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International expatriates medical insurance

General insurance conditions EMEX-GIC-032020

Covered through

Cooper Gay

Index

Information

The Coverholder & Insurer

Cooper Gay S.A., German Branch, St. Martin Tower, Franklinstraße 61-63, 60486 Frankfurt am Main, Germany, HRB Frankfurt am Main 88817. The headquarters of the company is Liege, Belgium.Cooper Gay S.A. is subject to the supervision of the Belgish Financial Authority (FSMA), Rue du Congrès 12-14, 1000 Brussels.

The Coverholder is authorised to enter into a contract or contracts of insurance to be in accordance with the terms of a binding authority on behalf of the insurer, Lloyd's Insurance Company S.A., Bastion Tower Marsveldplein 5, 1050 Brussels, Belgium, registered at the Belgium Central Register of Corporations 682.594.839 RLE. Lloyd's Insurance Company S.A. is regulated and authorized by the "Nationalbank of Belgium, Boulevard de Berlaimont 3, 1000 Brussels, Belgium".

Claims Department & Assistance Provider

Sedgwick Germany GmbH, Gladbecker Straße 1, 40472 Düsseldorf, Germany, HRB Düsseldorf 85175, is responsible for handling the claims and providing emergency assistance on behalf of the insurer during the insurance period or in the frame of other events enumerated in the insurance contract. The coverage and the conditions are determined by the insurance contract, any additional written agreements, the GIC's as well as the applicable legal provisions in force.

Compliance

The insurers products and services may not be available in all jurisdictions and are expressly excluded from this policy where prohibited by applicable law, including but not limited to, anti-corruption laws and economic sanctions programs. Any such coverage will be null and void. The contract does not replace participation in a state-run or local health insurance scheme or compliance to any other legislative requirements of any country whatsoever. The policyholder/insured should not stop contributing to a state-run insurance scheme unless they have been given advice about the risks of doing so.

The insurer and policyholder/insured agree that, except as explicitly stated in the present general insurance conditions of the insurance contract, nothing of value has been offered or provided by either of them or anyone acting on their behalf, in relation with this insurance contract.

Order of precedence of the clauses of the general insurance conditions

The general clauses are only valid insofar as they are not contradicted by or in conflict with the provisions and clauses of the different types of coverage. In case of contradictions or conflict, the clause of the specific coverage shall prevail over the general clause.

General contractual information

§ 1 Information concerning the contract

1 Conclusion of your contract
The contract has been concluded through our confirmation of cover. The begin of the contract and your insurance cover is the date stated in the insurance policy.

2 Instructions concerning revocation according to § 8 Par. 2 No. 2 VVG

2.1 Right of revocation
You can revoke your contractual declaration within two weeks without stating any reasons in a text form (e.g. letter or e-mail).

The deadline shall begin on the date after you have received the insurance policy, the contractual provisions including our General Insurance Terms and Conditions as well as the contractual information according to § 7 Par. 2 of the law governing insurance contracts and these instructions in a text form.

In electronic business transactions (online application or online conclusion of contract) the deadline for revocation shall not begin before we have also satisfied the additional duties which especially apply to this sales method according to § 312e Par. 1 Sentence 1 BGB (means for correcting input errors, confirmation of

the application).

In order to safeguard the deadline for revocation it is sufficient for the revocation to be sent in time. The revocation is to be directed at

Cooper Gay S.A.
German Branch
Franklinstraße 61-63
60486 Frankfurt am Main
Germany

2.2 Consequences of revocation
In the event of an effective revocation your insurance cover shall end and we shall reimburse you the part of your premium which relates to the period of time after receipt of the revocation.

We can retain the part of your premium, which relates to the period of time until receipt of the revocation if you have approved that the insurance cover shall begin before expiry of the deadline for revocation. If you have not granted such consent or if the insurance cover only begins after expiry of the deadline for revocation we shall reimburse you the total premium.

We shall reimburse you premiums immediately; by no later than 30 days after receipt of the revocation.

2.3 Special instructions
Your right of revocation is excluded if the contract was satisfied in full by both parties at your express wish before you exercised your right of revocation.

The right of revocation does not exist with contracts with a term of less than one month.

3 Term and conditions of termination
The contract shall apply to the period of time stated in the insurance policy. You can find the conditions of termination in the General Insurance Conditions § 3.

§ 2 Information concerning legal action

1 Which law shall apply?
German law shall apply to this contract.

2 Which court has jurisdiction?
2.1 The place of jurisdiction for actions from the insurance contract against us is Frankfurt am Main. If you are a natural person the course shall also have local jurisdiction in the district of which you have your place of residence at the time when the action is filed or, in the absence of such, your customary place of stay.

2.2 If you are a natural person actions from the insurance contract against you must be filed at the court that has jurisdiction for your place of residence or, in the absence of such the place of your customary place of residence. If you are a legal entity the court of jurisdiction is determined according to your registered seat or your branch.

2.3 If your place of residence, registered seat or your branch is located in a state outside of the European Union, Iceland, Norway or Switzerland, the place of jurisdiction is on the other hand Frankfurt am Main.

3 Contractual language
The contractual language is English. This document may only be completed and interpreted in English. The Policy Certificate for this plan will be generated in English and German.

§ 3 Who is responsible for your complaints?

1 Ombudsman
Our company is a member of the association of insurance ombudsmen. You can thus use the free out of court reconciliation proceedings.

The insurance ombudsman can deal with complaints up to an amount in dispute of currently € 80,000.--.

We undertake with decisions up to an amount of € 5,000.—to waive addressing a court and to acknowledge the arbitration award of the ombudsman.

The possibility to take legal action remains unaffected for you hereby.

The insurance ombudsman can be contacted at

beschwerde@versicherungsombuds mann.de
P. O. Box 080632, 10006 Berlin.

2 Supervisory authority
You can also direct complaints at the responsible supervisory authority; it is the "Nationalbank of Belgium, Boulevard de Berlaimont 3, 1000 Brussels, Belgium".

Information leaflet concerning data processing

§ 1 Preamble
Today insurances can only perform their tasks still using electronic data processing (EDP). Only this way can contractual relationships be processed correctly, quickly and in a cost effective manner; EDP also offers the insured community better protection form misuse than the former manual system.

We process your personal data in compliance with the EU Data Protection Basic Regulation (GDPR), the Federal Data Protection Act (BDSG), the relevant provisions of the German Insurance Contract Act (VVG) and all other relevant laws.

If you wish to insure yourself with us, we need your data for the conclusion of the contract and for the assessment of the risk to be assumed by us. If the insurance contract is concluded, we process this data in order to issue the policy or send you an invoice. We require information in the event of claims and benefits in order to check how you have covered yourself in detail and which benefits you receive from us. The conclusion or execution of the insurance contract is not possible without the processing of your data.

In addition, we need your personal data to compile insurance-specific statistics, e.g. for the development of new tariffs or to meet regulatory requirements. We also use selected data from all existing contracts within the group to examine the entire customer relationship, for example in order to advise you specifically on contract adjustments or amendments. They are also the basis for comprehensive customer service.

The legal basis for this processing of personal data for pre-contractual and contractual purposes is Art. 6 para. 1 b) GDPR. Insofar as special categories of personal data, e.g. your health data, are required for this purpose, we will obtain your consent in accordance with Art. 9 Para. 2 a) in conjunction with Art. 7 GDPR. Art. 7 GDPR. If we compile statistics with these data categories, this is done on the basis of Art. 9 Para. 2 j) GDPR in conjunction with Art. 7 GDPR. § 27 BDSG.

We also process your data in order to protect legitimate interests of ourselves or third parties (Art. 6 para. 1 f) GDPR). This may be necessary, for example:

a. to guarantee IT security and IT operation,
b. to advertise their own insurance products and other products of the Group companies and their cooperation partners, as well as market and opinion surveys,
c. for the prevention and clarification of criminal offences, in particular we use data analyses for the recognition of indications which can point to insurance abuse.

