International Medical Insurance Terms and Conditions

These International Medical Insurance Terms and Conditions (hereafter referred to as the "**Rules**") specify general conditions of international medical insurance contracts (hereafter referred to as the "**Contracts**" or "**Insurance Contracts**") concluded between the Insurer (as represented by the Coverholder) and the Policyholder.

Special conditions of insurance cover to be applicable in respect of a particular Insured Person are established in the respective Policy (including its attachments — the Schedule of Benefits and the List of Insured Persons) and the Certificate (if issued). Should there be a discrepancy between these Rules and the Policy, provisions of the Policy shall prevail. Should there be a discrepancy between the Rules/the Policy and the Certificate as issued in respect of an Insured Person(s), then the provisions of the Certificate shall prevail in respect of this Insured Person(s).

These Rules, the Policyholder's application for this insurance (including the documentation related to medical conditions and prior international medical insurance history), as well as other information and documentation provided by the parties to each other for the purpose of concluding the Contract, the relevant Policy signed by the parties thereto (including the Schedule of Benefits and the List of Insured Persons), and individual Certificates (if issued by the Coverholder), comprise the Insurance Contract.

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

Whenever within these Rules 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 these Rules and elsewhere in the Contract.

Information about the Coverholder:

Company name:	dhig GmbH
Registered at:	Am Heumarkt 10/1, 1030, 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:	Am Heumarkt 10/1, 1030, Vienna, Austria
E-mail:	contact@dhig.net
Website:	https://dhig.net

1. DEFINITIONS

The following terminology shall be used in these Rules and elsewhere in the Contracts to be concluded or concluded in accordance with these Rules:

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 Policy 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 Attacks), attempts of rescuing people or freight in peril; inhalation of gas or vapor, as well as absorption of poisonous 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 restrictions 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/paternity leave; those on compassionate leave; those on annual leave; those on study leave.

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. Depending on the Insured Person's age and gender, his/her general health condition, and occupational hazards, further consultations with Specialists could be recommended by a Physician, as well as specialized diagnostic tests, that 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 the 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 the 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.

Alcohol and Substance Abuse refers to excessive use of psychoactive substances - alcohol or drugs (both pharmaceutical or illicit) in a way that is detrimental to self, society, or both. This definition includes both physical dependence and psychological dependence. Physical dependence caused by prolonged use of a drug refers to an altered physiologic state in which withdrawal symptoms develop when the drug is discontinued. Psychologic dependence refers to a state of intense need to continue taking a drug in the absence of physical dependence. By these definitions, alcohol is a drug that can cause both physical and psychological dependence.

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, 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 Policy.

Application Form for Insurance means the application submitted to the Insurance company/Coverholder with necessary information regarding the Insured's name, address, age, height, weight, sex, occupation, Insurance history, medical history, and other factors. This information is important so that the Insurance company/Coverholder can properly determine whether the applicant meets their underwriting rules and determine the proper premium. It should be filled in and signed by the applicant and it is an integral part of

the Insurance Policy if it is issued. The Application is valid for 30 days since it was fully completed and signed by the applicant.

Assistance Service is a legal entity appointed by the Coverholder for the organization of medical services and the 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 these Rules 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 Policy.

Benefit means a Medical Treatment, good and services, 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. These Rules (including their 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 Policy and specifies the Benefits covered by the specific Insurance Contract. The Schedule of Benefits makes up an inseparable part of the Policy.

Certificate is a document issued by the Coverholder for an Insured Person, in confirmation of the Insured Person's insurance under the Contract in force. The Certificate should be read in conjunction with these Rules and the Policy.

Chronic Condition or a Chronic Disease means a disease, a consequence of Injury or medical condition that causes irreversible pathological changes, which has two 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 Policy/the Certificate.

Claim means a request for reimbursement of expenses for (the 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 a positive settlement of the Claim, whereby the Claim can be eligible for payment in full or in part.

Compassionate Trip Home means the cost of a one-way economy class air flight ticket to the Insured Person's Home Country if his/her close family member dies during the Policy 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 death of the fetus 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 the 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 the above stated conditions.

Complicated Pregnancy and Childbirth Benefit means reimbursement of costs related 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 diabetes and diabetes-related diseases are expressly excluded under the insured mother's Policy/Certificate, then no Treatment for diabetes during the Pregnancy shall be covered by this insurance, and no associated expenses shall be reimbursed.

Confirmed Previous Exclusions Underwriting means that the Coverholder was provided with evidence of insurance for the Insured Person by an international medical Insurer, which was in place immediately prior to the Insurance Start Date/start of the initial cover of this Insured Person under the Contract, and that the Coverholder agreed to confirm the same or similar Specific Exclusions and thus no further medical Underwriting is required.

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 is irrelevant whether a 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;
- the additional Insurance Premium quoted by the Coverholder was fully paid for his/her insurance under the Contract.

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. 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 of the Policy Period; this information is shown on the relevant Policy and Certificate. The Policyholder and the Insured Person are obliged to inform the

Coverholder about any long-term (for more than three months) or permanent move of the Insured Person from the Country of residence, following the procedure as set further in these Rules.

Coverholder means the company **dhig GmbH** (contact details as indicated in the introduction of these Rules), 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 limited to) the following: collecting insurance applications, Underwriting, issuing insurance offers, issuing, and signing Policies, Certificates and other Contractual documents, subsequent Contract administration, and Claims handling.

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

Day-Care Treatment/Day-Patient Treatment means Treatment in a Hospital or medical day-care center, 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: pain relief, 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: gum treatments, 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 (non-orthodontic).

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, provided within 90 days from the date of the Accident. Damage to the 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 the age of 24 if there is proof of the child continuing full-time education).

Disability means a partial or full loss of the ability to work or live normally, as confirmed by a qualified expert or by a specialized organization in the relevant country, as a consequence of a body Injury or a 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 licensed to practice medicine in the country where the Treatment is received. Insured Persons are allowed to select any Doctor qualifying these requirements, unless otherwise indicated in the Policy/Certificate. For the avoidance of any doubts, the contracting parties may specifically agree that certain or all Medical Treatments/goods/services (including but not limited to Hospitalization and Outpatient Care) are eligible (i.e. covered by this insurance) only if they are executed/provided at/by the specific

Doctors/Specialists/medical facilities as expressly indicated in the Policy/Certificate — such an agreement shall be set in the Policy and/or the Certificate.

