Insurance Terms and Conditions for Foreigners' Comprehensive Health Insurance

ITC FCHI dated December 1, 2018

Article 1. General Provisions

1. Foreigners' Comprehensive Health Insurance shall be governed by Act No. 89/2012 Coll., the Civil Code, as amended (hereinafter referred to as the "Civil Code"), and the provisions of the Insurance Contract, of which these Insurance Terms and Conditions for Foreigners' Health Insurance of 1 December 2018 (hereinafter ITC FCHI) are an integral part. Insurance shall be governed by the laws of the Czech Republic
2. The insurance fulfils the conditions of Act 326/1999 Coll., on the residence of foreign nationals in the Czech Republic, as amended.
3. The Insurer means INTER PARTNER ASSISTANCE, S.A., member of AXA Group, with its registered office at Avenue Louise 166, 1050, Brussels, Belgium, entered in the Commercial Register administered by Greffe de Tribunal de commerce de Bruxelles under registration number 0415591055, acting through INTER PARTNER ASSISTANCE, organization unit, with its registered office at Hvězdova 1689/2a, 140 62 Prague 4, ID number: 28225619, entered in the Commercial Register administered by the Municipal Court in Prague, file number A 59647 (hereinafter the Insurer).
4. The insurance is hereby designated nonlife damage insurance.

Article 2. Definition of Terms

Assistance Service is a legal entity that in the name and on behalf of the Insurer provides the Insured Party or an Authorized Person with insurance Indemnifications and related assistance services. The Assistance Service represents the Insurer in the application for, investigation, and settlement of Insurance Claims. The Assistance Service or a representative authorized by the Insurer is entitled to act on behalf of the Insurer in connection with all Insurance Claims defined within the present ITC FCHI. Address of Assistance Service: AXA Assistance CZ, s.r.o., Hvězdova 1689/2a, 140 62, Prague 4 - Pankrác.

Common Sports are the following common leisuretime and recreational sports: aerobics, airsoft, aqua aerobics, archery, badminton, baseball, basketball, beach volleyball, biking, billiards, board games, boccia, boomerang, bowling, bridge, bungee running, bungee trampoline, cards and other board games, cheerleaders, chess, cricket, crosscountry skiing along marked trails, curling, cycle ball, cycling, dancing, darts, dragboat - dragon boats, fencing (classic), fitness and bodybuilding, floorball, footbag, football, football tennis, frisbee, goalball, golf, handball, ice-skating, jogging, juggling (diabolo, fireshow, juggling, yoyo), korfball, low ropes course (up to 1.5 m), marbles, mini trampoline, modern gymnastics, mountain biking (except for downhill biking), mountaineering - climbing along marked trails without the use of climbing aids and Via Ferrata of difficulty level A, orienteering (including radio), paddleboat riding, petanque, rowing, scootering, showdown, skiing on marked trails, skittles, snorkelling, snowboarding on marked trails, softball, spinning, sports fishing, sports model building, sport shooting (shooting at targets with the use of firearms), squash, streetball, swimming, synchronized swimming, table football, table hockey, table tennis, tchoukball, tennis, volleyball, water polo, water skiing, yoga, and other sports of a similar risk level.

Foreign National is a natural person who is not a citizen of the Czech Republic.

Waiting Time is the period during which the Insurer is not obliged to provide insurance Indemnifications for events that would otherwise be deemed Insurance Claims. Waiting Time is counted from the beginning of the insurance term.

Single Premium is the insurance premium stipulated for the entire insurance period. The Insurer shall always be entitled to the full amount of the Single Premium.

Comprehensive Health Care is health care provided by the Insurer to an extent similar to the public insurance in the Czech Republic, subject to the insurance exclusions set out in Article 8 of ITC FCHI and the agreed insurance Indemnifications specified in Article 7 of ITC FCHI.

Home Country is the country of which the Insured Party is a citizen.

Newborn shall for the purpose of this insurance mean a child from birth to the end of three months of age.

Dangerous and High-Risk Sports and Activities are activities, the dangerous nature of which substantially exceeds the standard risk during sports, such as bungee jumping, ski jumping, parachuting, motorpowered and motorfree flying of any

kind, alpinism of any kind, water skiing, white water rafting and kayaking of any kind and diving of any kind, ski touring, backcountry skiing and snowboarding and skiing and snowboarding outside of the set operating hours on marked trails, acrobatic skiing, bobsled and skibob riding, snow rafting, motor sports of any kind, motor sports on snow, ice, and water, canyoning and spelunking, stunt performance, martial arts, downhill mountain biking, horse riding, skateboarding, skeleton riding, inline skating and activities aimed at beating sports records and other extreme and adrenaline sports. The hazardousness of sports shall be determined by the Insurer.

Authorized Person is a person eligible to collect insurance Indemnifications as a consequence of an Insurance Claim.

Insured Party's Relative is a person that is in a close personal relationship with the insured party in the meaning of Section 116 defined in Sec. 22 of the Civil Code, i.e. a relative in direct lineage, sibling, spouse, partner pursuant to another act governing registered partnership; other persons in a family or similar relationship refer to persons who are mutually close, so that if one of them suffered harm the other would just feel this to be harm to their own person. Relatives shall be deemed to include in-laws and persons who permanently cohabit.

Insurer is a legal entity authorized to perform insurance activities according to Act 277/2009 Coll., on insurance, as amended.

Insurance Term is the period for which the insurance is concluded.

Insurance Claim is an arbitrary event covered by insurance, described in detail in an insurance contract or insurance terms and conditions, which occurs during the insurance term and on the basis of which the insurer is obliged to provide performance in line with these insurance terms and conditions to the policyholder or a third person.

Insurance Indemnification is the payment which the Insurer is obliged to provide if an Insurance Claim occurs; the Insurer shall provide the Insurance Indemnification in accordance with the content of the Insurance Terms and Conditions and/or the Insurance Contract.

Policyholder is the person who has entered into the Insurance Contract with the Insurer.

Insurance is a legal relation established by an insurance contract whereby the insurer undertakes to the policyholder to provide insurance benefits to the policyholder or a third person in the event of an arbitrary event covered by insurance (insurance claim) and the policyholder undertakes to pay premiums to the insurer.

Insured Party shall mean an individual whose name or other unique identification is provided upon the arrangement of the insurance and to the health of which the insurance applies, or whose rights and justifiable interests form the subject of the insurance.

Postpartum and Newborn Care is the medical care provided to the Newborn of an insured woman for the duration of the insurance, where the health care is directly related to childbirth and is provided until the termination of the continuous hospitalization of the Newborn; the exclusions under Article 8 of ITC FCHI shall apply.

Business Stay is a stay associated with the performance of business, profession, occupation, or other gainful activities. If a Business Stay is agreed on, the insurance will also apply to a tourist or study stay.

Professional Sport is the achievement of sports results for payment or other remuneration.

Study Stay is the period of residence for the purpose of study; the insurance does not apply to events occurring in connection with any activities defined as "Business Stay".

Damage Claim is an event resulting in any damage which may justify the right to claim Insurance Indemnifications.

Terrorist Act is the use of force or violence or the threat of using force or violence by any person or a group of persons, independently or in someone's favour or in cooperation with any organization or government, committed for political, religious, ideological, or ethnic reasons or purpose, causing detriment to human health, material or immaterial assets or infrastructure, including the intention to influence any government or intimidate the population or part thereof.

Tourist Stay is a residential stay and/or a trip which may include Common Sports and activities at the recreational level; the definition of tourist trip does not include a Business Stay or engagement in any Dangerous and High-Risk Sports and Activities. If a Tourist Stay is agreed on, the insurance will also apply to a Study Stay.