Right of objection

You have the right to object to the processing of your personal data for direct marketing purposes.

If we process your data to safeguard legitimate interests, you may object to this processing if your particular situation gives rise to reasons that speak against data processing.

In addition, we process your personal data to fulfil legal obligations. This includes, for example, regulatory requirements, commercial and tax retention obligations or our duty to provide advice. In this case, the legal basis for the processing is the respective statutory regulations in conjunction with Art. 6 para. Art. 6 para. 1 c) GDPR.

§ 2 Declaration of consent in accordance with the Basic Data Protection Ordinance (GDPR)
The policyholder agrees that we may collect data resulting from the application documents or the execution of the contract (in particular premiums, insured events, risk/contract changes) to the extent necessary and

may transfer such data to other insurers for the purpose of assessing the risk and processing the insurance and reinsurance as well as assessing the risk and claims to other insurers and/or to the Gesamtverband der Deutschen Versicherungswirtschaft e.V./Verband der privaten Krankenversicherung e.V. (Association of the German Insurance Industry e.V. / Association of Private Health Insurers e.V.) for passing on such data to other insurers. This consent shall also apply irrespective of the conclusion of the contract as well as for corresponding checks of (insurance) contracts applied for elsewhere and for future applications.

The policyholder further consents to us and the reinsurers keeping his general application, contract and benefit data in joint data collections and passing them on to the intermediary(s) responsible for him insofar as this serves the proper performance of his insurance matters.

Health data may only be passed on to personal insurers and reinsurers; they may only be passed on to intermediaries to the extent necessary to draft the contract.

Without influence on the contract and revocable at any time, the policyholder further agrees that the intermediary(s) may use his (their) general application, contract and performance data for advice and support also in other financial services.

§ 3 Disclosure of information
In addition, the transmission of data that is subject to professional secrecy, such as that of a doctor, requires special permission from the person concerned (release from the duty of confidentiality). In life insurance, health insurance and accident insurance (personal insurance), the application or the notice of claim also contains a confidentiality release clause.

In the following, we would like to give you some important examples of data processing and use.

1 Data storage with your insurer
We store data which is necessary for the insurance contract. First of all, this is your application data, e.g. surname, first name, address, date of birth, occupation. In addition, insurance data such as customer number (partner number), sum insured, duration of insurance, premium, bank details and, if necessary, the details of a third party, e.g. an intermediary, an expert or a doctor (contract data) are recorded for the contract. In the event of an insured event, we store your information on the loss and, if applicable, also information from third parties, such as the degree of occupational disability determined by the doctor, the determination of your repair workshop regarding a total motor vehicle loss or, if a life insurance policy expires, the amount paid out (benefit data).

2 Data transfer to reinsurers
In the interests of its policyholders, an insurer will always ensure that the risks it assumes are balanced out. In many cases, we therefore cede some of the risks to domestic and foreign reinsurers. These reinsurers also require the corresponding underwriting information from us, such as insurance number, premium, type of insurance cover and risk and risk surcharge, as well as your personal details in individual cases. Insofar as reinsurers participate in the risk and loss assessment, they are also provided with the necessary documents. In some cases, reinsurers make use of other reinsurers, to whom they also transfer the corresponding data.

3 Transfer of data to other insurers
According to the Insurance Contract Act, the insured person must inform the insurer of all circumstances important for the assessment of the risk and the settlement of the claim when submitting the application, when amending the contract or in the event of a claim. This includes, for example, previous illnesses and insured events or notifications of similar other insurances (applied for, existing, rejected or cancelled). In order to prevent insurance misuse, to clarify possible contradictions in the information provided by the insured or to close gaps in the findings on the loss incurred, it may be necessary to request information from other insurers or to provide corresponding information in response to enquiries.

4 Data transmission to external service providers and other recipients
We work with selected external service providers to meet our contractual and legal obligations. In the list of service providers you will find the companies with which we have long-term business relationships. You can call up the current version from our data protection officer.

In addition, we may be obliged to transfer your personal data to other recipients, such as authorities to fulfil statutory notification obligations (e.g. social insurance institutions, tax authorities and the Central Allowance Office for Retirement Assets).

5 Data exchange with your employer
If your employer takes out group insurance with us for you as an employee, he will register you for insurance. He will inform us of your name, address, date of birth and sex.

6 Creditworthiness information
Like many other companies, we also check the general payment behaviour of new customers, for example, whom we do not yet know so well. This is a common procedure in the business world where we collect information from the credit agency CREDITREFORM.

7 How long do we store your data?
We store your data for the duration of your contract. In addition, we store your personal data for the fulfilment of legal obligations to provide evidence and to retain data. These result from the German Commercial Code, the German Tax Code and the Money Laundering Act. The retention periods are up to ten years.

If the insurance contract is not concluded, we will delete your application data three years after submission of the application.

8 What rights do you have?
In addition to the right of objection, you also have the right to information, correction and deletion of your data and to restriction of processing. Upon request, we will provide you with the data provided by you in a structured, common and machine-readable format. If you wish to view data or change anything, please contact us at the above address.

9 Complaints office
You have the option of contacting our data protection officer or a data protection supervisory authority. The data protection supervisory authority responsible for us is:

The Hessian Commissioner for Data Protection and Freedom of Information

P.O. Box 3163
65021 Wiesbaden, Germany
Phone: +49 611 1408 - 0
fax: +49 611 1408 – 611
https://datenschutz.hessen.de/

General insurance conditions

1. Insurance eligibility and acceptance

1.1 Eligibility

The insurance is available for private individuals and their dependents. The minimum age for being eligible for insurance coverage as primary insured shall be 18 years of age. The maximum age of entry for being eligible for insurance shall be 50 years of age. This plan is for EEA residents residing outside of their home country temporarily and for third country residents residing within the EEA area, holding a valid/active work permit and having their ordinary residence inside the EEA. The policy for incoming residents into the EEA will only become effective once the individual is physically within the EEA area.

1.2 Acceptance

The insured is considered as accepted into the insurance once he has successfully applied the insurance, accepted the terms and conditions and paid the insurance premium.

The insured is responsible to verify that the online purchase and transaction was successfully processed, that the insurance policy was issued and received by email and that the information on the insurance policy is accurate.

The insurer cannot be held responsible for any online technical errors.

1.3 Language

This policy is written in English. This policy may only be completed and interpreted in English.

2. Insurance territory

2.1 Area of coverage

The coverage is granted worldwide, with exclusions of the U.S. Territories, Canada and the Caribbean. Home country coverage is excluded. The right to benefits from the insurance coverage ceases as soon as the insured enters a territory excluded from the insurance contract.

3. General provision

3.1 Key points

The insurance contract is a mutual agreement, between the applicant and the insurer, covering all the key points of their relationship. The basis of this contract consists of the sum of declarations made by the policyholder, the insured person or a legal representative, and laid down in the contract or in further agreements as well as the medical history.

The key points and criteria of the contract are the following:

a) The general insurance conditions must be taken into account and approved;

b) The insurer must explicitly accept the application for the policy to be concluded;

c) The insurer must have received the payment of the premium in full - all applicable bank fees, credit card fees or any other charges are at the expense of the policyholder/insured;

3.2 Insurance policy

An insurance policy is the document that confirms the existence of an insurance contract between the policyholder/insured and the insurer.

With this document, the insurer confirms his willingness to enter into an agreement with the insured provided that all the key points of the contract are fulfilled, particularly only after the insurance premium has been paid.

3.3 Modification of insurance coverage

In case the insured will modify the insurance coverage, a written request to the insurer is required. If accepted by the insurer, the modification will only be effective on the next policy renewal date.