Emergency Care out of Primary Area of Cover means that, if the Insured Person is on a business, pleasure or compassionate trip (for a period of less than one month) out of the Primary Area of Cover and unexpectedly finds himself/herself in a situation of Medical Emergency (as a result of a body Injury from an Accident happened during the trip, or as a result of an acute Illness occurred during the trip, or as a result of an acute episode of such existing medical condition, which has been first time reported when being in the Primary Area of Cover). Treatment by a doctor must start within 24 hours of the emergency event. The scope of cover under this insurance shall be limited to the amount specified in the applicable Schedule of Benefits and the following Treatments shall be excluded:

- routine or elective Treatment;
- curative or follow-up non-emergency Treatment, even if the Insured is deemed unable to travel to a country within his/her geographical Area of Cover
- Treatment, which can be postponed until the Insured Person returns to the Primary Area of Cover;
- Treatment which has been planned in advance, before the trip out of the Primary Area of Cover;
- Treatment arising from circumstances that could have been reasonably anticipated by the Insured Person;
- Treatment for Maternity, including the care of the pregnant mother and her unborn child.

Emergency Medical Evacuation means that in the event of a critical medical condition, when a Doctor authorized by the Assistance Service in consultation with a local attending Doctor determines that it is necessary for the Insured Person to be transported to a different Hospital or Treatment facility for immediate expert Medical Treatment. In such cases, the Assistance Service will cover the costs as well as arrange - as soon as reasonably practical - the transportation of the Insured Person to the nearest appropriate Hospital or treatment facility offering adequate Medical Treatment under adequate medical supervision. Such a hospital may be located in another, nearest country or in the Insured Person's Home Country. The Assistance Service should be contacted to approve (pre-authorize) and arrange all Emergency Medical Evacuations. In dire emergencies in remote or underdeveloped areas where the Assistance Service cannot be contacted in advance, the Emergency Medical Evacuation must be reported as soon as possible. **The Emergency Medical Evacuation Benefit** also covers costs of transportation for one other person to accompany the Insured Person in an Emergency Medical Evacuation where Inpatient care is required following Emergency Medical Evacuation, or in case of an Emergency Medical Evacuation of a child who is not more than 18 years old. **The Emergency Medical Evacuation Benefit, as well as any other Benefit under the Contract,** shall not include the following:

- sea and offshore evacuation: if an Insured Person is injured or becomes ill at sea (i.e., cruises, yachting, etc.), the Coverholder will not be liable for organizing any assistance or Benefit payment until the Insured Person is on land. This also means that any costs related to an evacuation from sea to land will be excluded from the coverage under this insurance. Once on land, the Contract will cover Treatments, goods, and services as foreseen in the Contract. If an Insured Person is at sea, the Insurer would request the Insured Person to be evacuated by sea rescue to a country within their purchased Primary Area of Coverage, where circumstances allow.
- Mountain rescue: the costs of search and rescue action in the mountains.

Emergency Medical Evacuation Related Costs include:

- costs of a one-way economy class air flight ticket for the Insured Person's companion if approved by the Assistance Service when arranging Emergency Medical Evacuation;
- accommodation costs of a companion who has accompanied the Insured Person on an approved Emergency Medical Evacuation;
- costs of a one-way economy class air flight ticket to return the Insured Person and his/her companion back to their Country of residence following an approved Emergency Medical Evacuation;

- taxi costs for the Insured Person's companion to and from the Hospital to visit the hospitalized Insured Person, and
- accommodation costs for the Insured Person, following Hospitalization.

Erectile dysfunction (ED) is a type of sexual dysfunction that describes the inability to have an erection of the penis adequate for sexual intercourse.

Expatriate means a person whose residence is outside of his/her Home Country.

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 or 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 to life and health and include (but are not limited to): sky diving, gliding, mountain skiing or snowboarding outside special tracks, speleology and sandboarding; diving at depths exceeding 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 biking (riding downhill on a special bicycle); Bison-Track-Show (tractor racing); bungee 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); alpinism; 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.

Full Medical Underwriting means that the Policyholder or a natural person, for whom an insurance application is submitted, shall provide the Coverholder with a detailed medical history to enable the latter to decide whether to accept or decline such application and whether any specific conditions or Specific Exclusions/limitations shall become applicable to this natural person's insurance. The person to be insured can be requested by the Coverholder to provide extracts from his/her medical records or full medical history if available, and even undergo a medical examination in accordance with the Coverholder's requirements. Failure to do so entitles the Coverholder to reject an application for insurance.

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 a 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 Policy or in the Certificate. Should the Policyholder be late in paying the Insurance Premium or any part thereof, the Coverholder reserves the right to postpone the settlement of Claims under the Contract until the Policyholder has paid the full amount due, and/or to terminate the Contract as further detailed in these Rules.

HIV/AIDS Benefit means the cost of Treatment arising from, or related to, the 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 valid passport. If the Insured Person holds more than one passport, the nationality that has been declared in the insurance application will be regarded as the Home Country. For the purposes of the Contract, the Dependents are 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 (Inpatient Clinic) means a private or a public/state-owned organization, 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 diagnoses, and perform surgeries, give patients continuous Treatment, monitoring, and care, and where Doctors and medical personnel stay for 24 hours a day. Inpatient 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. Furthermore, it may be agreed in the Policy/Certificate that only the stay in and/or Medical Treatment, goods and services provided in a specific Hospital(s) (as expressly indicated in such Policy/Certificate) shall be eligible (i.e., covered by this insurance).

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

Hospitalization Daily Allowance is a cash benefit payable to the Insured Person as an alternative to the reimbursement of Hospitalization costs. The Hospitalization Daily Allowance Benefit (if indicated as covered by the Schedule of Benefits) is available if Inpatient accommodation and Treatment are provided by a public Hospital free of charge for both the Insured Person and for the Assistance Service, the Coverholder, or the Insurer as well.

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. An 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 due to a cause associated therewith, then such Illness is regarded to be the progression of the previous disease, not a separate disease.

Infertility is a term that combines three conditions: inability to conceive (sterility), inability to carry the pregnancy to term until the fetus becomes viable, and non-viability of the unborn.

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, or any other laboratory or instrumental diagnostic tests prescribed in that relation).

Injury means a bodily Injury caused by an Accident.

Insurance Expiry Date means the day when the insurance cover under the Contract ends. The Insurance Expiry Date shall be indicated in the Policy. An Insured Person can be excluded from the coverage under the Contract by the Policyholder's advance notification sent to the Coverholder, unless otherwise established by the Contract.

Insurance Premium means a payment for the 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 first Policy, when the insurance cover under the Contract goes into effect (subject to general and special conditions as set herein and elsewhere in the Contract). Should at any time during the Policy Period as set in the Policy (after the Insurance Start Date as indicated in the Policy) a new Insured Person(s) be included into the coverage under the Contract, then the insurance cover in respect of such newly included Insured Person will start from the date as indicated in respective Certificate and will end at the Insurance Expiry Date as set in the Policy, based on which the said Certificate was issued.

Insured Person means a natural person to whose benefit the Policyholder entered the Contract. When a natural person enters a Contract to his/her own benefit, he/she acquires the rights and obligations of the Policyholder as well as those of the Insured Person.