Injury is the unexpected and sudden impact of external powers or one's own bodily powers independently of the insured party's will, which occurred during the insurance term and which resulted in the insured party suffering bodily harm to health or death.

Public Sports Competition (or Competition) is a competition organized by any sports or similar organization, sports or other clubs, as well as all preparations for such activities or preorganized tour with the aim of reaching specific sports goals.

Article 3. Establishment, duration and termination of insurance, insurance term, premiums

1. An insurance contract, the subject of which is insurance, is concluded with the payment of premiums in the amount set out in the draft insurance contract.
2. In order for an insurance contract to be concluded, a draft insurance contract must be accepted by means of the payment of premiums within 30 days of the applicant receiving the draft insurance contract. Should the policyholder fail to pay premiums by the deadline set out in the previous sentence, the draft insurance contract shall cease to apply.
3. The insurer shall set the insurance conditions in line with the scope of insurance, risk assessment, indemnification limit, and any other facts decisive for its amount. Premiums shall be paid in a lump sum, their amount shall be set out in the insurance contract, and they shall be payable in the currency that the policyholder chooses when arranging the insurance contract.
4. Payment of premiums shall mean:
   a) The time premiums were credited to the account of the insurer's payment service provider, if the policyholder pays premiums to the insurer;
   b) The time premiums were credited to the account of the payment service provider of the insurer's representative, if the policyholder pays premiums to the insurer's representative;
   c) The provision of cash to the insurer, if the policyholder pays premiums in cash directly to the insurer or an employee authorized by it;
   d) The provision of cash to the insurer's representative, if the policyholder pays premiums in cash to the insurer's representative.
5. The insurer shall be entitled to premiums for the entire insurance term unless stipulated otherwise in the insurance contract or these ITC FHINU.
6. If an insurance contract has been entered into in line with paragraphs (1) and (2) of this Article, insurance shall commence (i.e., be effective) at 00:01 hours of the day stated in the insurance contract as the insurance start date.
7. Insurance shall be arranged for the insurance term stated in the insurance contract and shall terminate at 24:00 hours on the day stated in the insurance contract as the insurance end date.
8. Insurance is terminated:
   a) By the expiration of the insurance term;
   b) By written agreement of the contractual parties;
   c) By termination by the insurer or the policyholder;
   d) By other means set out in the Civil Code.
9. Insurance may only be terminated by written agreement if the written agreement is concluded no later than on the day stated in the insurance contract as the insurance start date; in that case, the insurer shall return to the policyholder any premiums paid, reduced by costs related to the conclusion of the insurance contract and its administration, which shall amount to 20% of the premiums assessed. The policyholder and the insured shall return to the insurer any and all documents confirming the conclusion of insurance.
10. Should insurance terminate prior to the expiration of the term of insurance for a reason other than that stated in the previous paragraph, the insurer shall be entitled to indemnification up to the end of the term of insurance, unless the Civil Code or the insurance contract stipulate otherwise.
11. Insurance cannot be interrupted during the insurance term.
12. The fact that the insured party becomes a participant in public health insurance is not a reason for the termination of this insurance.

Article 4. Territorial Scope, Types of Insurance

1. The insurance covers only Insurance Claims that occur within the territory of the Czech Republic.
2. The insurance applies to tourist, study and business stays.

Article 5. Insurance Programme

1. The insurance is agreed for one of the following insurance programmes:
   a) **STANDARD** - this insurance programme covers the provision of Comprehensive Health Care to the Insured Party in the Czech Republic; this programme is subject to Waiting Times according to Article 6 of ITC FCHI.
   b) **MOTHER** - this insurance programme covers the provision of Comprehensive Health Care to the Insured Party - mother, in connection with her pregnancy and childbirth, without any Waiting Times. Beyond the scope of the STANDARD insurance programme, the cover also includes postnatal care for the Insured Party's Newborns, born during the existence of the Insured Party's insurance.

2. The agreed insurance programme is indicated in the Insurance Contract.

Article 6. Subject of Insurance and Insurance Claim

1. The subject of the insurance is the Insured Party's health, provisions of Comprehensive Health Care, provided by the Insurer to an extent similar to public insurance, including preventive dispensary and pregnancy care, subject to the insurance exclusions set out in Article 8 of ITC FCHI and the agreed Insurance Indemnifications specified in Article 7 of ITC FCHI.
2. The Insurance Claims include illnesses, injuries or other changes to the Insured Party's health status which occurred during the period of the insurance, following the expiry of the Waiting Time and within the territory of the Czech Republic. The Waiting Time period applies to the following cases of payments for health care:
   - In pregnancy, during the threemonth period following the commencement of the Insurance Term;
   - In childbirth, during the eightmonth period following the commencement of the Insurance Term.

   No Waiting Time is applied if the Mother insurance programme is taken out.
3. Comprehensive Health Care is provided in the Insurer's contractual health care centres in the Czech Republic. In the event of a sudden deterioration of the Insured Party's health and if there is a serious risk of damage to the Insured Party's health or life due to default, the Insurer shall also cover the cost of the health care provided in a health care centre in the Czech Republic that has not signed an agreement with the Insurer for such type of insurance. The necessary and reasonable costs demonstrably incurred for the health care will be covered, until it is possible to arrange for the provision of health care in a contractual health care centre, and up to the amount paid by the Insurer to the contractual health care centre.
4. Events that arise from one cause and include all the circumstances and their effects, where there is a causal, time, or other direct connection among such events, shall be considered one Insurance Claim.
5. In connection with the Insurance Claim, the Insurer shall cover the reasonably and purposefully expended costs for:
   a) Comprehensive Health Care provided in a contractual health care centre;
   b) Medicines prescribed by the physician for outpatient care in connection with the Insurance Claim, up to the Insurance Indemnification limit set out in Article 7. Insurance Indemnification under the present ITC FCHI;
   c) Urgent and emergency treatment by a dentist in case of acute tooth pain, i.e., extraction or simple fillings (including X-rays), and the treatment for the purpose of immediate pain relief related to the oral mucous membrane, up to the Insurance Indemnification limit set out in Article 7. Insurance Indemnification under the present ITC FCHI;
   d) Pregnancy care and childbirth; if the Mother insurance programme is not taken out, Waiting Time according to Article 6 (2) of ITC FCHI shall apply, while no Waiting Times shall apply if the Mother insurance programme is taken out;
   e) Postnatal health care of the Newborn, if the Mother insurance programme is taken out under the Insurance Contract; the postnatal health care of the Newborn is covered by this insurance up to the Insurance Indemnification limit specified in Article 7 Insurance Indemnification under the present ITC FCHI;
   f) Transportation from a doctor's office to a health care centre or from a health care centre to another specialised health care centre, if the Insured Party's current condition requires this, according to the assessment of the Assistance Service or the Insurer, and if such transportation is prescribed by the attending physician;
   g) Repatriation of the Insured Party - patient, if it is necessary and possible from the medical perspective; repatriation is assessed, approved, and organized by the Assistance Service or the Insurer, and the Insured Party is repatriated to the territory of the country whose passport the Insured Party holds, or to another country in which the Insured Party has a residency permit;
   h) Transportation of the Insured Party's bodily remains back to the territory of the country whose passport the Insured Party holds, or to a different country where the Insured Party had a residency permit; the transportation of the remains must be performed by a specialized organization approved by the Assistance Service or the Insurer;

Article 7. Insurance Indemnification

Insurance Coverage	Limit of Insurance Benefit	
	STANDARD	MOTHER
Total Limit	1 600 000 CZK	1 600 000 CZK
repatriation and transport	real costs up to total limit	real costs up to total limit
dental treatment	5 000 CZK	5 000 CZK
medicaments prescribed within	5 000 CZK	5 000 CZK
postnatal care		300 000 CZK

1. The upper limit of the Insurance Indemnification for damage incurred in the Czech Republic corresponds to the Insurance Indemnification limit specified in the Insurance Contract and this Article of ITC FCHI. The said Insurance Indemnification

limits apply to one Insurance Claim only. Regardless of changes in the EUR/CZK exchange rates, the Insurer guarantees the Insurance Claim limit of EUR 60,000 converted according to the exchange rate of the Czech National Bank applicable as of the date of the occurrence of the Insurance Claim.

