification document;

f. social security-related data (including social security card number and other related data);

g. membership in an organization (for instance, when the Policyholder arranges insuring its members under the Contract);

h. travel-related data;

i. IP addresses when visiting the Insurer's/Coverholder's webpage without disabling cookies;

j. nationality, citizenship;

k. marital status;

l. employment-related data — data pertaining to occupation/profession (current and previous), employment start and termination date, vacation, pregnancy, as well as other working time and absence from work;

m. signature, photo;

n. results of Criminal Checks relating to prevention of Fraud and/or Terrorist Activities — if mandatory and requested by applicable laws;

o. Dependents/Spouse/Partner/Family Details;

p. bank and related financial/taxation data (including copies of bank cards, credit/debit card, and bank account details);

q. health and medical history, medical condition related Personal data, such as data on Medical Treatment, goods, and services as provided to data subjects; data resulting from medical reports or from death certificates; medical and medical Claims history; details of physical and psychological health or medical conditions; etc.;

r. other Personal data that may be shared by the data subject/Policyholder.

Personal data to be processed under the Contract will be obtained directly from data subjects or indirectly from third parties (e.g., family members and representatives, Policyholder, insurance intermediaries, Doctors, Providers, state institutions, and other third parties as authorized to disclose such Personal data).

12.3. The Privacy Notice / Privacy Policy of the Insurer, which may be found on its website, provides detailed information on Personal data processing by the Insurer. Full information about how Personal data shall be processed by the Coverholder is provided in the Privacy Policy, which can be viewed by clicking on the site terms and conditions at the website **www.dhig.net**.

12.4. The Controller of Personal data of the persons to be insured, Persons Insured and Dependents shall be the Insurer. The contact details of the Insurer are as indicated in the main body of the Certificate / Special Individual Certificate.

12.5. The Coverholder is the Processor of Personal data as appointed by the Insurer. Subject to specific terms as agreed between the Insurer and the Coverholder, the Coverholder is entitled to engage other Processors as may be necessary for Processing of Personal data for the purposes as set in paragraph 12.8 of this Policy.

12.6. For the purposes as set in paragraph 12.8 of the Policy, the Personal data may be disclosed to Reinsurers, co-insurers, Medical Consultants, the Assistance Service, other Providers, technical consultants, insurance administration service providers, lawyers, auditors, financial and tax related advisors, banks and fraud investigators, as well as supervising state authorities.

12.7. The contact of the data protection officer of the Coverholder: dpo@dhig.net. The contact details of a data protection officer of the Insurer (should the Insurer be obliged to appoint a data protection officer in accordance with applicable laws) are indicated in its Privacy Notice / Privacy Policy.

12.8. **Purposes of Personal data processing in relation to the Contract**: execution and administration of the Contract (including but not limited to Underwriting and Claims handling), administration of debt recoveries, insurance mediation, research or for statistical purposes, fraud prevention, meeting legal obligations, and arranging redistribution of the insurance risk (for arranging reinsurance and/or co-insurance), other purposes as allowed under applicable laws.

12.9. **Legal grounds** for Processing of Personal data under the Contract may be as follows:

a. Processing is necessary for the performance of the Contract — this shall include such activities as Underwriting, providing the Policyholder with offers/renewal offers/ information about quotation, assessing individual insurance application or health questionnaire completed by the Insured Person/Dependents/ persons to be insured, managing and administrating the Contract, handling Claims, and providing other services to the Insured Persons and Dependents.

b. consent of the data subject/explicit consent of the data subject — this will be relied on (for instance) for Personal data Processing activities related to Processing of health-related Personal data.

c. Processing is necessary for the compliance with legal obligations this will be relied on (for instance) when the Insurer has a legal or regulatory obligation to use such personal information;

d. Processing is necessary in order to protect vital interests of the data subject or another natural person,

e. Processing is necessary for the purpose of legitimate interests — this will be relied on (for instance): (a) when the Insurer has an appropriate business need to process Personal data and such business need does not cause harm to the Insured Person/Dependent. The Insurer will rely on this for activities such as maintaining its business records, developing, improving its insurance products and services related thereto, and providing information about its products and services to the Policyholder and to the Insured Persons; or (b) when the Insurer/the Coverholder needs to use such personal information to establish, exercise or defend Insurer's/Coverholder's legal rights. The Insurer/Coverholder will not use its legitimate interest to process data subject's Personal data when data subject's interests, rights, and freedoms take priority.

f. Other legal grounds as allowed by applicable laws.

12.10. Personal data may be processed both inside and outside of the European Economic Area (EEA) by the parties specified in paragraph 12.6 above, subject always to contractual restrictions regarding confidentiality and security in line with applicable data protection laws and regulations. When transferring Personal data outside EEA, appropriate safeguards for such data transfer (for example, standard data protection clauses as approved by the European Commission) as required by applicable laws shall be ensured. Personal data will not be disclosed to parties who are not authorized to process them. The Coverholder will not use personal information or pass it on to any other person for the purposes of marketing further products or services without an explicit consent of the data subject.

12.11. Where permitted by applicable law or regulation, the data subject shall have the following rights:

a. to access his/her Personal data to learn the origin of the data, the purposes and ends of the Processing, the details of the data Controller(s), the data Processor(s), and the parties to whom the data may be disclosed;

b. to withdraw his/her given consent at any time where his/her Personal data is processed based on such a consent;

c. to update or correct his/her Personal data so that it is always accurate;

d. to delete his/her Personal data from the records if it is no longer needed for the purposes indicated above, subject to regulatory Personal data retention requirements;

e. to restrict the Processing of his/her Personal data in certain circumstances, for example where the data subject has contested the accuracy of his/her Personal data, for the period enabling verifying its accuracy;

f. to obtain his/her Personal data in an electronic format;

g. to exercise the right to data portability;

h. to file to the relevant data privacy authority;

i. other rights as set by relevant applicable laws.