Insurer means the duly licensed insurance organization as indicated in the Policy, 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 a single) kidney(s), thus, requiring hemodialysis. If the Kidney Dialysis benefit is covered by the special conditions to the Policy, it means that the expenses for the hemodialysis shall be reimbursed under the Contract, if it is carried out in a Hospital or officially registered renal insufficiency Treatment center in the Country of residence of the Insured Person, and at a Provider closest to his/her residence address that can provide necessary Treatment. Neither the accommodation outside of a Provider nor transportation costs shall be reimbursed.

Lifetime Limit means the limit that applies to 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 a local Hospital for Medical Emergency or Inpatient 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, without which the person would die or be expected to suffer serious bodily Injury or major health deterioration and 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).

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 of at least 20 Primary Insured Persons, unless otherwise expressly agreed upon between the Coverholder and the Policyholder.

Medically Necessary means medical services, medications, products, and means of medical aid rendering that meet all the following criteria:

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 reasons other than to perform a prophylactic screening of the Insured Person;
e. required due to 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, has 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.

Moratorium Underwriting means that the Insured Person cannot submit a Claim in connection with his/her Pre-Existing Medical Conditions, which are declared by the Policyholder or by the Insured Persons in the application for insurance, and/or which are expressly indicated in the Policy/Certificate. If not otherwise specified in the Policy/Certificate, Moratorium Underwriting is established for the period of the first 2 years of continuous cover under the Contract. If within the Moratorium Underwriting period the Insured Person has not suffered any symptoms related to the Pre-Existing Medical Conditions, has not consulted any Doctor, Specialist, or any other medical practitioner for check-ups, follow up examinations, Medical Treatment, or advice in connection with Pre-Existing Medical Conditions, and has not been prescribed or taken any Drugs, or other medicine including over-the-counter drugs, special diets, injections, physiotherapy for that condition or any Related Medical Condition, then upon the expiry of the Moratorium Underwriting period such Pre-Existing Medical Conditions become eligible for cover unless otherwise expressly set in the Policy/Certificate.

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

Newborn Care means customary examinations required to assess the integrity and basic function of the Newborn's organs and skeletal structures. These essential examinations are carried out immediately following birth and not later than 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.

In case there is more than one baby born, the benefit will be split between the newborns.

Cover doesn't include further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests. However, if for medical reasons the Newborn needs any follow-up investigations and treatment, these are covered under the newborn's own policy (if they have been added as a dependent).

Non-malignant skin formations mean, benign skin formations that have a slow to moderate growth rate, do not invade surrounding tissues, do not metastasize, and are not considered to pose a health hazard.

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 aged 35 and above, no more than 3 routine prenatal ultrasound 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.

When a pregnancy spans two Insurance Years and the benefit limit changes at Policy Renewal, the following rules apply:

- In year one – the benefit limits apply to all eligible expenses.
- In year two – the updated benefit limits apply to all eligible expenses incurred in the second year, less the total benefit amount already reimbursed in year one.

- If the benefit limit decreases in year two and the Insurer/Coverholder has already paid up to or over this new amount for eligible costs incurred in year one, then the Insurer/Coverholder will pay no additional benefit in year two.

Nuclear, Chemical and 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 Inpatient 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 also includes a non-invasive cancer (in situ).

Optical Care means Prescription glasses and/or contact Lenses within the insurance coverage, provided by an optometrist in case of modification of dioptre superior or equal to 0.5, except dioptric sunglasses and frames. The Optical care products must be purchased not later than 90 days after the prescription and within the valid insurance coverage.

Outpatient Care (Outpatient Treatment) means Medical Treatment provided to the Insured Person when he/she is not a registered Inpatient in a Hospital or a Rehabilitation center, 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.

Outpatient Care also includes visiting a patient at home by the Doctor, provided that this visit is arranged by the Assistance Service or approved by it in accordance with the Contract, if the reason for the Doctor's visit is the health condition of the patient insured under the Contract who is not able to get to the Hospital by him/herself without putting his/her life at risk (due to specific manifestations of the disease) or without the risk of further deterioration of health (progression of the disease or its complications). If visiting a patient at home is made not in a situation of Medical Emergency, then only the cost of a Doctor's consultation (as well as services of a nurse if Medically Necessary) can be claimed for reimbursement, but not the cost of the Doctor's/nurse's transportation. If (in the opinion of the Coverholder) the Insured Person is able to get to the Doctor by him/herself without the risk to his/her life or further deterioration of the health state but prefers to invite the Doctor to his/her home, such a visit is not covered by this insurance and no such expenses shall be reimbursed.

Outpatient Surgery means a Surgery carried out as an Outpatient Treatment or at a Surgery room within one day and where 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, Prescription Drugs and dressings provided 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 and ordered by the treating Doctor. Physiotherapy Benefit includes Kinesitherapy, provided by a registered physiotherapist following a referral by a treating Doctor and excludes therapies such as Rolfing, Pilates, Fango, Milta and therapies which are not medically necessary.

Policyholder means a natural person who, or a legal entity that entered into a Contract on the terms and conditions provided herein and elsewhere in the Contract.

Policy Period is a period of time shown on the Policy/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. Any expenses incurred / illnesses reported out of the Policy Period are not covered.

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.

However, any medical conditions that occur between the date of signing the Application Form and the date of issuing the Insurance Certificate or the Policy start date will be considered pre-existing.

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, 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 Outpatient 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 one 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 Area of Cover means the geographic region or a group of countries, in which all Benefits indicated in the Schedule of Benefits as covered, shall apply. The applicable Primary Area of Cover is indicated in the Policy and/or Certificate.

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/herself, then he/she may select an adult (18 years old or older) 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.

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.

a. **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.
b. **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 an organization or a Doctor duly licensed for Outpatient Medical Treatments and consultations, or a Hospital, a duly licensed medical science and Treatment organization or a pharmacy, a certified Rehabilitation center or a preventive care organization, an establishment giving medical assistance and transportation services, a funeral bureau, a translation bureau, or another service Provider, which (acting in compliance with the local legislation) provides Medical Treatment or 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 Policy.

Psychiatric Illness means a mental or nervous disorder that meets the criteria for classification under an international classification system such as the **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. The treatment of mental disorders must be carried out by a psychiatrist or clinical psychologist. This insurance covers psychotherapy

(on an Inpatient or Outpatient basis) in case the Insured Person is initially diagnosed by a psychiatrist and referred to a clinical psychologist for further treatment.

Reconstructive Surgery means a surgical procedure(s) which is required to restore the 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 comes into force 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 Policy Period.

Rehabilitation means an Inpatient or Outpatient 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. Treatment must take place in a licensed rehabilitation facility and start within 5 days of discharge from acute medical and/or surgical treatment.