3.4 Change of name/address

Any changes of name or address (es) of the policyholder/insured have to be notified in writing within 30 days to the insurer. In the meantime the last known address will remain valid.

3.5 Right of withdrawal

The policyholder/insured shall have a period of fourteen (14) calendar days to withdraw from the policy without penalty and without giving any reason. The period of withdrawal shall begin either from the day of the conclusion of the online contract. The policyholder/insured will be entitled to the return of the full premium paid, on the condition that no claim has been submitted.

For compliance with this deadline it is sufficient for the policyholder/insured to send his/her notice of withdrawal by post or e-mail to the insurer.

3.6 Acceptance of medical service providers

Only invoices issued by qualified medical service providers, possessing recognized and valid diplomas of the country in which the insured is being treated and where they are authorized to practice will be taken into consideration.

3.7 Expenses covered

The services provided in the context of the insurance conditions should be effective, appropriate and economical. Effectiveness, adequacy and cost effectiveness have to be scientifically proven. If this is not the case the insurer reserves the right to reasonably reduce the benefits accordingly.

In- and outpatient treatment must be received in the appropriate medical facility, and experimental treatment is excluded.

The medical expenses must correspond to the expenses usually incurred by a similar service or supply and do not exceed the normal charges incurred under the best prevailing conditions for such a service or supply in the locality where the service or supply is received. If usual and prevailing expenses charged can not be determined due to the unusual nature of the service or supply, the insurer will determine to what extent the charge is reasonable, taking into account:

- The complexity involved
- The degree of professional skill required
- All other relevant factors

The usual tariffs in the territory of the treatment define the amount and the duration of the insurance benefits.

If no special conditions have been negotiated such as the compulsory consultation of a predefined medical network, the insured can be treated by a certified medical practitioner of choice.

3.8 Medical expenses

Necessary and reasonable medical care or treatment due to an involuntary illness or injury is covered.

The coverage comes into effect when the medical treatment starts and coverage ends as soon as the medical results indicate that further treatment is no longer necessary.

Should the treatment be extended to an illness or the consequences of an accident without causal connection to the original incident any claims arising out of those treatments will be treated as caused by a new incident.

3.9 Partial benefits

If the insured does not benefit at all or only partially from the insurance policy, the insurer cannot be obliged to refund the benefits covered in kind. If the costs entailed by an occurrence are less than those set out in the insurance policy, the insured is not entitled to claim the difference.

3.10 Copayment

A copayment of twenty (20) percent is applied on all benefits on the next policy renewal date after the insured person has reached 50 years of age.

A copayment means that a certain percentage of the coverage will be at the expense of the insured.

3.11 Maximum insured sum

An annual maximum insured sum is the maximum amount that is covered during a policy year.

The benefits list states the different maximum insurance benefits per policy year.

3.12 Subsidiarity

Coverage is subsidiary to any benefits that are provided by the compulsory social insurances, other insurance branches (e.g. accident insurance, health insurance of the home country), service agreements or associations to which the insured is a party or pays a contribution, whenever the latter do not offer the insured person sufficient protection.

3.13 Right of option

Within the first three years of your insurance cover, we offer you the option of increasing your insurance cover to the comfort tariff without a new health check, unless you have already opted for the comfort tariff at the outset.

In these cases we do not carry out a new risk assessment, i.e. the risk assessment is carried out under the terms of the new tariff, but using the original risk call at the start of the initial contract.

4. Insurance start, duration, renewal and end date

4.1 Start date of insurance

The insurance coverage starts on the date and under the conditions defined in the insurance policy. Please also see paragraph 3.1 c) and 5.1 respectively which need to be met in order to successfully establish insurance coverage.

Addition of a dependent is possible under the same conditions as a new insured. The enrollment of an additional dependent is possible only from the next policy renewal date.

4.2 Duration of insurance

The duration of coverage is stated in the insurance policy, the minimum duration is one (1) year.

The insurance year begins on the effective date of the insurance, as indicated on the insurance policy and ends one year later.

4.3 Insurance renewal

After the annual insurance period has expired, as long as no party wishes to terminate the policy, it will be automatically renewed for a new period of one (1) year. The maximum insurance period is five (5) years. After five (5) years the insured is not able to renew the plan anymore and the policy will cease.

4.4 End of insurance

The coverage expires on the same day that the insurance policy expires. All treatments received outside of the policy duration are not covered.

For the Insured, the insurance under this policy shall automatically terminate:

- if any premium on this policy is not paid on the due date or within the grace period;
- if the insured is a dependent child, on the thirty-first (31st) of December of the year during which the dependent child becomes twenty-four (24) years old or when he/she is no longer considered to be a dependent child or upon the date of marriage;
- if the dependent is the spouse or legal partner, upon the date of divorce or legal separation from the insured, or as from the end of the legal partnership;
- if it becomes unlawful for the insurer to provide any of the coverage available under this contract;
- if the insurer has been provided with misleading information or if information has been withheld that should have been provided and could have affected the Insurer's assessment of the risks to be insured under this contract;
- upon the death of the insured.
- if the insured person (only for non-EEA citizens) is no longer residing in the EEA area.

5. Premium payment

5.1 Payment of the insurance premiums

Receiving premium payment is an essential part of the insurance contract whatever which mode of payment has been agreed upon. The premium is to be paid in advance on a monthly, quarterly, half-yearly or yearly basis unless otherwise agreed upon in writing by both the policyholder/insured and the insurer.

Premiums have to be paid in full before the chosen start date of the insurance - fees that arise due to the payment are entirely at the expense of the policyholder/insured, before the start date of the rates and

before the annual renewal due date of the insurance. Taxes and charges as established by the applicable laws will be added to the amount of the premium, and have to be paid in full by the policyholder/insured.

The premium payment frequency can be altered if requested at least one (1) month before the policy renewal date.

In any case, the insurance policy will be only issued after the payment is credited on the bank account of the insurer.

Withholding the payment of a premium in order to compensate some outstanding benefit is not permitted.

The premium is calculated always for an entire year.

5.2 Non payment of insurance premium

In case of failure by the policyholder/insured to pay the premium on the due date, the insurer cancels the insurance contract and notifies the policyholder/insured in writing by letter or e-mail.

5.3 Adjustment of the premiums

In case the insurer increases the premium rate, he will notify the policyholder/insured at least one (1) month before the policy renewal date, in writing by letter or e-mail, of the premium increase and of the date as from which the new premium will become effective.

If the policyholder/insured does not agree with the new premium conditions, he/she can terminate the contract through notification of cancellation to the insurer in writing by letter or e-mail to the insurer before the next policy renewal date.

The premiums are age related and there will be no notification in the event of a premium increase due to a change of age band. The new premium rates will become effective as from the next policy renewal date after the insured's birthday. There is no possibility to terminate the policy due to an age band-related premium increase.

5.4 Modification of insurance conditions

The insurer has the right to modify the insurance conditions including those relative to an already existing contract.

The new conditions will be notified to the policyholder/insured no later than one (1) months prior to their becoming effective, unless there is a case of emergency, force majeure or a legal, administrative or judicial obligation that bears no delay.

In the absence of a termination of the existing insurance contract in writing by the policyholder/insured, the new insurance conditions will come into effect and be viewed as accepted.

The insurer may at any time modify the wording of the terms and conditions, however only to exclude typing errors or obvious inaccuracies, to get rid of uncertainties in the interpretation, to explain a certain passage in the text or to change the conditions in favor of the policyholder/insured.

5.5 Salvatory clause

The present invalidity or the future invalidation of one of the provisions to be found in the insurance conditions and the appearance of a legal gap (lacuna) do not have any effect on the validity of the other clauses.

In order to replace or add to the invalid or missing clause, the insurer will add a clause that makes sense and which will be within the realms of possibility and tolerance and the closest it can get to the original contents of the contract of the parties.