The data subject may exercise his/her rights by contacting the Insurer (under contact details as indicated in the main body of the Certificate and/or in its Privacy Notice / Privacy Policy) and/or

Coverholder at **data@dhig.net**, while providing his/her name, Contract number, the Policyholder, e-mail address, and the purpose of the request. Where permitted by applicable law or regulation, the data subject shall have the right to object to Processing request stopping Processing of his/her Personal data under the Contract. Under such circumstances, the Processing of Personal data will be stopped, unless permitted by applicable laws and regulations. Should the Coverholder be not in the capacity to duly respond to received data subject's request (e.g. because the Coverholder is the Processor and not the Controller of Personal data of this data subject), then the Coverholder will refer such request to the respective Controller of this Personal data.

12.12. The Personal data collected under the Contract will be retained for a period of time equal to the duration of relevant Insurance Period (including any renewals thereof) and for up to the following 10 years from the date the Contract expires, save for cases where a longer retention period is required for possible disputes, requests of the competent authorities or pursuant to the applicable laws. The specific term of retention of Personal data shall be as determined by the Controller of this data (i.e. the Insurer) and applicable laws. Once the retention period is over the data will be deleted or anonymized as obligatory under applicable laws.

12.13. In order to prevent or detect fraud and money laundering, the Insurer / Coverholder may check personal details with fraud prevention agencies and sanction websites, who may record a search. Searches may also be made against other insurers' databases. If fraud is suspected, information will be shared with those insurers. Other users of the fraud prevention agencies may use this information in their own decision-making processes.

12.14. The Insurer / the Coverholder may also conduct credit reference checks in certain circumstances.

12.15. The Insurer / the Coverholder may use automated tools with decision-making to assess individual application for insurance or individual health questionnaire and for Claims handling processes. If the Insured Person objects to an automated decision, the Insurer / Coverholder may not be able to offer the insurance quotation.

13. COMPLAINTS

13.1. Should the Insured Person have questions or complaints (including but not limiting to complaints regarding the Assistance Service or Providers as engaged by the Coverholder), he/she may firstly call the helpline phone as set in the main body of the Certificate. If the question/complaint is not resolved to the satisfaction of the Insured Person, then he/she is entitled to contact the Coverholder per e-mail: **complaints@dhig.net**. The Coverholder will handle the complaint as soon as practicably possible and present the complaining person with an answer within a reasonable period of time from the moment of receipt of a complaint, but not later than 60 calendar days.

13.2. Should the Insured Person be not satisfied with the answer/reaction of the Coverholder, he/she may contact the Insurer per client service e-mail as set in the main body of the Certificate.

14. FINAL PROVISIONS

14.1. Confidential information

In accordance with this Policy, the following information shall be deemed to be confidential:

a. the amount of the Insurance Premium paid under the Contract and special conditions of insurance, if any has been agreed between the parties to the Contract;

b. the Personal data as processed under the Contract:

c. other data that is acknowledged to be confidential under the applicable laws and/or common sense/common business practice.

Save for the exceptions foreseen in the Contract, the Coverholder, the Policyholder, the Insured Person, and Dependents shall take sufficient measures to prevent disclosure of the confidential information to un/authorized third parties.

14.2. Applicable law

The specific law to be applicable in respect of the Contract, as well as legal jurisdiction (courts) for solving disputes shall be set in the main body of the Certificate / Special Individual Certificate, unless otherwise required by law.

14.3. Correspondence

Written correspondence between the Coverholder and the Policyholder/the Insured Person must be sent by e-mail or post. The sender shall cover the costs of sending his/her/its mail deliveries.

14.4. Language of correspondence

The Coverholder, the Policyholder and the Insured Persons shall communicate in English, unless otherwise expressly indicted elsewhere in the Contract.

14.5. Changes in taxation regulation

The Coverholder shall not be responsible for the consequences of possible changes in the tax legislation applicable to the Policyholder or to the Insured Person.

14.6. Circumstances beyond reasonable control

The Coverholder shall not be liable for any failure or delay in the performance of its obligation under the Contract, caused by or resulting from any circumstances beyond its control, i.e. Force Majeure circumstances, which shall include (but are not limited to): events that are unpredictable, unforeseeable, or unavoidable (such as extremely severe weather, floods, earthquakes, storms, lightning, fire, subsidence, epidemic, pandemic, acts of terrorism, outbursts of military hostilities (whether or not the war is declared), riots, explosions, strikes or other labor unrest, civil disturbance, sabotage, disorganization of governmental authorities or financial authorities, telecommunication networks or money transfer system breakdowns, and any other act or event outside of reasonable control of the Coverholder). For the avoidance of any doubts, the Coverholder is released from its obligations under the Contract, if execution of such obligations becomes impossible as a result of international sanctions.

14.7. If at the time of submitting a Claim under the Contract, the Insured Person has more than one insurance in force covering this Claim, i.e. the same Medical Treatment, good and/or services, then the Coverholder will only pay the Claim on a proportionate basis if the claimant is entitled to reimbursement from any other source in respect of the same Benefit (or any part thereof). The Insurer shall have the right to make a claim on any other insurance that the claimant has in force.