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

Related (Incidental) Medical Condition means any disease, bodily Injury, or health deterioration, including psychotic / psychiatric 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 the insurance coverage.

Repatriation or Local Burial 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 post-mortem remains to be transported to his/her Home Country or the Country of residence, or to be buried locally or cremated. 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 of 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 Outpatient 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.

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

Specific Exclusion means any exclusion that is applied in respect of the Insured Person, based on the results of the Full Medical Underwriting undergone before his/her enrollment in the Contract and/or due to other reasons. The Specific Exclusions are indicated in the Policy and/or in the Certificate and are applicable in addition to the general exclusions described in these Rules.

Spouse means a person recognized as a Spouse by the 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 Policy 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 or in an Outpatient medical facility, in order to treat, diagnose, improve organism's functions, using various methods of tissue separation, removal, and adnation.

Terrorist Attack means the 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 the government and/or frighten the population or a part thereof; or the use of biological, chemical, radioactive or nuclear substances, materials, means, or weapons.

Transplantation of kidney, heart, heart-lung, liver, bone marrow, and stem cell (both autologous and donor-provided) mean the transplantation Surgery where the Insured Person is the recipient. Expenses relating to the acquisition of transplant materials and the 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 has to be made in accordance with the World Health Organization (WHO) guidelines.

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 services which are most likely to be incurred if medical services of similar complexity is demanded from other Doctors, Hospitals, or Outpatient 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 the 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 assume the consideration of the 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 the Benefits, as specified in the Schedule of Benefits and/or elsewhere in the Policy or 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 Policy 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.

These checks and tests may include blood tests (e.g., full blood count, determination of hematocrit, hemoglobin, and other blood tests, including tests for hereditary forms of hemoglobinopathies), urinalyses, height and weight measurements, ultrasound and/or x-ray imaging tests, check of senses, neurologist examinations, detection of hereditary and metabolic diseases, tuberculin samples.

2. ENTERING INTO THE INSURANCE CONTRACT

2.1. This insurance is designed for Expatriates of any nationality living or working outside of their Home Country, and for the internationally mobile Local nationals.

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 sanctions, prohibitions, or restrictions imposed by law or regulations.

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 **65**. 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 Policy.

2.6. Children are eligible for cover under this insurance subject to the following conditions:

2.6.1. If a child was born as a result of any medical procedures to stimulate pregnancy or infertility Treatment, or born through surrogacy or been adopted, then the Coverholder reserves the right to apply any Underwriting requirements and even reject the insurance application based on Underwriting results, and the insurance cover in respect of such child may commence not earlier than upon the expiry of the first 90 calendar days of the child's life.

2.6.2. If a child was not born as a result of any medical procedures to stimulate pregnancy or infertility Treatment and was not born through surrogacy and was not adopted, then the Policyholder is entitled to request the inclusion of this child into the list of Insured Persons from the day of the child's birth if all the following conditions are met:

a. one of his/her parents has been Insured Person under the Contract continuously for at least 11 months before the child's birth;

b. an application for the insurance of the child has been received by the Coverholder during the first 30 calendar days since the child's birth;

c. the Policyholder has agreed to pay the Insurance Premium quoted by the Coverholder for the child's insurance.

In such circumstances, the Policyholder is released from the obligation to inform the Coverholder about the child's state of health.

2.6.3. The insurance coverage shall come into force not from the child's date of birth, but from the day determined by the Coverholder via its Underwriting process (and the Coverholder reserves the right to apply any Underwriting requirements and even reject insurance application based on Underwriting results) in the following cases:

a. if none of the child's parents has been Insured Person under the Contract continuously for at least 11 months before the child's birth; or

b. if the application for insurance in respect of the child has not been received by the Coverholder within the first 30 calendar days since child's birth.

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 the 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, or by e-mail via sending the relevant requests to the Coverholder.

2.9. 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).

2.9.1. Based on the received information, the Coverholder does Underwriting, issues a proposal for the insurance, etc. In its proposal, the Coverholder shall:

- define individual modification of Benefits and/or partial or total exclusion of benefits (e.g., related to the Pre-Existing Medical Conditions);
- introduce a Waiting Period, or propose an additional Insurance Premium, and/or
- include other limitations/Specific Exclusions/special conditions or accept the risk without any special provisions/waivers.

2.9.2. For actions described herein the Coverholder may approach Medical Consultants and/or Underwriters (whenever necessary).

2.10. Unless otherwise agreed, the Coverholder will not accept, and will not enroll in an active policy any person that has been already covered under same contract, and subsequently excluded. Such a person can only be enrolled upon renewal of the policy.

2.11. For an employer or any legal entity or affinity group applying for this insurance, the Coverholder (at its sole discretion) can offer the Medical History Disregarded condition or request the same Underwriting Rules as those established hereby for Individual Underwriting, or can modify the Schedule of Benefits, the Underwriting conditions, and forms for completion. The Coverholder also reserves the right to request claims experience report for over a 3-year term immediately preceding the application for insurance, if the group was covered by another Insurer under a medical insurance scheme.

2.12. The following Individual Underwriting guidelines shall apply if an application for insurance comes from a natural person or from a group of less than 20 persons, who could be recognized as Primary Insured Persons:

a. If a person submitted for insurance is less than 60 years old on the Insurance Start Date/the start date of the initial cover of this person under the Contract (when the very first insurance cover under the Contract in respect of this person begins after the Insurance Start Date), he/she is eligible for cover on a Moratorium Underwriting, Full Medical Underwriting, or Confirmed Previous Exclusions Underwriting basis. However, the Full Medical Underwriting and Confirmed Previous Exclusions Underwriting options are not available when applying for this insurance via the internet.

b. If a person submitted for insurance is aged 60 or older on the Insurance Start Date/the start date of the initial cover of this person under the Contract (when the very first insurance cover under the Contract in respect of this person begins after the Insurance Start Date), he/she will only be eligible for insurance subject to a Full Medical Underwriting.

c. If the applicant for insurance selects a Moratorium Underwriting, the person submitted for insurance will be offered by the Coverholder to complete the Moratorium Application Form.