2. The Insurance Indemnification and its amount shall be determined by the Insurer in accordance with ITC FCHI and the Insurance Contract, on the basis of the presented documents.
3. Insurance claim investigation
   - 3.1 Should an event occur which the person who considers himself the authorized person connects to a claim to indemnification, he shall inform the insurer thereof without undue delay, give it a true explanation of the occurrence and the scope of the consequences of the events, thirdparty rights, and any multiple insurance; at the same time, he shall present to the insurer the necessary documents and proceed in the manner stated in the insurance contract and insurance terms and conditions. If the person who considers himself an authorized person is also the policyholder or insurer, then the policyholder and the insured party shall also have the obligations stated in this paragraph.
   - 3.2 Without undue delay of the notice pursuant to paragraph 3.1 of this Article, the insurer shall launch an investigation required for ascertaining the existence and scope of its obligation to perform. The investigation shall be completed with the communication of its results to the person who claimed a right to insurance indemnification; at the request of that person, the insurer shall inform that person in writing about the scope of indemnification or the reasons of its denial.
   - 3.3 If the notice referred to in previous paragraphs knowingly contains untrue or grossly misrepresented material information concerning the scope of the event reported, or if any information pertaining to the event is knowingly withheld, the insurer shall be entitled to compensation for any costs purposefully expended on the investigation of the facts with respect to which that information was communicated to it or withheld. Should a policyholder or another person claiming a right to indemnification cause investigative costs to be incurred or increased by a breach of an obligation, the insurer shall be entitled to reasonable compensation from that person.
   - 3.4 If warranted by reasons related to the investigation of an insurance claim, the insurer may request information about the state of health and an establishment of the state of health or the cause of death of the insured party, provided that the insured party or, in the event of the insured party's death, an authorized person, has given its consent. Should the insured party or the authorized person fail to grant their consent to the insurer or recall their consent during the investigation of an insurance claim, and should this fact have a material impact on the detection or determination of the amount of insurance benefits, the insurer may reduce insurance benefits in proportion to the impact of the fact on the scope of the insurer's obligation to perform.
   - 3.5 The verification based on the previous paragraph shall be carried out on the basis of an examination by a physician appointed by the insurer. In that case, the insurer shall pay:
   - The costs related to the medical examination or check-up;
   - The travel costs amounting to the price of public second-class bus or rail passenger carriage;
   - The costs of the issuance of a medical report, if requested.
   - 3.6 Should the insurer not request a medical examination, check-up, or a medical report, it shall not pay the costs related thereto.
4. Insurance benefits shall be payable within 15 days of the end of the investigation pursuant to the previous paragraphs. If the investigation required for verifying an insurance claim, the scope of indemnification, or the person authorized to receive benefits, cannot be completed within 3 months of the event being reported, the insurer shall inform the person who made the report, as to why the investigation cannot be completed; should the person who made the report so request, the insurer shall inform him of the reasons in writing. The insurer shall provide a reasonable advance payment on indemnification to the person who is claiming indemnification, should the person so request; this shall not apply if there is a good reason to refuse the granting of an advance.
5. Insurance indemnification shall always be payable in the country in which the insurance claim occurred, unless otherwise agreed.
6. If the breach of an obligation by the policyholder, insured, or another person who is entitled to indemnification, has had a material impact on the occurrence of an insurance claim, its course, an increase in the scope of the consequences of the event, or on the establishment or determination of the amount of indemnification, the insurer may reduce insurance indemnification in proportion to the impact of that breach on the scope of the insurer's obligation to perform.
7. If the insurance claim was willfully caused either by the person who is claiming a right to indemnification or a third person at that person's instigation, no person shall be entitled to indemnification under this insurance.
8. The obligation of the insurer to provide benefits shall be restricted by exceptions and indemnification limits.

Article 8. Exclusions

1. The Insurer is not obliged to provide Insurance Indemnifications, with the exception of preventive and dispensary care related to the pregnancy of an insured mother and the delivery of her child, in the event that:

a) The Insured Party or the person claiming insurance indemnification does not respect the instructions of the Insurer or the Assistance Service and does not effectively cooperate with them, or does not submit the documents required by the Insurer or the Assistance Service;
b) The Insured Party refuses to undergo repatriation suggested by the Insurer;
c) The Insured Party refuses treatment or the necessary medical examinations by a physician or health care centre designated by the Insurer or the Assistance Service;
d) The Insurer has been unable to investigate the Damage Claim because the Insured Party or the person claiming insurance indemnification did not relieve the attending physician or other institutions from their non-disclosure obligation vis-à-vis the Insurer or the Assistance Service, as requested by the Insurer or the Assistance Service;
e) The Insured Party or the person claiming insurance indemnification prevented the Insurer or the Assistance Service from contacting the attending physician or other institutions as requested by the Insurer or the Assistane Service;
f) The Insured Party or the person claiming insurance indemnification have knowingly provided the Insurer or the Assistance Service with false or incomplete information regarding the Damage Claim;
g) The Damage Claim occurred in connection with any disturbances provoked by the Insured Party or the person claiming insurance indemnification or in connection with a crime committed or attempted by them; such an exclusion does not apply in the event of an injury;
h) The Damage Claim occurred in connection with the Insured Party's or the person´s claiming insurance indemnification active or passive engagement in warfare, peace missions, combat or military events, participation of the Insured Party in an uprising, demonstration, riot or unrests, public violence, strikes or by the intervention or decision of public administration authorities;
i) The Damage Claim was caused by the Authorized Person or another person based on the initiative of the Insured Party or Authorized Person;
j) The Damage Claim occurred in relation to the Insured Party's or the person´s claiming insurance indemnification active participation in a Terrorist Act or in preparation for it;
k) The Damage Claim occurred outside the Czech Republic;
l) The Damage Claim occurred in connection with the consumption of alcohol or other narcotic, toxic, or psychotropic substances; this exclusion is not applied in the case of an injury;
m) The Damage Claim occurred in connection with Dangerous and High-Risk Sports and Activities or in connection with Professional Sport, or during participation in Competitions or preparations for such Competitions;
n) The Damage Claim was caused by nuclear energy or nuclear risks, or chemical or biological contamination;
o) The Damage Claim occurred as a consequence of the deliberate conduct, fault, or contributory fault of the Insured Party or the person claiming insurance indemnification; this exclusion does not apply in the event of injury.