6. Obligations of the insured

6.1 Double insurance

If the same risk is covered for the same period of time by more than one insurer to the extent that the combined sums insured exceed the insurance value, the policyholder/insured are obliged to inform all insurers in writing immediately.

If the policyholder/insured has intentionally omitted to notify the insurer of these facts or taken out a double insurance in view of obtaining an illicit profit, the insurer shall henceforth automatically be relieved of any contractual obligations.

6.2 Increase of risk

An increase of risk is of significance if it affects the risk evaluation that has been established during the insurance contract. All factors that might influence the decision of the insurer to accept the contract or to accept it under the agreed conditions are important (especially important is the insured's state of health, illnesses can be considered a risk increase, or if he/she undertakes dangerous activities, etc.).

If the insured causes a significant increase of risk during the duration of the insurance, the insurer will cease to be bound by the insurance contract. The insured has the obligation to inform the insurer immediately in writing.

If the increase of risk is not caused by the insured this will only lead to an automatic cancellation of the policy if the insured has neglected to notify the insurer as stated above. If the insured provides such a notification the insurer reserves the right to terminate the policy following the notification.

Obesity is an increase of risk and is diagnosed when a person has a Body Mass Index (BMI) of over thirty (30). If significant weight gain leads to obesity during the insurance period it is considered to be a significant increase of risk.

Except for changes in the state of health of the insured incurred after acceptance into the insurance, the insured is obliged to inform the insurer of any change in circumstances or conditions that may increase the risk of illness or accidents (e.g. dangerous professional activity). The insurer may then propose new insurance conditions (within a period of one (1) month after having received notification of the increase of the risk) or cancel the insurance coverage, within one (1) month, retroactively as from the moment of the start of the increase of the risk.

6.3 Immediate notice/communication of a claim

In case of any imminent or declared incident all insured have the obligation to contact immediately the dedicated claims management.

Should verification of a claim no longer be possible due to the failure of the insured to notify the insurer in a timely way, and due to this late notification a claim can no longer be identified or verified, the Insurer will not reimburse the claim that cannot be identified or verified.

In case of a medical assistance, it is mandatory to contact the 24/7 alarm center number as soon as possible after the incident has occurred.

Tel : +49 (0) 211 54014750
Email: sc-medical@de.sedgwick.com

Tel : +49 (0) 211 5401 4239
Email: sc-claims@de.sedgwick.com

If the insured is entirely unable to notify the insurer immediately and it can be proven that a personal or indirect contact with the dedicated claims management prior to consulting a certified medical practitioner at the moment of the event was impossible because of the patient's life threatening situation, a notification in a timely manner by the policyholder/insured, the police, the hospital or any party to the incident, will be considered a valid notification.

All inpatient treatments (except emergency hospital admissions), are subject to pre-authorization. This means that in case of non-emergency hospitalization (planned treatments) for which the diagnosis of the medical condition has been established more than five (5) days before actual admission into a hospital the insurer has to be informed - by e-mail at the latest five (5) days before the hospitalization will take place.

The following information is required:

- diagnosis;
- description of the required treatment;
- name and address of the facility where the inpatient treatment and stay will take place;
- expected length of stay;
- estimated costs;

In case of failure to comply with the pre-authorization requirement, a penalty of twenty-five (25)% will be applied by the Insurer, meaning that the reimbursement of the eligible expenses will be reduced to seventy-five (75)% of the amount the Insured would normally be entitled to if he/she had duly fulfilled the said requirements.

In case of an emergency hospitalization, the insurer has to be informed as soon as possible and at the latest before discharge from the hospital.

6.4 Obligation to minimize claims

The insured is obliged to take all reasonable steps to avoid or minimize any claims.

6.5 Consequences of the violation of the obligations

Besides the consequences of disregarding articles already mentioned above, upon infringement of the contractual obligations the following consequence can be applied to the insured:

Should the disregard of the obligations happen with the intention of defraud, the contract with the insured will automatically be null and void. The insurer will no longer be bound to provide services and benefits and can ask for a refund of the reimbursements already received by the insured. The insurer will not refund any premiums paid by the insured.

In the event of other violations or any disregard to the insured's obligations, the insurer has the right to reduce coverage proportionally to arising damages.

The policyholder/insured are solely responsible for the execution of the contractual obligations.

7. Hospital (in-patient) plan

7.1 Accommodation

The following costs for inpatient care in a hospital and in the contractual territory, are covered:

a) Inpatient treatment in a public or private medical establishment; Fees for private rooms and chief doctor treatment are not covered.
b) Admission to a hospital or surgical establishment;
c) Medical costs arising during the hospital stay as an inpatient;
d) Intensive care in a public or private medical establishment
e) Accommodation, operating theatre & recovery room in a public or private medical establishment.

If no special conditions have been negotiated such as the compulsory consultation of a predefined medical network, the insured may chose between the public or private clinics, which are permanently staffed with qualified medical personnel, who can make a diagnosis and who have the necessary diagnostic and therapeutic means at their disposal and work with scientifically recognized methods.

Reimbursement of costs depends on the coverage and what has been agreed on in writing when the insured informed the insurer about the intention of inpatient treatment.

The insurer provides coverage for services for medical examinations, healing methods and medication generally accepted by conventional medicine. Coverage will also be provided for methods and medication that have proven to be effective in practice when conventional methods or conventional medication do not exist or cannot be applied. The insurer can, however, reduce coverage by adapting the coverage to the amount that would have had to be paid if conventional methods and medication were applied.

The insurer will pay up to the policy limits stated in the benefits list for charges incurred in a hospice facility, hospital or convalescent facility for accommodation and other services and supplies given to an the insured

while a full-time inpatient for pain control and other acute and chronic symptom management when given as a part of a hospice care program. The hospice care program must be pre-authorized by the insurer in advance and must provide a centrally administered program of palliative and support services to terminally ill insured and their families. Terminally ill means the patient has a prognosis of eight months or less. A medically supervised interdisciplinary team of professionals and volunteers will provide these services.

If it is considered a legal abortion according to the Criminal Code of the country in question and if the abortion is medically necessary because of imminent danger to body and soul (profound distress) of the pregnant mother, the insurer will pay for the abortion and it will be considered an illness.

7.2 Psychotherapy and similar treatments when necessary during a hospitalization

The insurer will only reimburse the costs for inpatient psychotherapy if authorization has been given in advance in writing after have received an assessment by the insurers own expert. With the hospital plan, only treatment that is directly in connection with inpatient treatment is covered.

Psychiatry and psychotherapy refer to treatment of mental or nervous disorders, carried out by a psychiatrist or clinical psychologist. 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 triggered by a particular event such as bereavement, relationship or academic problems or acculturation.

The disorder must meet the criteria for classification under an international classification system such as the Diagnostic and Statistical Manual (DSM-IV) or the current International Classification of Diseases (ICD).

Psychotherapy is covered according to the insurance contract, provided the treatment is prescribed and performed by a certified medical practitioner.

7.3 Laboratory and x-ray expenses

With the hospital plan, only treatment that is directly in connection with inpatient treatment is covered.

Diagnostic tests are investigations such as x-rays or blood tests, undertaken in order to determine the cause of the presented symptoms.

The costs for lab examinations, x-rays, scanner and MRI's, if prescribed by a certified medical practitioner for valid reasons are covered.

7.4 Organ transplant

The inevitable transplant of an organ is covered. However, the costs related to finding matching donor organs (organ bank) are not included in this coverage.

An organ transplant is the surgical procedure concerning the following organ and/or tissue transplants: heart, heart/valve, heart/lung, liver, skin, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular/skeletal and cornea transplants.

Expenses incurred for the acquisition of organs are not covered.

7.5 Medication

Medication approved by the state's authorities is covered according to the benefits list. Homeopathic treatments are also covered. Under the hospital plan, only treatments that are directly in connection with inpatient treatment are covered.