Moratorium Underwriting means that the Insured Person will not be covered for any Pre-Existing Medical Condition as indicated in Article 1 "Definitions" of these Rules.

d. If the applicant for insurance selects the Full Medical Underwriting, the person submitted for insurance will be offered by the Coverholder to complete the Full Medical Underwriting Application Form. The latter will review the information received to ascertain whether the person under consideration will be accepted for insurance with or without Specific Exclusions/limitations or other special conditions. If the Coverholder decides to apply Specific Exclusions/limitations/other special conditions, the applicant will be advised in writing or by e-mail and will need to send the Coverholder a written confirmation that these Specific Exclusions/limitations/other special conditions established by the Coverholder are accepted by the applicant, and to do so before the insurance can start. The Coverholder reserves the right to refuse an application for insurance, and, if so, the Coverholder shall inform the applicant accordingly. Any Pre-Existing Medical Conditions not declared on the Full Medical Underwriting Application Form will not be insured and the Insurer will not be liable for the reimbursement of the relevant expenses.

e. If the applicant selects the Confirmed Previous Exclusions Underwriting, he/she will be offered to complete the relevant form. This type of Underwriting allows the person submitted for insurance not to undergo the Full Medical Underwriting and not to be exposed to the Moratorium Underwriting conditions, in exchange for disclosing previous insurance terms and conditions and carrying forward specific exclusions/limitations from his/her previous medical insurance policy that was in place immediately prior to the Insurance Start Date/start of the initial cover of this person under the Contract (when the very first insurance cover under the Contract in respect of this person begins after the Insurance Start Date) of insurance requested from the Coverholder. However, even if such specific exclusions/limitations are accepted by the Coverholder, all other exclusions, benefit limitations, and special conditions (including but not limited to Special Exclusions and Benefit limitations) detailed in these Rules and the Policy/Certificate to be issued shall also apply and prevail. The Coverholder will review the information provided on the Confirmed Previous Exclusions Underwriting Application Form to ascertain whether the relevant exclusions/limitations/other special conditions are acceptable in part or in full, and whether an additional Insurance Premium should be charged for this. The Coverholder shall inform the applicant of its decision and the applicant will need to send the Coverholder a confirmation in writing or by e-mail that the confirmed previous exclusions/limitations/other special conditions and/or Insurance Premium surcharge as established by the Coverholder are accepted by the applicant, and to do so before the insurance can start. Based on the Insurance Start Date/start of the initial cover of the Insured Person under the Contract (if the very first insurance cover under the Contract in respect of this person begins after the Insurance Start Date), the coverage level as detailed on the previous certificate of insurance as well as other relevant circumstances, the Coverholder will decide whether any Waiting Periods will be applied under the Contract in respect of this Insured Person. The Insurance Start Date/the start date of the initial cover of the Insured Person under the Contract (if the very first insurance cover under the Contract in respect of this person begins after the Insurance Start Date) must follow the expiry of the previous medical insurance policy and there should be no break in coverage from the previous Insurer.

2.13. Every Policyholder shall inform the Coverholder about any (known to the Policyholder) person to be enrolled under a Contract, having any Pre-Existing Medical Conditions, or having an invalidity status, or not being Actively-at-Work at the date of application for this insurance, reasons for their not being Actively-at-Work, if known to the Policyholder, and the dates of their expected return to work. This requirement is not applicable in case of the Contract's renewal if made without interruption of insurance.

2.14. A person applying for insurance or submitted for enrollment under the Contract (person to be insured according to the Policyholder's request) who is having or had suffered any of the Pre-Existing Medical

Conditions mentioned below, can be covered if such condition is expressly declared by that person or by the Policyholder when applying for insurance, and if the Coverholder expressly confirmed the cover of such Pre-Existing Medical Condition in the Policy/Certificate (this confirmation is essential even if the Medical History Disregarded condition applies under the Policy):

a. Oncological diseases, diagnosed at the time of application for insurance or suffered within 5 years immediately preceding that time;
b. any kind of brain tumors or cerebral cysts and other intracranial structures, skull bones, sinuses, or spinal cord cysts;
c. diagnosed leukemia or any blood diseases (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 attacks, heart valves diseases (including cardiac defects), heart murmur, or rheumatism
e. diseases classified as congenital abnormalities, deformations, and chromosome disorders, and (or) complications associated therewith;
f. systemic damages 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 a body mass index above 35.0, or state of body mass deficit with a body mass index below 18.5 (the body mass index is calculated as a ratio between the body weight (in kilograms) and the square of body height (in meters);
i. stroke or cerebral hemorrhage;
j. any diabetes form;
k. psychiatric Illnesses or behavioral disorders;
l. tuberculosis;
m. chronic Hepatitis of B, C, E, F, or G forms;
n. disabilities;
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. cystic fibrosis;
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.
oo. Epilepsy

The conditions listed above are essential for the purpose of Underwriting by the Coverholder. Failure to disclose this information (or any part thereof) releases the Insurer from liability under the Contract in connection with the non-disclosed condition.

2.15. Policies to be issued in accordance with these Rules shall indicate:
a. names of the Insurer, the Coverholder, and the Policyholder;
b. reference to these Rules;
c. Primary Area of Cover:
d. 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's health condition and other factors affecting the insurance risk;
h. Insurance Premium, its payment currency, and other payment-related conditions;
i. 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.

2.16. 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.

2.17. The content of the Certificates issued in connection with insurance Policies shall be agreed upon between the Policyholder and the Coverholder, and such Certificates 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.

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

2.19. Upon the signing of the Contract, the Coverholder's liability in respect of the Insured Person to settle Claims shall start from the 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 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 the expected level of the insurance risk (risk of utilization of the Benefits);
b. state of health of the persons to be insured, based on the results of medical questionnaires and, if necessary, a 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, and Primary Area of Cover;
e. previous voluntary medical insurance claims experience, if available;
f. price level of the applicable network of Providers, if applicable, and their geographic location.

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 for 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. The Insurance Premium can be paid annually, semi-annually, or quarterly. The specific amount, payment frequency and currency of the Insurance Premium shall be established in the Policy. The Insurance Premium shall be paid via wire transfers or by credit/debit card (Visa/MasterCard/American Express).

3.4. Unless otherwise 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 Policy 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 Policy 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 the provisions of Article 10 of these Rules.

4. SUMS INSURED AND LIMITS OF BENEFITS

4.1. The Contract shall be deemed as executed in full or fully executed in respect of a Benefit, when the sum of the expenses incurred for Treatments and related goods/services provided to the Insured Person during the Policy 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 these Rules and elsewhere in the Contract, a Policy/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 Policy 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 a 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 Policy to the Contract.

5.2. If the Insured Person wants to apply for reimbursement of incurred expenses, he/she must do so within a period of 90 days immediately after incurring such expenses, or as soon as practicably possible in the given circumstances, by submitting a Claim form adopted by the Coverholder with supporting medical documentation, original invoices and receipts attached.

5.3. When the Insured Person receives a Treatment for a condition/Benefit covered by the Contract, he/she is eligible to Claim the 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. The reimbursement of certain expenses incurred in certain circumstances can be claimed only if the 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. Emergency Medical Evacuation;
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. Home visit by a Doctor;
f. Nursing at home (if the Insured Person requires more than 4 nurse visits);
g. Palliative Treatment of terminal Illness and hospice care;
h. HIV/AIDS Treatment;
i. Outpatient Treatment if its cost will likely exceed the equivalent of 5 hundred EUR;
j. any medical condition for which Treatment cost will likely exceed the equivalent of 5 thousand EUR;
k. Treatment of Cancer;
l. Repatriation or Burial;
m. Treatment in connection with Normal or Complicated Pregnancy and childbirth, if relevant benefits are indicated as covered by the Schedule of Benefits;
n. other specific cases as set in the Policy or elsewhere in the Contract.