2. The Insurer is not obliged to pay any Insurance Indemnification for events that occurred prior to the premium payment.
3. Furthermore, the Insurer is not obliged to pay any Insurance Indemnification under the following circumstances:
   a) the medical care is related to the treatment of illnesses or injuries which existed prior to the signing of the Insurance Contract, including medication;
   b) the medical care is related to the treatment of illnesses or injuries, the cause or symptoms of which existed prior to the signing of the Insurance Contract or during the Waiting Time;
   c) there are complications which occurred during the treatment of the illnesses or injuries to which this insurance does not apply;
   d) the purpose of the stay is treatment or continued treatment which began outside of the Czech Republic;
   e) examinations, check-ups, or other medical procedures are in the personal interest of the Insured Party and do not serve any medical purpose (e.g., abortion, examination and treatment of infertility and artificial insemination and the costs associated with contraceptives and hormone therapy, issue of a medical certificate upon the patient's own request);
   f) non-acute dental treatment and related services, cost of dentures, dental crowns, bridges, removal of plaque or tartar;
   g) treatment by the Insured Party's Relative or a person without the corresponding qualifications, medical acts outside of a health care centre registered in the Czech Republic, treatment using methods which are not scientifically recognized in the Czech Republic;
   h) purchase of medicines and medical aids without a prescription, supplementary medicines, vitamin products, and food supplements;
   i) vaccination with the exception of compulsory vaccination in accordance with the No 258/2000, on protection of public health, as amended. and vaccination against tetanus and rabies in relation to injury;
   j) spa care or treatment, physical and bath therapy;
   k) acupuncture and homeopathy;

l) medical care provided in a non-contractual health care centre;
m) postpartum and Newborn Care of Insured Partys - mothers, if the Mother insurance programme is not effective as of the date of the Damage Claim;
n) examination and treatment of congenital defects, as of the time of diagnosis, if the Mother insurance programme is not effective as of the date of the Damage Claim;
o) treatment of addictions, including all complications and related diagnoses;
p) production and repair of prostheses (orthopaedic, dental), glasses, contact lenses, or hearing aids, and the purchase of braces of other than the basic model;
q) medical expenses that would not be paid from public health insurance were the insured person a party thereto;
r) payments for cosmetic and aesthetic surgeries;
s) reimbursement of costs of regulatory fees and surcharges;
t) complications caused by violation of the treatment regime established by the attending physician.

Article 9. Transfer of Insured Party‘s Right to Insurer

1. If the person who is entitled to indemnification, the insured party, or a person who has expended salvage costs has acquired a right to damages or another similar right in connection with an impending or actual insurance claim, the account receivable, including appurtenances, security, and other related rights shall transfer to the insurer upon the payment of insurance indemnity, up to the amount of the performance paid out by the insurer to the authorized person. This shall not apply in the event that this right of that person arose with respect to a person living in the same household or a person who is dependent on it in terms of sustenance, unless the insurance claim was caused by that person wilfully.
2. The person whose right transferred to the insurer shall provide to the insurer any and all necessary documents and inform it of anything that is required for the making of the claim, in particular, shall provide to the insurer true and complete information about the insurance claim, the third person with respect to whom he has a right to damages or another right, that person’s insurer, or legal representative, and any other persons acting on behalf of the third persons, and about any damage compensation received from the third person or that person’s insurer.
3. Should the person whose rights transferred to the insurer claim damages from a third person who is responsible for the occurrence of the insurance claim, or from the third person’s insurer, that person shall inform the third person or the third person’s insurer about the insurer’s right to damages pursuant to this Article. The person whose right transferred to the insurer shall also provide necessary cooperation to ensure that the insurer’s right with respect to the third person or third person’s insurer can be claimed. The person whose right transferred to the insurer shall also take any and all measures to ensure that the insurer’s right to damages pursuant to this Article is not statute-barred or does not cease to exist.
4. Should the person whose right transferred to the insurer frustrate the transfer of the right to the insurer, the insurer shall be entitled to reduce insurance indemnity by the amount that it could have otherwise have obtained. If the insurer has already provided performance, it shall be entitled to compensation up to that amount.

Article 10. Processing of Personal Data

1. The insurer as a controller is entitled to process the personal data of the policyholder and the insured (hereinafter collectively also referred to as the "Data subject") to the extent necessary to properly fulfill the obligations of the insurer set forth in the insurance contract and generally binding legal regulations. The insurer is entitled to process the personal data of the Data subject for the time necessary to secure the rights and obligations arising from the insurance contract and for the period resulting from the generally binding legal regulations (eg. the Archives Act, the Anti-money laundering Act, accounting or tax regulations, etc.).
2. The controller shall:
   - take measures to preventing unauthorized or random access to personal data, or the alteration, destruction, loss, unauthorized transmission, other unauthorized processing or other abuse thereof; this obligation shall apply even after the termination of the processing of personal data;
   - only process true and precise personal data;
   - gather personal data only to the extent required for the purpose specified;
   - not combine personal data obtained for different purposes;
   - ensure the protection of the private lives of the Data subjects when processing the personal Data;
   - provide, at the request of Data subjects, information about the processing of their personal data.
3. The controller is entitled to transfer personal data for the purposes and for the period stipulated in the provisions of paragraph 1 of this Article to other entities (hereinafter referred to as "the processor").
4. The controller undertakes to ensure that any person who comes into contact with personal data (in particular controller’s employees, processors, employees of the processor) adhere to the obligations set by generally binding legal regulations,

insurance contract and the insurance terms and conditions, including after the termination of a contractual or employment relationship.

Article 11. Form of legal actions, Delivery of Correspondence

1. Legal actions aimed at modifying or terminating the insurance agreement must be made in writing.
2. An insurance claim may be reported by telephone or e-mail; should the insurer so request of the person claiming the right to insurance indemnification, the insurance claim report must be made in writing on the relevant form of the insurer.
3. Correspondence in the investigation of an insurance claim may be delivered by e-mail to the e-mail address of the insurer and/or the person who is claiming the right to insurance indemnification, or by fax to the fax number of the insurer and/or person claiming the right to insurance indemnification.
4. Should the person making a claim to insurance Indemnifications so request in writing, the insurer shall inform the person of the outcome of the investigation of the insurance claim in writing or shall inform that person in writing as to why investigation cannot be closed within the set time period.
5. Legal actions that must be made in writing must be delivered to the other party in line with the provisions of this Article.
6. Legal actions in written form (hereinafter referred to as "Correspondence") shall be delivered to the addressee:
   a) Through a postal license holder, pursuant to a special legal regulation, to the last known address of the addressee for whom the correspondence is intended; or
   b) Electronically signed, pursuant to special legal regulations; or
   c) In person by the insurer's employee or authorized person.
7. The mailing address for all correspondence designated for the insurer shall be delivered to the insurer's authorized representative, AXA ASSISTANCE, Hvězdova 1689/2a, 140 62, Prague 4, Czech Republic. Delivery to the authorized representative of the insurer shall be deemed to constitute delivery to the insurer.
8. If the addressee was not present, the correspondence shall be deposited with the postal license holder. Should the addressee fail to collect the correspondence within 15 calendar days of its being deposited, the last day of that time period shall be deemed to be the date of delivery, even in the event that the addressee did not find out about the correspondence being deposited.
9. If the addressee refused to take delivery of the correspondence, the correspondence shall be deemed delivered on the day of his refusal to take delivery.
10. If the addressee does not dwell at the place of delivery, without having informed the insurer thereof, the correspondence shall be deemed delivered on the day when it was returned as undeliverable.
11. Any and all legal actions and notices pertaining to insurance shall be made in Czech.

Article 12. Rights and Responsibilities

I. Policyholder's Responsibilities

1. Should the policyholder arrange insurance for the benefit of an insured party, the policyholder shall be deemed to have an insured interest in the life and health of the insured party. The policyholder shall provide the insurance terms and conditions to the insured party and inform him about the contents of the insurance contract and the contents of the insurance terms and conditions. Should insurance terminate prior to the expiration of the agreed insurance term, the policyholder shall return the proof of insurance and the insurance contract to the insurer within 5 business days of the termination of the insurance.
2. If the insurance is terminated prior to the end of the stipulated Insurance Term, the Policyholder shall return the Insured Party's Card and the Insurance Contract to the Insurer, within five working days following the date of termination of the insurance.
3. Upon withdrawal from the insurance contract according to the Civil Code, the Policyholder shall return the insurance certificate to the Insurer within seven working days following the day on which the Policyholder sent the Insurer its written notice of withdrawal from the Insurance Contract. If the Policyholder fails to meet the obligations stipulated in the previous sentence, the Insurer shall be entitled to claim the Policyholder's payment of a penalty in the amount of the premium under the Insurance Contract, from which the Policyholder intends to withdraw.
4. If the Policyholder is also the Insured Party, the Policyholder shall comply with all the obligations of the Insured Party.