Medication, wound dressings and medical equipment have to be prescribed by a certified medical practitioner or another agreed specialist. Certified medical practitioners who are next of kin of the insured or the policyholder will not be taken into consideration.

The prescribed medication has to be bought at the pharmacy. The purchase of more than one package of the same medication has to be written on the certified medical practitioners prescription.

Products such as pure alcohol for medical use, cotton, sun protection, products for dental care, shampoo,

food for special diets, mineral water, special sorts of wine, fresh or dried glands, contraceptives, cosmetics, sanitary products, anti-alopecia, insect repellent spray, etc. are non medical substances and therefore not covered.

7.6 Nursing at home

Nursing at home or in a convalescent home refers to nursing received immediately after or instead of eligible inpatient or day-care treatment. The insurer will only pay the benefit where the treating certified medical practitioner decides (and the insurer agrees) that it is medically necessary for the member to stay in a convalescent home or have a nurse in attendance at home. Coverage is not provided for spas, cure centers and health resorts or in relation to palliative care or long term care.

Following a stay in a hospital or in replacement of an inpatient treatment in a hospital, a daily amount will be covered for each contractual year.

7.7 Physiotherapy

With the hospital plan, only treatment that is directly in connection with inpatient treatment is covered.

Prescribed physiotherapy refers to treatment by a registered physiotherapist following referral by a certified medical practitioner. Physiotherapy is initially restricted to 6 sessions per condition, after which the referring medical practitioner must review the treatment.

Should further sessions be required, a progress report must be submitted to the insurer, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as rolfing, massage, pilates, fango and milta therapy.

7.8 Post-hospital outpatient treatment

Post-hospital outpatient treatment is covered if prescribed by a medical provider and within the limitation and maximum sum defined in the insurance benefits list.

7.9 Surgical/Medical appliances

Surgical and medical appliances are covered if prescribed by a medical provider and within the limitation and maximum sum defined in the insurance benefits list.

7.10 Medical aids/equipment

Prescribed medical aid refers to any instrument, apparatus or device which is medically prescribed as an aid to the function or capacity of the insured person, such as hearing aids, speaking aids (electronic larynx), crutches or wheelchairs, orthopedic supports/braces, artificial limbs, stoma supplies, graduated compression stockings as well as orthopedic arch-supports. Medical aids that form part of palliative care or long term care are not covered.

7.11 Kidney dialysis

The insurer cover sudden kidney failure resulting from an illness or accident and within the limitation and maximum sum defined in the insurance benefits list.

7.12 Voluntary treatment abroad

If the necessary medical treatment for which you are covered is available locally, but you choose to travel to another country within your geographical area of coverage for treatment, the insurer will reimburse all eligible (meaning reasonable and customary) medical costs incurred within the terms of your contract, however travel expenses are not covered. In any case coverage in such situations is subjected to mandatory pre-authorization of the insurer.

8. Outpatient plan (optional)

8.1 Emergency outpatient treatment

Emergency outpatient treatment is a treatment received in a casualty ward/emergency room following an accident or sudden illness, where the insured does not, out of medical necessity, be admitted in a hospital

as inpatient.

The treatment must be received within 24 hours of the emergency event.

8.2 Laboratory and x-ray expenses

Diagnostic tests are investigations such as x-rays or blood tests, undertaken in order to determine the cause of the presented symptoms.

The costs for lab examinations, x-rays, scanner and MRI's, if prescribed by a certified medical practitioner for valid reasons are covered.

8.3 Alternative medicine

Following therapies are covered if prescribed by the general practitioner :

Services of officially licensed masseur or those of kinesitherapy (thermo therapy, electrotherapy, physiotherapy) if they are authorized and licensed within the contractual territory.

Services of officially licensed chiropractors and osteopaths are only covered if they are authorized and licensed within the relevant contractual territory.

The costs for alternative medical treatment will be reimbursed (medical physicals and tests, therapy, medication) provided that a therapy will only be granted on medical prescription and can only be performed by physician, an official herbalist (recognized by the authorities) or by an official therapist for alternative medicine. The coverage of costs for medication/remedies is always linked to the prescription of the treatment by a certified medical practitioner and if the insurer deems it necessary a second opinion will be obtained through a private medical expert.

8.4 Physiotherapy, logopedics and orthopedics

Physiotherapy, logopedics and orthoptics are only covered if prescribed by a certified medical practitioner. The therapist must be licensed and authorized within the relevant contractual territory.

Logopedics refers to treatment carried out by a qualified speech therapist to treat diagnosed physical impairments, including, but not limited to, nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

8.5 Medication

Approved medication by the state's authorities, homeopathic treatments, wound dressings and medical equipment are covered if prescribed by a certified medical practitioner or another agreed specialist.

The prescribed medication has to be bought at the pharmacy. The purchase of more than one package of the same medication has to be written on the certified medical practitioner's prescription.

Products such as pure alcohol for medical use, cotton, sun protection, products for dental care, shampoo, food for special diets, mineral water, special sorts of wine, fresh or dried glands, contraceptives, cosmetics, sanitary products, anti-alopecia, insect repellent spray, etc. are non medical substances and therefore not covered.

8.6 Medical aids/equipment

Prescribed medical aid refers to any instrument, apparatus or device which is medically prescribed as an aid to the function or capacity of the insured person, such as hearing aids, speaking aids (electronic larynx), crutches or wheelchairs, orthopedic supports/braces, artificial limbs, stoma supplies, graduated compression stockings as well as orthopedic arch-supports. Medical aids that form part of palliative care or long term care are not covered.

Prescribed aids such as bandages and supporting bandages, support stockings, orthopedic insoles, support plasters, correcting tapes, orthopedic equipment to support the upper body, the arms, the legs, hearing aids, electronic larynx, artificial arms, legs or feet are covered according to the insurance contract.

Costs for other prescribed medical aids and sanitary devices, such as any other equipment, orthopedic

shoes, appliance for massage, inhalators, infrared and blue-light lamps for therapy as well as heating pads, their installation, use and maintenance, are not covered according to the insurance contract.

8.7 Accidental dental treatments

Accidental dental treatments are covered if caused by an accident and if the treatment was given within 24 hours after the accident.

9. Assistance

9.1 Assistance conditions

The insurer will assist the policyholder/insured within the legal and contractual scope during the contractual period. The policyholder/insured must notify immediately the insurer to obtain assistance. However, providing emergency assistance does not prejudice the insurers decision concerning the financial coverage according to the present general insurance conditions.

9.2 Ambulance transport (ground, sea, air)

In case of a medical emergency, the insurer covers the transportation by ground, sea or air to the closest appropriate facility. The limitation and maximum sum defined in the insurance benefits list is applicable.

9.3 Medical evacuation

Medical evacuation means that if the emergency treatment for which the insured is covered is not available locally, the insured may be transported to the closest appropriate facility. Only the reasonable and customary costs of treatment and transport that have to be pre-authorized by the insurer are covered. Should it not be a medical emergency, the travel to and from the medical facility is not covered. In every case pre-authorization from the insurer is mandatory.

The insurer covers the costs per contractual year for urgent medically indicated transportation so as to provide the insured with appropriate treatment at the nearest possible hospital or an approved medical service.

Medical evacuation related costs will only be reimbursed if the insured's state of health does not allow for use public or private transportation.
Costs related to transportation per contractual year are not covered, in the event of:

- An illness or accident intentionally provoked by the insured, self-mutilation or attempted suicide;
- Addiction or alcoholism;
- Ethylic state, open drunkenness or if proven that the insured party while being involved in an accident had alcohol in his blood of more than 0,5 g/lt.

The insurer covers the transportation costs, the insurer's coverage is subsidiary to any other provider.