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

a. diagnosis;
b. description of the 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 the 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 the Usual, Customary, and Reasonable expenses and charges for the Treatment and assistance in normal circumstances, but not by more than 25 percent. However, if an un-pre-authorized Treatment or service appears to be not Medically Necessary, then no reimbursement of relevant expenses can be claimed.

5.4.3. In the case of an Emergency Medical Evacuation or a Hospitalization in a situation of Medical Emergency, the pre-authorization requirement can be replaced by the 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. If the Insured Person or his/her authorized representative would like to invite a Doctor to visit the Insured Person at home, then a pre-authorization of the Assistance Service must be received by telephone prior to the Doctor's invitation being made. The pre-authorization can be obtained if the reason for the Doctor's visit is the health condition of the Insured Person, who is not able go to the Doctor's place by him/herself without putting his/her life at risk (due to specific manifestations of the disease) or without the risk of further deterioration of his/her health (progression of the disease or its complications). The Assistance Service reserves the right to request that the Doctor's visit is made by the Doctor appointed by the Assistance Service itself; however, the Assistance Service is not obliged to arrange Doctor's visit,

other than in the course of an emergency Hospitalization. If visiting the Insured Person at home is made not in a situation of Medical Emergency, then only the costs of a Doctor's consultation (as well as the services of a nurse, if necessary) can be claimed for reimbursement, not the cost of the Doctor's transportation. If by the opinion of the Assistance Service, the Insured Person is able to get to the Doctor by him/herself without the risk to his/her life or further deterioration of his/her state of health, but the Insured Person still prefers to invite the Doctor at to his/her home, this visit is will not be covered by this insurance and no expenses related thereto shall be reimbursed.

5.4.5. The Assistance Service may need to contact the Insured Person or his/her Doctor to obtain additional medical information necessary to decide on the pre-authorization. Should the Assistance Service decide to pre-authorize the requested Treatment/ provision of goods and/or services for 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 stating 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).

5.4.6. 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 or his/her legal representative. In the 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 not be 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 Provider for an appointment directly. In case when the Policy/Certificate foresees a specific network or list of Doctors, Hospitals, or other Providers eligible under the Contract, then the Insured Person shall contact such eligible Doctors/Hospitals/other Providers.

5.6. If the Insured Person has no indication whether possible costs of a desirable Outpatient 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 five 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 Inpatient or Day-patient Medical Treatment/Day-Surgery and internal rules established by a relevant medical facility;

b. not to hand out his/her insurance card or 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 Outpatient 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 with any Illness or being given any status from those indicated in Paragraph 2.13 of these Rules;

f. to undergo additional medical examination and/or provide additional medical information, whatever is required by the Coverholder/Assistance Service, in case that an Illness or a status indicated in Paragraph 2.13 of these Rules is diagnosed/given to the Insured Person;

g. to timely pay the 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 as envisaged by the Insurance Contract, directly from the Insured Person, then the relevant amount can be paid to the Provider by the Coverholder, under the 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 limited to the amounts transferred, as well as transfer costs and currency exchange related costs). The above-mentioned reimbursement shall be due within 30 days since the relevant payment request is sent by the 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 the Policyholder accordingly. **The Policyholder shall be liable to pay all the debts of the Insured Persons and Dependents (as covered by the Contract that the Policyholder is part of) 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 the processing, adjudication, and payment of Claims to the Assistance Service; therefore, solely for the purpose of Article 6 of the Rules, the Coverholder does also mean the Assistance Service.

6.3. Any reimbursement due from the Insurer under the Contract (including but not limited 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 the Usual, Customary, and Reasonable expenses and charges as defined in Article 1 "Definitions" of these Rules.

6.4. For the Coverholder to make a decision on the reimbursement of the 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 the 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 the 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, results or interpretation of results of prescribed and paid tests, and other related documentation);

c. originals of paid invoices clearly indicating the Provider's, as well as the Insured person's (or his/her legal representative's name) names and address, the detailed list of services/goods provided, and their costs. In some jurisdictions, documents proving the legal ground for the 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 a 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 the specialized diagnostics, described in the definition for Adult Health Screening (Check-up): the documents confirming that those examinations and tests are being prescribed by a physician;

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 limited 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 the settlement of this Claim, for auditing purposes. Should the Coverholder be liable to reimburse the expenses paid directly by the Insured Person, the Coverholder reserves the right to request a proof of payment (e.g., bank statement, etc.) of the 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 with unreadable handwriting or damaged 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 the 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 these Rules, or to accept the copies of certain documents, if submitted (copies of the) 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 the 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 described in Paragraphs 6.4–6.7 of these Rules, 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 an explanation or 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 the 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 of the claimant's choice (provided 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 its equivalent 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 these Rules, the paid Claim value, besides the amount that the claimant (Provider or Insured Person or his/her legal representative) becomes eligible for, subject to the 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 the conversion of the equivalent 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 the local regulations, a 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 an 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 this Contract; or

c. the aggregate (during the whole Policy Period) amount of the 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 the expiration of the Policy Period or before the Policy Period commencement date; or

e. the Policyholder's obligation to pay the 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 Policy or Certificate, no insurance coverage is provided, 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 that are not indicated as covered in the Schedule of Benefits;

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

7.1.3. Any Pre-Existing Medical Conditions not declared on the Full Medical Underwriting Application Form (if requested by the Coverholder);

7.1.4. 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. However, claims for any injuries relating to acts of terrorism or war from insured persons who choose to remain in the region against the advice of their respective country/-ies or Embassy/-ies will not be covered as it is considered that they deliberately expos themselves to danger.

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

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

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

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

7.1.9. military maneuvers, exercises, or weapon tests;

7.1.10. 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;

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

7.1.12. 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;

7.1.13. preparation of or participation in crimes or misdemeanors;

7.1.14. 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;

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

7.1.16. sleep studies and other Treatments relating to sleep apnea; Treatment of sleep disorders, including insomnia, obstructive sleep apnoea, narcolepsy, snoring and bruxism;

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

7.1.18. 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;

7.1.19. 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;

7.1.20. Diagnostics tests and procedures, treatment of Erectile Dysfunction, as well as taking "Viagra" or other sexual enhancement drugs and their respective generic equivalents;

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

7.1.22. attending maternity/delivery preparation classes;

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

7.1.24. genetic counseling, screening, and testing.