II. Insured Party's Responsibilities

1. In addition to the obligations stipulated by the Civil Code and the Insurance Contract, the Insured Party is obliged to act so as to avoid the occurrence of Insurance Claims; the Insured Party shall in particular avoid violating obligations aimed

at the prevention or mitigation of risks, imposed by the applicable legal regulations. The obligations stipulated in this paragraph for the insured shall also apply to the person claiming insurance indemnity.

2. If a Damage Claim occurs, the Insured Party shall first contact the Assistance Service or the Insurer with a request for the providing of services corresponding to the insurance cover, truly and duly inform the Assistance Service or the Insurer of the Damage Claim, in particular the date and place of the Damage Claim and the Insured Party's address; for this purpose, the Insured Party shall ask the Insurer's Assistance Service to provide instructions and follow such instructions. If objective circumstances accompanying the Damage Claim do not allow the Insured Party to contact the Assistance Service with a request for assistance prior to the provision of services, the Insured Party shall do so immediately after the circumstances of the Damage Claim allow.
3. In the event of illness or injury, the Insured Party shall seek medical help without undue delay, present their identification card and insurance certificate, follow the physician's instructions, and if subsequently requested by the Insurer, the Insured Party shall undergo examination at the Insurer's expense by a physician designated by the Insurer.
4. Based on a request of the Insurer or the Assistance Service, the Insured Party shall undergo repatriation, if this is feasible given the Insured Party's medical condition. If the Insured Party fails to comply with this duty, the Insurer shall be authorized to terminate the provision of Insurance Indemnifications.
5. The Insured Party is also obliged to have the transportation set out in the provisions of Article 6 (5) (f), (g) and (h) approved in advance by the Insurer's Assistance Service and proceed according to its instructions.
6. Upon the occurrence of a Damage Claim, the Insured Party is obliged:
   a) to take all actions to reduce the extent of the damage and its consequences;
   b) if the Insured Party claims repayment of expenses incurred in connection with a Damage Claim, the Insured Party shall notify the Insurer without undue delay, using the respective "Damage Claim Report" form, of the occurrence of the Damage Claim, and provide true explanation thereof; if as a result of violating the obligation stipulated under point II of clause 5 of this Article, the Insurer's costs related to the Insurance Claim increase, the Insurer shall be entitled to claim the compensation for these costs from the party that violated the obligation;
   c) to follow the instructions of the Insurer and/or Assistance Service and to cooperate with them effectively, to fulfil other obligations imposed by the Insurer and/or Assistance Service, the present ITC FCHI or the applicable legislation;
   d) to report the Damage Claim without undue delay to the police at the place of the occurrence, if the event occurred under circumstances suggesting a crime or misdemeanor, and to submit the police report to the Insurer;
   e) to secure sufficient evidence concerning the Damage Claim, based on the investigation carried out by the police or other authorities;
   f) to reply truthfully and fully to all questions from the insurer or assistance service concerning insurance and the damage claim and the extent of the consequences of a damage/insurance claim;
   g) to enable the Insurer and/or the Assistance Service to carry out all necessary investigations of the Damage Claim decisive for consideration of the claim for Insurance Indemnifications and the amount thereof, and provide the necessary cooperation in this respect;
   h) to inform the Insurer, without any undue delay, that criminal proceedings have been instituted against the Insured Party in connection with the Damage Claim, and truly inform the Insurer of the progress and results of such proceedings;
   i) for the purpose of ascertaining information about the state of health or the cause of death of the insured party, to relieve the attending physician of their nondisclosure obligation with respect to the insurer or assistance service;
   j) to provide cooperation, in the event of repatriation, so as to ensure the subsequent hospitalization at a health care centre in the country whose passport the Insured Party holds, or in a different country where the Insured Party has a residency permit;
   k) to collect the originals of all invoices and receipts, where the health care centre requests direct payment of the costs related to the Damage Claim;
   l) to submit the following documents to the insurer: complete medical documentation, original bills, and receipts for the payment of medical treatment, medication prescribed by the physician (including a copy of the prescription issued to the Insured Party's name) and transports, the police report (if the event was investigated by the police) including other references requested by the Insurer and/or Assistance Service.
7. Upon the request of the Insurer or the Assistance Service, the Insured Party shall at its own cost arrange for the official translations of documents into Czech, as may be necessary for the investigation into the Damage Claim.
8. If the Insured Party has taken out insurance of the same or similar character with another insurance company, the Insured Party shall inform the Insurer of this fact.
9. Persons claiming an Insurance Indemnification must submit the documents required by the Insurer or the Assistance Service if this may affect the determination of the Insurer's obligation to pay the Insurance Indemnification and the amount of such an Insurance Indemnification.
10. If the obligations stipulated in this Article are violated, the Insurer is authorized to adequately reduce the Insurance Indemnification or to refuse to pay any Insurance Indemnification at all.

III. Insurer's Rights and Responsibilities

1. Apart from the obligations stipulated by the Civil Code and the insurance contract, the insurer also has the following obligations:
   a) to discuss with the Insured Party or the person claiming insurance indemnification the results of the investigation required to determine the scope and value of the Insurance Indemnification, or to notify the Insured Party about such determination, without undue delay;
   b) to return to the Insured Party or the person claiming insurance indemnification any requested documents, with the exception of original receipts of payment based on which the Insurance Indemnification has been provided.
2. The Insurer is not obliged to examine any potential excessiveness of the insurance, particularly if the payment of the costs of the Insured Party's medical care is also secured in a different manner.
3. The Insurer is in particular authorized:
   a) to ascertain the occurrence, the course, and the extent of the damage claim (including the requesting of witness testimonials from involved parties, expert assessments, and other documents if applicable);
   b) to request and verify medical reports;
   c) to reduce insurance indemnification according to the Civil Code;
   d) to reduce the Insurance Indemnifications if the Insurance Indemnifications have been paid at the full amount and subsequently, a claim for the decrease of the Insurance Indemnifications occurs. The Insurer is entitled to claim the balance between the paid and reduced Insurance Indemnification against the person in whose favour the benefit has been provided.
4. If the Insured Party violates the obligations required by the applicable legislation and the present ITC FCHI, the Insurer shall be entitled to adequately decrease the Insurance Indemnification or to refuse the payment thereof.
5. If the Insured Party violates the obligations set out in ITC FCHI and should this lead to any extra or increased cost of the investigation into the Damage Claim incurred by the Insurer, the Insurer is authorized to claim the compensation of such costs from the Insured Party.

Article 13. Final Provisions

1. The present ITC FCHI shall form an integral part of the Insurance Contract.
2. The present ITC FCHI are issued in Czech and English. In case of any contradiction between the two language versions, the Czech version shall prevail.
3. Czech is the communication language.
4. Where the Insurer's ITC FCHI refer to the generally binding legal regulations, this shall mean the legal regulations valid and effective in the Czech Republic.
5. Unless the parties involved in the insurance are able to reach an amicable agreement, all disputes arising from the insurance or in connection herewith shall be referred to the courts in the Czech Republic, according to the generally binding legal regulations.
6. Should any provision of ITC FCHI become invalid or disputed as a consequence of any changes to the generally binding legal regulations, the generally binding legal regulation that best fits the nature and purpose of such a provision shall apply.
7. If the Insured Party withdraws their consent, at any time during the insurance, to the identification and reviewing of their health status and if this fact may affect the examination necessary for the identification of the scope of the Insurer's obligation to provide benefits, the Insurer reserves the right to reduce or refuse to provide the Insurance Indemnification.
8. In order for the insurance to become and remain effective, the Insured Party must have a legal residency permit in the Czech Republic, subject to the fulfilment of the terms and conditions stipulated in the applicable legal regulations.
9. The Insurer's costs related to the establishment and management of the insurance amount to 20% of the unused insurance premium.
10. These Insurance Terms and Conditions shall become effective on 1 Decemeber 2018.