9.4 Medical repatriation

As soon as the insured's condition requires it, with authorization of the insured and with pre-authorization from the insurer, the insurer will arrange and pay for the repatriation to the country of residency. The limitation and maximum sum defined in the insurance benefits list is applicable.

The insurer has the right to choose the type of transportation deemed most appropriate (by air, land or sea).

The insurer will cover reasonable and usual repatriation costs actually incurred by the transport. The limitation and maximum sum defined in the insurance benefits list is applicable.

9.5 Repatriation of mortal remains caused by any covered medical case

In the event of the death of the insured caused by any covered medical case, the insurer will arrange for the repatriation of the mortal remains from the place of his death to the funeral site within his/her country of residence or home country. The repatriation is carried out in accordance with the applicable national laws and international conventions.

The insurer will cover the transfer costs of the mortal remains and will take care of all formalities required

for the transportation of the mortal remains. The limitation and maximum sum defined in the insurance benefits list is applicable.

9.6 Search and rescue

The insurer covers the costs for search and/or rescue incurred by the competent authorities up to the sum defined in the insurance benefits list.

10. Table of benefits

	Annual plan maximum sum EUR 1'000'000	Annual plan maximum sum EUR 1'000'000
Inpatient treatments	**STANDARD**	**COMFORT**
Accomodation	Semi-Private-Room	Semi-Private-Room
Physicians & Specialists	100%	100%
Surgeons & anesthetist	100%	100%
Nursing at home	100%	100%
Medication	100%	100%
Post-hospital outpatient treatment	Up to EUR 25'000 Up to 12 month	Up to EUR 25'000 Up to 12 month
Inpatient psychiatric treatment	100%	100%
Organ transplant	Up to EUR 150'000	Up to EUR 150'000
Surgical/Medical appliances	100%	100%
Physiotherapy	100%	100%
Mobility aids	100%	100%
CT, MRI and PET scans	100%	100%
Kidney dialysis	Up to EUR 15'000	Up to EUR 15'000
Palliative care	100%	100%
Treatment for cancer	Up to EUR 100'000	Up to EUR 100'000

Outpatient treatments (optional)	**STANDARD**	**COMFORT**
General practitioner consultations	Not included	Up to EUR 2'500
Specialist	Not included	Up to EUR 1'500
X-ray, Laboratory Tests	Not included	Up to EUR 1'000
Prescribed medication	Not included	Up to EUR 1'000
Physiotherapy, logopedics and orthopedics	Not included	Up to EUR 500
Alternative medicine & treatments	Not included	Up to EUR 500
Accepted medical aids/equipment	Not included	Up to EUR 300
Accidental dental treatment	Not included	Up to EUR 500

Assistance in/out patient	**STANDARD**	**COMFORT**
Ambulance transport (air, sea, ground)	EUR 10'000	EUR 10'000
Medical repatriation	EUR 100'000	EUR 100'000
Evacuation	EUR 50'000	EUR 50'000
Search and rescue	EUR 10'000	EUR 10'000

Repatriation of mortal remains	EUR 10'000	EUR 10'000
Assistance 24 / 7	included	included

11. Definitions

11.1 Inpatient treatment (Hospitalization)

Admission to a hospital establishment for medical intervention for a period of at least 24 hours.

Hospital accommodation refers to general ward or semi-private room.

Deluxe, executive rooms and suites are not covered. Accommodation includes charges for services, such as general nursing care, that occur in connection with the hospital stay.

Hospital also includes clinics and medical units that are managed by certified medical practitioners and medical staff who treat ill or injured patients.

Not included are wellness hotels and thermal baths, establishments for elderly and chronically ill individuals as well as socio-medical and similar establishments that are not suited for the treatment of acute illness.

11.2 Outpatient treatment

Outpatient treatment refers to treatment provided in the practice or surgery of a certified medical practitioner, therapist or specialist that does not require the patient to be admitted to a hospital.

Outpatient surgery is a surgical procedure performed in a surgery, hospital, day-care facility or outpatient department that does not require the patient to be admitted in a hospital.

11.3 Stabilization center

The place where the insured is taken to following an incident in order to prepare for transfer or repatriation.

11.4 Medical necessity

Medical necessity refers to those medical services or supplies that are determined to be medically necessary and appropriate.

They must be:

- Essential to identifying or treating a patient's condition, illness or injury.
- Consistent with the patient's symptoms, diagnosis or treatments of the underlying condition.
- Consistent with the diagnosis and customary medical treatment for a covered illness or injury
- In accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time.
- Required for reasons other than the comfort or convenience of the patient or his/her physician.
- Proven and demonstrated to have medical value.
- Considered to be the most appropriate type and level of service.
- Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of a patient's medical condition.
- Provided only for an appropriate duration of time.
- The charges are fair and reasonable for the treatment.
- The treatment may not be of experimental, investigational or research nature.

As used in this definition, the term "appropriate" shall mean taking patient safety and cost effectiveness into consideration. When specifically applied to inpatient treatment, medical necessity also means that a diagnosis cannot be made, or treatment cannot be safely and effectively provided on an outpatient basis.

11.5 Accident

An accident is an injury which is the result of an unexpected event, independent of the will of the insured and which arises from a cause outside of the insured's control. The cause and symptoms must be medically and objectively definable, allowing for a diagnosis and require therapy.

11.6 Sudden illness

Any unintended negative change in health that requires professional examination, treatment or medical care and which is not due to an accident or a pre-existing condition.

11.7 Emergency

An emergency constitutes the onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment occurring within 24 hours of the emergency event will be covered. Once the emergency condition is stabilized, the insurer will coordinate the post stabilization care as foreseen in the general insurance conditions.

11.8 Chronic condition

A chronic condition is defined as a sickness, illness, disease or injury, which has one or more of the following characteristics:

- Is recurrent
- Is without a known, generally recognized cure
- Is not generally deemed to respond well to treatment
- Requires palliative treatment
- Requires prolonged supervision or monitoring
- Leads to permanent disability

10.9 Acute medical condition

A medical condition that is likely to respond quickly to treatment which aims to return the insured to the state of health he/she was in immediately before suffering from the disease, illness or injury, or which leads to full recovery.

11.10 Consultation

A consultation is any consultation or discussion with a certified medical practitioner or specialist and the issue of any prescriptions.

11.11 Certified medical practitioner

A medical practitioner who holds primary degrees in medicine or surgery as recognized by the World Health Organization and who is legally licensed to practice in the country where treatment is provided.

Certified medical practitioner fees refer to non-surgical treatment performed or administered by a certified medical practitioner.

11.12 Specialist

A certified medical practitioner qualified, duly licensed and recognized as such by the relevant officials of the country in which the treatment is being given.

11.13 Anesthetist

An anesthetist is a certified medical practitioner or a technician trained to administer anesthetics.

11.14 Medication

Drugs, medicine and corrective devices (including prosthesis when used as an integral part of a surgical procedure) prescribed by a certified medical practitioner or specialist.

11.15 Palliative care

Palliative care refers to inpatient, day-care or outpatient treatment, following the diagnosis that the condition is terminal and treatment can no longer be expected to cure the condition.

Treatment given to an insured for the primary purpose of temporary relief of symptoms, as curing the medical condition is no longer an option.

11.16 Pathology

Tests carried out to help determine or assess the nature of disease and the changes in structure and functions brought about by disease.

11.17 Psychiatric illness

Treatment of a mental disorder carried out by a clinical psychologist. The disorder must be associated with present distress, or substantial impairment of the individual's ability to function in a major life activity (eg. 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 and acculturation.

The disorder must meet the criteria for classification under an international classification system such as Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Diseases (ICD-10).

11.18 Treatment

Any medically necessary surgical procedure or medical intervention required to cure or provide relief of an acute medical condition.