7.1.25. 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);

7.1.26. 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;

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

7.1.28. body injury or diseases caused by any Professional sport, or by any Extreme sport;

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

7.1.30. Medical Treatments without Doctor's prescription;

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

7.1.32. rejuvenation, anti-aging and spa treatments, cosmetic treatments, NdYAG procedures, diet resorts, and convalescent rest;

7.1.33. removal of external non-malignant skin formations and nevi;

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 an 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 Diagnostics and/or Treatment;

7.1.39. taking contraceptive medicine and methods;

7.1.40. abortion, except in the case of Medical Necessity to save the 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. medical services that are provided as a package (e.g. obstetric or health screening packages), when no individual pricing can be given for a service, not covered by the insurance, but included in that package;

7.1.44. undergoing remedial teaching course;

7.1.45. pre- and post-natal classes;

7.1.46. orthomolecular treatment;

7.1.47. undergoing sex change Surgery and all related Treatments;

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

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

7.1.50. Pre-Existing Medical Condition or a medical condition which is a side effect of such condition, except as provided for under the Moratorium Underwriting;

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

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

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

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

7.1.55. all costs related to orthotics, for example insoles;

7.1.56. Kidney Dialysis (Renal Insufficiency);

7.1.57. 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 the words “organ transplant”;

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

7.1.59. Feeding therapy;

7.1.60. Behavioural and personality disorders Treatment for conditions such as conduct disorder, attention deficit hyperactivity disorder, autism spectrum disorder, oppositional defiant disorder, antisocial behaviour, obsessive-compulsive disorder, phobic disorders, attachment disorders, adjustment disorders, eating disorders, personality disorders or treatments that encourage positive social-emotional relationships such as family therapy.

7.1.61. Any costs for services and/or goods appointed/prescribed and/or purchased before the issuing of the contract, even if the financial documents for it, are dated after the conclusion of the contract;

7.1.62. Any costs arising after the Insurance Expiry Date unless the Contract has been renewed for subsequent 12 months. Any costs incurred after the completion of the Policy Period;

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

7.1.64. Dental:

a. Services performed solely for cosmetic reasons; replacement of a lost or stolen appliance;

b. Implants;

c. Dental veneers

d. Replacement of a bridge, crown, or denture within 5 years after the date it was originally installed unless:

- the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth;
- the bridge, crown, or denture, while in the mouth, has been damaged beyond repair as a result of an Injury received while an Insured Person is insured for these Benefits;

e. any replacement of a bridge, crown, or denture that is or can be made useable according to common dental standards;

f. procedures, appliances, or restorations (except full dentures) whose main purpose is to:
- change vertical dimension;
- diagnose or treat conditions or dysfunction of the temporomandibular joint;
- stabilize periodontally involved teeth;
- restore occlusion;

g. porcelain or acrylic veneers of crowns or pontics on, or replacing the upper and lower first, second, and third molars;

h. bite registrations; precision or semi-precision attachments; or splinting;

i. night mouth guards or other services for teeth grinding;

j. instruction for plaque control, oral hygiene, and diet;

k. Prosthesis Over Implant — a prosthetic device supported by an implant or implant abutment;

l. crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture;

m. replacement of teeth beyond the normal complement of 32;

n. athletic mouth guards; myofunctional therapy.

7.1.65. Other Medical Treatment, services, and goods, which are excluded from the cover under other provisions of these Rules/the Contract.

7.2. Unless otherwise is envisaged by the Contract or unless the Medical History Disregarded condition is envisaged by the Contract, Dental Basic Restorative Treatment, Dental Preventive & Diagnostic Treatment, and Dental Orthodontic Treatment (if foreseen by the applicable Schedule of Benefits) will be available subject to the condition that the Insured Person attended for regular dental inspections and underwent all required Treatments in the one-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), or immediately prior to claiming the said Dental Treatment Benefit, whichever is later.

7.3. Dental Benefits (if indicated as covered in the applicable Schedule of Benefits) are subject to the following limitations:

Clinical Evaluation	Oral	1 per 6-month consecutive period.
Prophylaxis (Cleanings)		Only 1 prophylaxis per consecutive 6-month period.
Fluoride Treatments		Limited to persons less than 14 years old. Only 1 per consecutive 12-month period.
X-rays (Routine)		Bitewings: only 1 set in any consecutive 12-month period. Limited to a maximum of 4 films per set.
X-rays (Non-routine)		Complete Mouth Survey or Panoramic x-rays: only 1 in any consecutive 6-month period.

Periapical X-rays	A maximum of 4 periapical x-rays that are not performed in conjunction with an operative procedure are payable in any consecutive 12-month period.
Intraoral Occlusal X-rays	Limited to 2 films in any consecutive 12-month period.
Models	Not covered.
Sealants	Per tooth, on an unrestored permanent bicuspid or molar tooth for a person less than 14 years old — only 1 Treatment per tooth per lifetime.
Minor Periodontics (Non-surgical)	Root planing-1 per quadrant per 36 consecutive months.
Periodontal Surgery	1 per 36 consecutive months per area of the mouth (same service).
Crowns and Inlays Replacement	limited to 1 per 60 consecutive months. Benefits are based on the amount payable for nonprecious metals. No porcelain or white/tooth-colored material on molar crowns or bridges. Replacement must be indicated by major decay.
Stainless Steel & Resin Crowns	1 per 36 consecutive months for participants younger than age 16.
Bridges	Replacement limited to 1 per 60 consecutive months, if unserviceable and cannot be repaired. Benefits are based on the amount payable for nonprecious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Dentures and Partials	Replacement limited to 1 per 60 consecutive months, if unserviceable and cannot be repaired.
Relines, Rebases	Covered if more than 12 months after installation; 1 per 36 consecutive months.
Adjustments	Covered if more than 12 months after installation; 1 per 12 consecutive months.
Repairs — Bridges	Covered if more than 12 months after installation
Repairs — Dentures	Covered if more than 12 months after installation
Endodontics	Root canal re-Treatment 1 per 24 consecutive months if necessity demonstrated.

7.4. 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.

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 by 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, a respective new Policy (if necessary) and an amended Schedule of Benefits shall be issued. If the

Policyholder requests an upgrade of 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. Should the Insured Person long-term (for more than 3 months) or permanently move out of the Primary Area of Cover, it means that the Coverholder and the Policyholder (who has arranged the insurance in respect of this Insured Persons) must both agree on changes to be made to the Policy (for instance, changing the Primary Area of Cover) and other provisions of the Contract, subject to conditions foreseen herein in this Article. The Coverholder hereby explicitly points out that changing the Primary Area of Cover might require a respective adjustment of the Insurance Premium and/or other special conditions.

8.2.2. Any changes to the Policy shall be made upon a respective written agreement between the Coverholder and the Policyholder by issuing the amended Policy, Certificate (if it was issued before), and/or issuing a new insurance card (if it was issued before).