Supplementary Insurance Terms and Conditions for Foreigners' Health Insurance, applicable to the Schengen Area and Transit Countries

SITC FHI dated December 1, 2018

Article 1. General Provisions

1. The Foreigners' Comprehensive Health Insurance, concluded between the Insurer, INTER PARTNER ASSISTANCE, S.A., member of AXA Group, with its registered office at Avenue Louise 166, 1050, Brussels, Belgium, entered in the Commercial Register administered by Greffe de Tribunal de commerce de Bruxelles under registration number 0415591055, acting through INTER PARTNER ASSISTANCE, organization unit, with registered office at Hvězdova 1689/2a, 140 62 Prague 4 - Pankrác, Czech Republic, ID number: 28225619, entered in the Commercial Register administered by the Municipal Court in Prague, under Section A, File 59647, whose activities are supervised by Czech National Bank, Na Příkopě 28, 115 03 Prague 1 (hereinafter the Insurer) is subject in particular to Act 37/2004 Coll., the Civil Code, as amended (hereinafter referred to as the "Civil Code"), the Insurance Contract, the Insurance Terms and Conditions of the Foreigners' Comprehensive Health Insurance, ITC FCHI dated 1 December 2018 (hereinafter ITC FCHI) and the present Supplementary Insurance Terms and Conditions of the Foreigners' Comprehensive Health Insurance, SITC FHI dated 1 December 2018 (hereinafter SITC FHI), supplementing the provisions of ITC FCHI, and the provisions of the Insurance Contract, of which SITC FHI form an integral part. In the event of a discrepancy between the provisions of the Insurance Contract and the provisions of the Insurance Terms and Conditions, the contract shall prevail. In the event of a discrepancy between the ITC FCHI and the provisions of these SITC FHI, the provisions of these SITC FHI shall prevail; an instance when these SITC FHI contain a more detailed regulation of the rights and obligations of the contractual parties to which the ITC FCHI refer shall not be deemed to constitute a discrepancy.
2. SITC FHI govern the terms and conditions for the health insurance of Foreign Nationals in the Schengen Area, outside the Czech Republic and transit countries, rendered only to the extent of urgent and emergency care. In case that the provisions of SITC FHI are inconsistent with the provisions of I TC FCHI are always applicable the provisions of SITC FHI.

Article 2. Definitions

Further to the provisions of ITC FCHI, the following terms are specified below:

Acute Disease is a sudden disorder of the Insured Party's health, occurring during the existence of the insurance, which directly threatens the life or health of the Insured Party, independently of their will, and requires urgent and immediate treatment. Acute Diseases do not include such health disorders where treatment began before the commencement of the insurance or where the symptoms of the health disorder occurred prior to the commencement of the insurance, even though they were not medically examined or treated. Furthermore, Acute Diseases do not include such health disorders where medical care is appropriate and purposeful but may be postponed and only provided after the Insured Party's return to the country whose passport the Insured Party holds or another country in which the Insured Party has a residency permit.

Urgent and Emergency Health Care is health care provided to the Insured Party in the event of an injury or acute disease, where delays could cause serious deterioration of health condition, damage to health, or loss of life. The scope is further defined by the exclusions from the insurance and agreed Insurance Indemnification limits set out in the SITC FHI. The Urgent and Emergency Health Care is provided within the Schengen Area, outside the Czech Republic, and in transit countries.

Schengen Area is the territory of most European countries in which persons can cross borders of the contractual countries at any point without having to go through border control.

Transit Country means the country through which the Insured Party must necessarily pass when travelling along the fastest and shortest way from the Home Country to the place of insurance and back.

Article 3. Territory, Purpose of Stay

1. The territorial scope of the insurance is extended with the present SITC FHI to cover Insurance Claims occurring within the Schengen Area outside the Czech Republic and the territory of Transit Countries.
2. For the territory of the Schengen Area outside the Czech Republic and the territory of Transit Countries, the insurance is valid to the extent of Urgent and Emergency Health Care.
3. As regards the purpose of the Insured Party's stay within the territory of the Schengen Area outside the Czech Republic and the territory of Transit Countries, the insurance applies to a Tourist Stay only.
4. The duration of the stay within the territory of the Schengen Area outside the Czech Republic must not exceed 30 days.

Article 4. Insurance Indemnification

Foreigners' health insurance covering urgent and emergency care	Limit of Insurance Benefit
Total limit	1 600 000 CZK (at least 60 000 EUR)
- repatriation and transportation	real costs up to total limit
- dental care	5 000 CZK

1. The upper limit of the Insurance Indemnification for damage incurred within the Schengen Area outside the Czech Republic corresponds to the Insurance Indemnification limit specified in the Insurance Contract and this Article of SITC FHI. The said Insurance Indemnification limits apply to one Insurance Claim only. Regardless of changes in the EUR/CZK exchange rates, the Insurer guarantees the Insurance Claim limit of EUR 60,000 converted according to the exchange rate of the Czech National Bank applicable as of the date of the occurrence of the Insurance Claim.
2. The Insurance Indemnification and its amount shall be determined by the Insurer in accordance with ITC FCHI, the present SITC FHI and the Insurance Contract, on the basis of the presented documents.

Article 5. Insurance Claim

1. The Insurance Claim is a sudden Acute Disease or Injury of the Insured Party, occurring during the valid period of the insurance and requiring Urgent and Emergency Health Care, or Assistance Services, in accordance with the terms and conditions, and the agreed insurance cover. The obligation to provide benefit is limited by the Insurance Indemnification exclusions and limits.
2. Events that arise from one cause and include all the circumstances and their effects, where there is a causal, time, or other direct connection among such events, shall be considered one Insurance Claim.
3. The insured risk includes a change in the Insured Party's health condition as a consequence of an Acute Disease or Injury.
4. In connection with the Insurance Claim, the Insurer shall cover the reasonably and purposefully expended costs for:
   a) Urgent and Emergency Health Care, which includes:
      i. Urgent and emergency examination necessary for the determination of diagnosis and treatment procedure;
      ii. Urgent and emergency medical treatment (outpatient);
      iii. Urgent and emergency treatment in a health care centre (residential), in a standard room with standard equipment and standard medical care, over a necessary period of time; diagnostic examinations, treatment including surgery, anaesthetic, medication, medical supplies, and hospital meals;
      iv. Medicines prescribed by a physician in connection with an Insurance Claim and corresponding to the concept of Urgent and Emergency Health Care;
      v. Urgent and emergency treatment by a dentist during acute tooth pain, i.e., extraction or simple fillings (including X-rays), and treatment for the purpose of immediate pain relief related to the oral mucous membrane, up to the Insurance Indemnification limit set out in ITC FCHI;
   b) Transportation from a doctor's office to a health care centre or from a health care centre to another specialised health care centre, if the Insured Party's current condition requires this, according to the assessment of the Assistance Service or the Insurer, and if such transportation is prescribed by the attending physician;
   c) Transportation from a health care centre back to the place of residence within the territory of the Schengen Area, where the current health condition does not allow for the use of public transportation services;
   d) Repatriation of the Insured Party - patient, if it is necessary and possible from the medical perspective; repatriation is assessed, approved, and organized by the Assistance Service or the Insurer, and the Insured Party is repatriated to the territory of the country whose passport the Insured Party holds, or to another country in which the Insured Party has a residency permit;

e) Transportation of the Insured Party's bodily remains back to the territory of the country whose passport the Insured Party holds, or to a different country where the Insured Party had a residency permit; the transportation of the remains must be performed by a specialised organization approved by the Assistance Service or the Insurer.