Complementary treatment means therapeutic and diagnostic treatments that exist outside the institutions where conventional western medicine is taught. Such medicine includes chiropractic treatment, osteopathy, homeopathy and acupuncture as practiced by approved therapists.

Oncology treatment refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis on.

Long-term care refers to care over an extended period of time after the acute or emergency treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long-term care can be provided at home, in the community, in a hospital or in a nursing home.

11.19 War and Terrorism

War :

- armed conflict, declared or undeclared, between one State and another, an invasion or a state of siege.
- also considered as acts of war are: all similar actions, the use of military force by a sovereign nation to achieve certain economic, geographic, nationalistic, political, racial, religious or other ends.
- civil war: armed conflict between two (2) or several parties belonging to one and the same state, the members of which are of different ethnic origin, religion or ideology.
- also considered as acts of civil War are: an armed rebellion, revolution, sedition, insurrection, a coup d'état, the consequences of martial law and border closings ordered by government or by local authorities.

Terrorism :

- any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption;
- commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not;
- robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorists acts.

Terrorism shall include any act that is verified or recognized by the (relevant) government as an act of terrorism.

Description of benefits :

With respect to the risks and consequences of War and Terrorism, all consequences of active participation of the insured (and/or his/her covered dependents) in operations of war and terrorism are explicitly excluded from all coverage. In case the insured is victim of acts of war and terrorism without any active involvement on behalf of the insured or his/her beneficiaries in these acts, the insured is covered within the limits and the ceilings of the cover. The optional insurance covers (accidental death and disability) are not valid when the insured (or covered dependent) is travelling to or from or is residing in a country or a part of a country publicly known to be in state of war or civil war at the time damages (bodily injury, or death) to the insured or his/her covered dependents happen. In the event the insured, whilst abroad, is faced with the sudden, unanticipated occurrence of a new (outbreak of) war or warlike situations and acts, the insurance coverage remains valid for fourteen (14) days starting from the beginning of the hostilities.

11.20 Pre-existing conditions

Pre-existing conditions includes all treatments, symptoms or diagnosis that was detected, known or should have known existed, by a medical provider or by the insured before the start date of the insurance contract. Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been shown at any point prior to commencement of coverage, irrespective of whether any medical treatment or advice was sought.

Any change in health, disease, illness or infirmity, be it physical or psychological that objectively existed prior to the start date of the insurance contract and whose manifestation, consequences or complications require treatment, professional examination, tests or a medical intervention during the period of coverage by the insurance is considered and part of pre-existing conditions.

11.21 Policyholder

The policyholder is the physical person or legal entity concluding the insurance policy on his own behalf or on behalf of another person and who as a result is liable to pay the premiums. In the event the insurance is concluded by the policyholder on behalf of another person, the insured is considered the sole beneficiary of any insurance benefits and can claim accordingly.

11.22 Insured

The insured is a physical person who is the beneficiary of the insurance covers within the insurance contract.

11.23 Age limitations

Individuals can only apply and conclude an insurance contract after having reached the age of 18 years old.

Children under the age of 18 years old can only obtain coverage together with their parents or legal guardians as dependents.

Applications and conclusions are only accepted until the age of 50 years old.

11.24 Dependent

A dependent is a spouse or partner and/or unmarried children, (including any step, foster or adopted child) which is financially dependent on the policyholder. A dependent is considered as such up to the day before their 18th birthday or up to the day before their 24th birthday if enrolled in full time education. Every dependent must be named in the insurance policy and defined as a dependent.

11.25 Next of kin

A next of kin is a person who has a close relationship with the insured, whilst not necessarily being related.

11.26 Third party

A person who is not in any way related to the insured, nor a spouse or a flat mate, nor in a work relationship nor an organ of a relevant legal entity.

11.27 Home country

The home country is the country of nationality mentioned in the passport of the insured. If the insured person holds more than one passport, the home country will be that country, which has been mentioned from the insured during the application process.

11.29 Country of residence

The country of residence is the country in which the insured has his place of residence in civil law.

11.30 Ordinary residence

The place where in the settled routine of an individual's life, he or she regularly, normally or customarily lives.

12. Exclusions

The following events are not covered :

- If the insured commits a crime, an offence or acts in a rash way that leads to the claim;
- If the insured takes drugs and/or alcohol and/or hallucinogenic products and toxic substances which lead or contribute to the incident
- If there are harmful effects to the insured's health that resulted from the production and the use, intentionally or unintentionally, of chemical, biological, bio-chemical, electro-magnetically substances meant to be used as a weapon (independently from any possible concurring causes), as well as damages due to nuclear or any other form of radiation.
- If the incident occurred outside the territory fixed in the insurance policy or insurance policy or outside the effective period of coverage.
- Illnesses and injuries that arise out of the participation in extreme sports. Extreme sports or Adventure sports are recreational activities perceived as involving a high degree of risk. These activities often involve speed, height, a high level of physical exertion, and highly specialized gear. The following activities are considered as extreme sport : BASE jumping, BMX, Bodyboarding, Bungee jumping, Canyoning, Climbing, Extreme pogo, Extreme skiing, Extreme ironing, Flowriding, Freediving, Freeflying, Freeride, Freerunning, Freeskiing, Freestyle scootering, Freestyle skiing, Hang gliding, Ice canoeing, Ice climbing, Ice yachting, Inline skating, Ironman Triathlon, Kite ice skating, Kitesurfing, Land windsurfing, Longboarding, Mixed Martial Arts, Motocross, Motorcycle sport, Mountainboarding, Mountain biking, Off-roading, Paragliding, Parkour, Powerbocking, Rafting Rallying, Rock climbing, Sandboarding, Sand skiing, Skateboarding, Ski jumping, Skimboarding, Skydiving, Skysurfing, Slacklining, Snowboarding, Snowskating, Snowmobiling, Speedflying, Speedriding, Speed skiing, Street luge, Surfing, Underwater diving, Wakeboarding, Water skiing, Waveski, Whitewater kayaking, Windsurfing, Wingsuit flying, Zorbing... This list is non exhaustive and the insurer reserves the right to evaluate other activities as extreme sport.
- Practising sports professionally or as part of an official competition organised by a sporting association for which a licence is issued, plus training in view of entering competitions;
- Ignoring official prohibitions or official rules concerning the safe practice of a given sports and/or leisure activity;
- Taking part in a motor racing at any level.
- Disease/Disorder including their consequences from an accident due to war or warlike conditions or those stemming from military service in a country not specifically listed;
- Illnesses or accidents and their consequences intentionally provoked;
- Treatments by certified medical practitioners, dentists and hospitals that have been explicitly excluded from the service package that are notified to the insured or to the person taking decisions on his behalf.

- Outpatient treatment in a spa or hot spring resort.
- Care and treatment provided by the spouse, by in-laws or by offspring, or by a next of kin;
- Any cosmetic surgeries, the consequences or complications thereof;
- Expertise, certificates, written evidence, opinions, instructions or estimates issued by the provider to the extent that they have to be submitted by the insured to the insurer;
- In the event that the services provided are deemed not efficient, appropriate, and economic by an independent medical expertise sought by the insurer.
- Aptitude testing, educational testing and services.
- Services for mental disorders or illnesses that are not medically necessary.
- Services related to drug and alcohol abuse, including private or special nursing, or services rendered by a physician.
- Chronic brain syndrome, senility, mental retardation.
- In the event that the provided services for treatment or any other care exceed the real necessary medical costs, the insurer may reduce the benefits in such a way as to reach an acceptable amount. The insurer has also the right to reduce the benefits if other types of medical care, less expensive, would have been just as appropriate.
- Any fertility/infertility services, tests, treatments, drugs and/or procedures and pregnancy arising from such treatment.
- Any claim relating directly or indirectly to pregnancy, pregnancy terminations, pregnancy complications antenatal classes or midwifery costs, delivery costs, postnatal costs or any medical conditions relating to pregnancy or childbirth.
- All dental treatments (excepted accidental dental treatments).
- All pre-existing conditions are excluded.
- Accidents caused by the symptoms of epilepsy and malaria
- All treatments within the home country of the insured.
- Any claim relating directly or indirectly caused by an epidemic or pandemic.