8.2.3. The Primary Area of Cover as set in the Policy may be changed only once per Policy Period. The Policyholder can also request to make this change on the Anniversary Date.

8.2.4. The Primary Area of Cover may not be changed if the Insured Person intends to reside in the USA for a period of more than 3 consecutive months or if the Insured Person intends to travel to the USA for the purpose of receiving Medical Treatment.

8.2.5. 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 Primary Area of Cover may not be changed, and the Contract shall be terminated.

8.2.6. The Primary Area of Cover 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 practically possible. The Coverholder will confirm the receipt of the information on changes and update its records and may need to issue a new Policy or Certificate or a new insurance card.

8.4. If the Policyholder wishes to enroll a new Insured Person in the Contract, the Coverholder reserves the right to request that such new person undergoes Full Medical Underwriting, unless otherwise is envisaged by these Rules or agreed upon between the Policyholder and the Coverholder. The Coverholder will calculate the additional Insurance Premium due by the Policyholder. No back-dated enrollments are allowed, unless expressly agreed by the Coverholder. The Dependent must have the same insurance cover as the Primary Insured Person, unless expressly agreed by the Coverholder. The Coverholder will issue each new Dependent with a Certificate and an insurance identification card.

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 these Rules shall be applicable for cases mentioned in this paragraph of the Rules. Should the Repatriation or Local Burial Benefit be indicated as covered by the applicable Schedule of Benefits, the Assistance Service will help with 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 Policy Period;

9.1.2. the Policyholder's failure to pay the second or any subsequent Insurance Premium installment within the Grace Period. In the case described in this point, the Contract terminates from the date set forth in the 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 goods 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 the 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 Claim statement, proving that the Coverholder's obligations under the Contract were fulfilled in full;

9.1.4. the Policyholder's unilateral termination of the Contract. In the case described in this point, the Contract terminates from the date of the Coverholder's receipt of the 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 indicated 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 the 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 set in the 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 Policy 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 Policy is cancelled by the Policyholder after the Cooling-off Period expired, or 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 the Contract where less than five persons are insured at the Contract cancellation moment, unless otherwise agreed between the parties in the Contract;

9.4.2. if five 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 established in the Policy):

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 the relevant period, as specified in the Policy;

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 Policy Period, for which the Insurance Premium was received by the Coverholder.

9.5. Subject to the respective instructions of the Policyholder, the transfer of the refundable Insurance Premium amounts can be postponed till expiry of the original Policy Period or off-set against the 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 Rules and the Insurance Premium rates approved by the Insurer at the time of each Anniversary Date, which the Coverholder will inform the Policyholder in writing prior to the Anniversary Date.

10.2. For the avoidance of any doubts, the Coverholder is entitled to apply the revised Rules as of the 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 the respective Anniversary Date as foreseen in Article 8 of these Rules.

10.5. The Contract shall be recognized as renewed upon receipt by the Coverholder of the 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 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. The original Insurance Start Date shall be maintained provided that the Insurance Premium is paid on or before the Anniversary Date and there is no break in cover.

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 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 a decision about on the terms and conditions on which a person could be insured under a Contract (including the level of Insurance Premium, Waiting Period, Moratorium Underwriting, Specific Exclusions, the Schedule of Benefits to be applicable, and other special insurance conditions), it fully relies on the information provided by the Policyholder and the Insured Person.

11.2. If the Coverholder establishes that, when entering 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 Benefits as paid by the Coverholder under such Contract;

e. demand reimbursement of all other costs 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 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 Policy shall automatically lapse in line with point (a).

11.4. If the Coverholder establishes that (when entering 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 the 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 Benefits as paid by the Coverholder under such Contract;

d. demand reimbursement of all other costs/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 terminated as of 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 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). Therefore, all the definitions and terms as used in this Contract in respect of Processing of Personal data shall be interpreted with regards to this General Data Protection Regulation.

12.2. The following Personal data of data subjects will 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 shall be obtained directly from data subjects or indirectly from third parties (family members and representatives, Policyholder, insurance intermediaries, Doctors, Providers, state institutions, and other third parties as authorized to disclose such Personal data).

12.3. Full information about how Personal data shall be processed under the Contract 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 Policy.

12.5. The Coverholder is the processor of Personal data as appointed by the Insurer. 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 these Rules.

12.6. For the purposes as set in paragraph 12.8 of the Rules, 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: dpo@dhig.net.

12.8. The Personal data is collected by the Coverholder or on its behalf and may be used by the Coverholder and/or persons engaged by it (when acting under the Coverholder's instructions) **for the purposes of** the 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).

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.

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 the 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.

The data subject may exercise his/her rights by contacting the 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.

12.12. The Personal data collected under the Contract will be retained for a period of time equal to the duration of relevant Policy Period (including any renewals thereof) and for 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. Once the retention period is over the data will be deleted or anonymized.

12.13. In order to prevent or detect fraud and money laundering, the Coverholder may check personal details with fraud prevention agencies and sanction websites, who may record a search. Searches may also be made into 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 Coverholder may also conduct credit reference checks in certain circumstances. Further details can be found in our full Privacy Policy explaining how the information held by fraud prevention agencies may be used.

12.15. 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 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 limited 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 Policy. 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 not be satisfied with the answer/reaction of the Coverholder, he/she may contact the Insurer per client service e-mail as set in the Policy.

14. THE CONTRACT AND OTHER INSURANCE-LIKE ARRANGEMENTS

14.1. The Contract is supplemental and secondary to any social/state insurance (e.g., compulsory medical, personal accident/life insurance and the like), or to any other private or collective insurance providing coverages similar to those envisaged by this Contract.

14.2. Any expense, damage, loss, guarantee of payment or organisation of medical treatment are to be claimed by the Insured Person (or by their legal representatives) preferentially from the social/state insurance or from other insurers (under policies of which similar benefits are provided) as if this Contract had not existed.

14.3. The benefits covered under this Contract can be claimed only if any corresponding expense, damage, loss, guarantee of payment or organisation of medical treatment is not covered wholly or partially by other insurance arrangements.

14.4. This Contract does not cover expenses, damages, losses, guarantees of payment or organization of medical treatment, covered by other insurers, including national, governmental, municipal, public or private health programs or by the employer, as well as expenses incurred by the Insured Person as a

result of his/her discretionary refusal of treatment to be conducted or guaranteed according to the standards/rules of any of the indicated programs.

14.5. The Coverholder has the right to request and receive from the Insured Person (his legal representatives) information regarding insurance policies providing coverage similar to the current policy, under which the latter can exercise insurance rights.

15. FINAL PROVISIONS

15.1. Confidential information

In accordance with these Rules, 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.

15.2. 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 Policy of this Contract, unless otherwise required by law.

15.3. 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.

15.4. Language of correspondence

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

15.5. 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.

15.6. 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.