Article 6. Exclusions

1. The Insurer is not obliged to provide Insurance Indemnifications if:
   a) The Insured Party or the person claiming insurance indemnification does not respect the instructions of the Insurer or the Assistance Service and does not effectively cooperate with them, or does not submit the documents required by the Insurer or the Assistance Service;
   b) The Insured Party refuses to undergo repatriation;
   c) The Insured Party refuses treatment or the necessary medical examinations by a physician designated by the Insurer or the Assistance Service;
   d) The Insurer could not investigate the Damage Claim because the Insured Party or the person claiming insurance indemnification did not relieve the attending physician or other institutions from their non-disclosure obligation vis-a-vis the Insurer or the Assistance Service, as requested by the Insurer or the Assistance Service;
   e) The Insured Party or the person claiming insurance indemnification has prevented the Insurer or the Assistance Service from contacting the attending physician or other institutions as requested by the Insurer or the Assistance Service;
   f) The Insured Party or the person claiming insurance indemnification has knowingly provided the Insurer or the Assistance Service with false or incomplete information regarding the Damage Claim;
   g) The Damage Claim occurred as a consequence of the violation of legal regulations by the Insured Party or the person claiming insurance indemnification within the territory of the Schengen Area outside the Czech Republic;
   h) The Damage Claim occurred in connection with any disturbances provoked by the Insured Party or the person claiming insurance indemnification or in connection with a crime committed or attempted by the Insured Party or the person claiming insurance indemnification;
   i) The Damage Claim occurred in connection with the Insured Party's active or passive engagement in warfare, peace missions, combat or military events, participation of the Insured Party in an uprising, demonstration, riot or unrests, public violence, strikes or by the intervention or decision of public administration authorities;
   j) The Damage Claim was caused by the Authorized Person or another person acting on the initiative of the Insured Party or the Authorized Person;
   k) The Damage Claim originated in work carried out in places not designated for such purposes;
   l) The Damage Claim occurred in relation to the Insured Party's or the person´s claiming insurance indemnification active participation in a Terrorist Act or in preparation for it;
   m) The Damage Claim occurred in the Czech Republic, or in a country whose passport the Insured Party holds, or in a country where the Insured Party is a participant of the public health insurance system;
   n) The Damage Claim occurred as a consequence of suicide, attempted suicide, or selfinflicted trauma by the Insured Party;
   o) The Damage Claim occurred in connection with the consumption of alcohol or other narcotic, toxic, or psychotropic substances;
   p) The Damage Claim occurred in connection with Dangerous and High-Risk Sports and Activities or in connection with Professional Sport, or during participation in Competitions or preparations for such Competitions;
   q) The Damage Claim occurred in connection with business activities, performance of occupation, employment, or other gainful activities;
   r) The Damage Claim was caused by nuclear energy or nuclear risks, or chemical or biological contamination;
   s) The Damage Claim occurred as a consequence of the deliberate conduct, fault, or contributory fault of the Insured Party or the person claiming insurance indemnification;
   t) Any events occurring after the 30-day period of continuous residence in a country of the Schengen Area outside the Czech Republic or within a Transit Country.
2. The Insurer is not obliged to pay any Insurance Indemnification for events that occurred prior to the premium payment.
3. Furthermore, the Insurer is not obliged to pay any Insurance Indemnification under the following circumstances:
   a) the medical care is related to the treatment of illnesses or injuries which existed prior to the signing of the Insurance Contract, including medication;
   b) the medical care is appropriate and purposeful but may be postponed and only provided after the Insured Party's return to the country whose passport the Insured Party holds or another country in which the Insured Party has a residency permit;

c) preventive check-ups, follow up examinations or medical examinations and treatment not related to a sudden illness or injury; check-ups, examinations, and treatment under letter c) of this paragraph require consent of the Assistance Service;
d) there are complications which occurred during the treatment of the illnesses or injuries to which this insurance does not apply;
e) The purpose of the stay is treatment or continued treatment;
f) Examinations, check-ups, and other medical procedures are in the personal interest of the Insured Party, and do not serve a medical purpose;
g) Examinations, check-ups, and other medical procedures relating to laboratory examination (including laboratory and ultrasound treatment) in connection with pregnancy, abortion, any complications in a risky pregnancy, any complications after the 18th week of pregnancy, childbirth including premature childbirth and postnatal period, examination and treatment of infertility and artificial insemination and the costs related to contraception and hormonal treatment; any complications in pregnancy, should the Insured Party be pregnant when taking out the insurance;
h) non-acute dental treatment and related services, cost of dentures, dental crowns, bridges, removal of plaque or tartar;
i) Treatment by the Insured Party's Relative or a person without corresponding qualifications, medical acts outside of a health care centre registered in the Schengen Area, treatment using methods which are not scientifically recognized in the Schengen Area;
j) purchase of medicines and medical aids without a prescription;
k) Vaccination with the exception of vaccination against tetanus and rabies in relation to injury;
l) Physiotherapy, physical, and bath treatments, care at specialised treatment institutes, acupuncture and homeopathy, chiropractic treatment, exercise therapy, or selfsufficiency training;
m) Medical treatment provided beyond the scope of Urgent and Emergency Health Care;
n) Examination and treatment of mental and psychological diseases and disorders, psychotherapy and psychoanalysis;
o) Examination and treatment of congenital defects;
p) treatment of addictions, including all complications and related diagnoses;
q) production and repair of prostheses (orthopaedic, dental), glasses, contact lenses, or hearing aids, and the purchase of braces of other than the basic model;
r) compensation for extra medical care and services;
s) payments for supplementary medicines, vitamin products, and food supplements;
t) payments for cosmetic and aesthetic surgeries;
u) reimbursement of costs of regulatory fees and surcharges;
v) complications caused by violation of the treatment regime established by the attending physician.
w) examination and treatment of hepatitis, from the diagnosis;
x) organ transplants, treatment of haemophilia, insulin therapy, except for the provision of emergency care, treatment of chronic renal insufficiency with haemodialysis, or with peritoneal dialysis, treatment with growth hormone, inter feron treatment, and medication initiated prior to the valid period of the insurance;
y) examination and treatment of contagious venereal diseases, including HIV/ AIDS, from the moment of diagnosis;

Article 7. Insured Party's Responsibilities

If a Damage Claim occurs in a Transit Country or a country of the Schengen Area outside the Czech Republic, then in addition to the obligations of the Insured Party specified in Article 13 (II) of ITC FCHI, the Insured Party shall upon the request of the Assistance Service be obliged to document that he/she has been staying outside the Czech Republic for fewer than 30 days. This obligation shall also apply to a person who is claiming a right to insurance Indemnifications.

Article 8. Final Provisions

1. The present SITC FHI complement the provisions of ITC FCHI and form – together with ITC FCHI – an integral part of the Insurance Contract.
2. These Supplementary Insurance Terms and Conditions shall become effective on 1 December 2018.

Addendum - Coverage Areas

1. The Hamilton Hudson Gold Plan supplements these AXA terms and conditions contained in this document of AXA's jurisdiction and liabilities for comprehensive health insurance in the Czech Republic for foreigners as well as emergency only coverage in the BU Schengen zone.

2. Medical Expenses Not Covered by AXA such as local private clinics or expenses incurred beyond the EU Schengen Zone are addressed and limited to the terms and conditions of Sirius International, the insurer and Access HMO the plan's administrator and are subject to its separate schedule of limitations, exclusions, deductibles, coinsurance and copayments. See the Schedule of Benefits contained in the document below with full details and definitions.