13. Sanction Clause

Without prejudice to the other contractual provisions, insurance cover shall only exist insofar and as long as no economic, commercial or financial sanctions or embargos of the European Union directly applicable to the contracting parties conflict with this.
This shall also apply to economic, commercial or financial sanctions or embargos imposed by the United States of America with respect to Iran, unless contrary to European law.

14. Claim

Considered as a claim are all unintentional event that occurs within the period of coverage and under the conditions specified in the insurance contract and which causes the insurer to fulfill the obligation to provide benefits to the insured within the legal and contractual obligations.

All outpatient treatments will need to be paid in advance and can be claimed afterwards. The insurer shall reimburse the covered, reasonable and customary medical expenses up to the limits defined in these general insurance conditions following the receipt of the claim form and the relevant and complete written evidence of the medical expenses. Reimbursements shall be made to the insured, but if the insured has deceased, payment shall be made at the sole discretion of the insurer, or to any person submitting

satisfactory evidence that he/she is entitled to such payment. Benefits may be directly assigned to hospitals.

14.1 How to submit a claim

The insurer will only consider reimbursement or payment if all requested documents concerning the incident have been submitted by e-mail scans or by mail. Each claim has to be submitted to the dedicated claims management using the claim forms made available by the insurer - as soon as possible after the event giving rise to the claim has occurred.

The dedicated claims management has the right to request the original documents if deemed necessary. The dedicated claims management has the right to ask for evidence that the bills, of which the reimbursement is being requested, have already been paid.

In the event of another insurance company participating in the reimbursement of the expenditures, copies of the invoices will suffice, provided a receipt issued by the other insurance company is submitted.

All invoices and honorary notes have to include the name and address of the treating certified medical practitioner, the insured, the date of treatment, details of the different medical services as well as the diagnosis (name of the affliction, DRG number, ICD 10 code etc.). The prescriptions have to be sent to the dedicated claims management and have to be accompanied by the honorary fees of the certified medical practitioner, bills for medication, equipment etc.

The submission of a medical center's document certifying the inpatient care in a hospital together with admission and discharge always stating the treated disorder/disease is compulsory.

All bills and honorary fees have to be submitted to the dedicated claims management immediately upon receipt.

The dedicated claims management has the right to reimburse the authorized bearer or sender of the correct and complete documents.

Costs of treatments in a foreign currency will be converted at day's value (date of receipt) in EUR.

Expenses such as inherent costs of transmissions and translations will be deducted from the benefits.

Money transfer fees or taxes are not covered by the insurer.

14.2 Documentation

Any documents have to be submitted to the insurer as soon as possible, however at the latest 365 days after the occurrence of the incident, proven by postal stamp or official certification, the insured must spontaneously and at his/her own expense, provide the insurer with the requested documents listed below. Beyond the delay of 365 days, no claim shall qualify for reimbursement and consequently the insured forfeits the right for reimbursement.

In case of an accident the insured must provide an accident report and/or statements drawn up by the police authorities, fire department or any other emergency service as well as:

- date and detailed description of circumstances and place of the accident;
- identity of persons involved, as well as of witnesses and persons possibly liable;
- official report from local authorities (police or other).

The complete medical report written by the certified medical practitioner consulted or provided by the hospital the insured was admitted to or treated in, in relation with the claim;

Medication and other prescriptions for the pharmacy;

Invoices for the medical treatments undergone by the insured, any stay in a hospital and purchases of medication;

Furthermore, the insured and the policyholder have to provide the insurer with any other information and proof relating to the incident, which might help to clarify the circumstances of the incident/claim and allow an estimate of the extent of its consequences, provided they ought to know of this information.

In view of clarifying the circumstances of the announced incident, and in order to estimate the extent of its consequences and verify its veracity the insurer reserves the right to request, from the insured and at the latter's expense, supplementary information, facts and proof. If the insurer formulates this request in writing a delay of at least thirty days can be granted (formal notice) in order to receive these documents. If the insured lets the time elapse, all rights to the claim will have been forfeited.

On the insurer's request, the insured has to undergo a medical check-up done by a certified medical practitioner appointed and paid for by the insurer.

14.3 Non transferability of claims

Claims of the insured arising or likely to arise from the insurance contract can neither be transferred nor held as a deposit. Especially rights to benefits stemming from the insurance contract cannot be transferred to a next of kin, a hospital, debt collecting agency, a company, an insurance taker, a work colleague or an authority, etc.

14.4 Subrogation

The Insurer has full rights of subrogation for any benefits paid within the framework of this insurance contract. The rights and claims of any natural person or legal entity that benefits in whole or in part from the coverage provided in the insurance contract as stated in the conditions of insurance against the third party responsible for the event shall pass to the insurer up to the level of compensation and costs paid by the insurer in view of fulfilling this insurance contract.

Should the insured have a right to compensation by a third party and notwithstanding the contractual subrogation, this right has to be passed on in written form to the insurer up to the level of the amount of the benefits the insured is likely to receive from the third party. Thus, this right will pass to the insurer. If the insured waives the right to compensation or its relative security, without prior agreement of the insurer, the latter will be released from all obligations up to the sum the insured would have received or could have been entitled to by the third party.

Therefore, when asked to confirm this right to the Insurer in order to assist the Insurer in recovering from a third party any amount paid or which will be paid by the Insurer to the Insured or expenses made on behalf of the Insured, the Insured shall be obliged to provide this confirmation in writing to the Insurer.

Any defense inherent in the insurance policy, which the Insurer may raise against the Policyholder may also be raised against the Insured, whoever he/she may be.

14.5 Coordination of benefits - other insurances

If the insured is entitled to a reimbursement by another insurer or social security system, the coverage will be applied on the difference between the eligible medical expenses and the reimbursement made by the other insurer. However, in case the insurance is offered as a supplementary insurance, the amount reimbursed by the other insurance will be deducted from the amount of reimbursement. In any case, the insured has to attach copies of the pertaining medical bills and the settlement notes (with details of the amount reimbursed) provided by the other insurer or the social security system concerned. Total reimbursement for any given claim will never exceed the total amount of expenses actually incurred by the insured.

14.6 Medical confidentiality

By accepting this general insurance conditions, the insured releases all certified medical practitioners and paramedical staff who have examined or treated him both before and after the incident from their obligation to maintain medical confidentiality with respect to the insurer. The insured commits to reiterating consent after the claim and/or to signing an ad hoc form for the insurer. A refusal will mean the loss of all contractual rights to the claim.

15. Termination of the contract

The insurer and the policyholder have the right to terminate the policy by notifying the other party in writing by letter or e-mail at the latest one (1) month before the end of the current contractual year.

Besides the legal and contractual clauses that make it possible to declare/render the contract invalid, to terminate it retroactively, to terminate it with immediate effect and to terminate it within a certain different

delay, an unintentional culpable attitude of the policyholder/insured will entitle the insurer to terminated the insurance policy within one (1) month from the moment of the insurer's becoming aware of the irregularity.

The insurance contract automatically terminates with the death, the bankruptcy, or the official insolvency of the policyholder.

When the insured returns to live and/or to work in his/her home country, thereby ending the period of expatriation abroad, the policyholder/insured have to notify the insurer in writing by letter or e-mail, of the exact date of relocation to the home country. The insurance contract and the coverages are automatically terminated the day the insured relocate definitively to its home country also if the insurer was not properly informed.

16. Applicable law

German law shall apply to this contract.

17. Validity

The present insurance conditions are valid from March 1st, 2020 and replace all previous conditions governing the same product.