Sirius International
ACCESS HMO
UnitedHealthcare

Supplementary Insurance Terms and Conditions for Foreigners' Health Insurance, applicable outside the Schengen Area and Listed Private Clinics

SIIC FHI dated January 1, 2013

A. AGREEMENT - Sirius International Insurance Corporation (publ) (the Company) promises and agrees to provide the Insured Person with the benefits described in the Master Policy, as outlined herein and coverage for which is certified hereunder by the Company. The Company makes this promise and agreement in consideration of the Assured's Application, the Insured Person's Application and payment of Premium, and subject to all of the Terms of the Master Policy and as contained therein, including any Riders. The Master Policy is effective as of January 1, 2013, and shall remain in effect until terminated in accordance with Section B(17), below. This Certificate shall be effective as of the Effective Date of Coverage shown on the Declaration, and shall remain in effect until terminated in accordance with Section B(18), below. This Certificate is not part of the insurance contract. The contract is the Master Policy, the Application, the Declaration, and any applicable Riders. This Certificate is merely a description of and evidence of the Insured Person's rights and benefits under the contract. The Declaration likewise is evidence of the coverage under the contract and a statement of the Effective Date of Coverage, subject always to the terms of coverage contained within the contract. The Company hereby recognizes Access HMO Inc., as the Company's authorized agent and representative, and as the Plan Administrator of the Master Policy and this Certificate. Subject to the provisions of Section B(6), below, all communications, notices and payments to the Company that are required or permitted under the Master Policy and/or as described in this Certificate should be transmitted through the Plan Administrator, and receipt of same by the Plan Administrator shall be considered receipt by the Company. THIS INSURANCE IS ISSUED PURSUANT TO APPLICABLE SURPLUS LINES LAW. PERSONS INSURED BY SURPLUS LINES CARRIERS DO NOT HAVE THE PROTECTION OF STATE INSURANCE GUARANTY LAWS TO THE EXTENT OF ANY RIGHT OF RECOVERY FOR THE OBLIGATION OF AN INSOLVENT UNLICENSED INSURER.

B. CONDITIONS AND GENERAL PROVISIONS - The following Terms are conditions precedent to the Company's liability under the insurance provided to the Insured Person pursuant to and in accordance with the Terms of the Master Policy, as represented by this Certificate (such insurance being sometimes referred to herein as "this insurance" or "the plan"):

(1) ENTIRE AGREEMENT - The Master Policy, including the Application, the Declaration, and any Riders, shall constitute the entire agreement among the Company, the Assured, and the Insured Person. This Certificate, including the Application, the Declaration, and any Riders, is an outline and evidence of the insurance provided by the Master Policy. This Certificate does not extend or change the coverage provided by the Master Policy. The insurance evidenced by this Certificate is subject to all Terms of the Master Policy, including the Application, the Declaration, and any Riders.

(2) PREMIUM - Payment of required Premium shall be remitted to the Company on or before the Effective Date of Coverage.

(3) PROOF OF CLAIM - When the Company receives notice of a claim for benefits under this insurance from or on behalf of an Insured Person it will provide the Insured Person with Claimant's Statement and Authorization Forms ("Claim Forms") for filing Proof of Claim. The following items must be submitted by or on behalf of the Insured Person to be considered a complete Proof of Claim eligible for consideration of coverage under this insurance ("Proof of Claim"):

(a) a duly completed, timely submitted, and signed Claim Form; and

(b) all original itemized bills and statements of services rendered from all Physicians, Hospitals and other healthcare or medical service providers involved with respect to the claim; and

(c) all original receipts for any costs, fees or expenses that have been incurred or paid by or on behalf of the Insured Person with respect to the claim, including without limitation all original receipts for any cash and/or credit card payments

.

The Insured Person and/or Physician, Hospital and other healthcare and medical service providers and supplier shall have ninety (90) days from the date a claim is incurred to submit a complete Proof of Claim, and the Company at its option may pend resolution and adjudication of submitted claims and/or may deny coverage: for Proofs of Claim submitted thereafter; or for incomplete Proofs of Claim; and/or for failure to submit a Proof of Claim; provided, however, that the Company at its option may

waive the requirements of subsection B(3)(a), above, regarding submission of a new Claim Form for subsequent claims incurred by an Insured Person relating to a continuing Illness, Injury or other medical condition for which a properly completed and signed Claim Form has previously been submitted and received.

(4) APPEALING A CLAIM - In the event the Company denies all or part of a claim, the Insured Person shall have ninety (90) days from the date that the notice of denial was mailed to the Insured Person's last known residence or mailing address to file a written appeal with the Company. Upon receipt of a written appeal, the Company shall have an opportunity for further reasonable investigation and/or review as set forth in Section B(22), and will respond in writing as soon as reasonably practicable, and in any event within ninety (90) days from receipt thereof.

(5) ASSIGNMENT, CHANGE OR WAIVER - Notwithstanding any law, statute, judicial decision, or rule to the contrary which may be or may purport to be otherwise applicable within the jurisdiction, locale or forum state of any healthcare or medical service provider, no transfer or assignment of any of the Insured Person's rights, benefits or interests under this insurance shall be valid, binding on, or enforceable against the Company (or the Plan Administrator) unless first expressly agreed and consented to in writing by the Company. Any such purported transfer or assignment not in compliance with the foregoing Terms shall be void *ab initio* and without effect as against the Company (or the Plan Administrator), and the Company shall have no liability of any kind under this insurance to any such purported transferee or assignee with respect thereto. The Terms of the Master Policy as evidenced by this Certificate shall not be waived, modified or changed except by the express written agreement of the Company.

(6) SERVICE OF SUIT; VENUE; CHOICE OF LAW; TRIAL BY COURT - The contract of insurance between the Insured Person and the Company as represented by the Master Policy and evidenced by this Certificate shall be deemed issued, finalized and made in Indianapolis, Indiana. Sole and exclusive jurisdiction and venue for any court action or administrative proceeding relating to this insurance shall be in Marion County, Indiana, for which the Insured Person expressly consents. The subjects, risks and benefits of insurance covered by the Master Policy and evidenced by this Certificate are not intended or considered by the Insured Person or the Company (or the Plan Administrator) to be resident, located, or to be performed in any particular State of the United States. Indiana law shall govern all rights and claims raised under this Certificate of Insurance.

In the event of the failure of the Company to provide benefits or pay or reimburse any amount claimed to be due under this insurance, the Company, at the request of the Insured Person and upon receipt of lawful process or summons, will submit to the jurisdiction of a court of competent subject matter jurisdiction located in Marion County, Indiana, provided there exists an independent statutory and constitutional basis for *in personam* jurisdiction over the Company in said court and by said forum State. The Company consents to personal jurisdiction and venue in the Circuit and/or Superior Courts of Marion County, Indiana, and in the United States District Court for the Southern District of Indiana, Indianapolis Division (assuming that federal jurisdiction is otherwise appropriate and lawful). All trials regarding any dispute under this insurance shall be exclusively presented to and determined solely by the court as the trier of fact, without a jury. The Company reserves the right, acting by and through the Plan Administrator, to initiate and pursue actions for declaratory judgment and/or other appropriate relief with respect to the validity, binding effect, administration of and/or any dispute or controversy arising under this insurance. In any suit instituted by or against the Company pursuant to the Terms of this Section B(6), the Company will abide by the final decision of such court or of any appellate court in the event of an appeal.

Nothing in this Section B(6) constitutes or should be deemed, considered or understood to constitute a waiver of the Company's rights to: (i) oppose venue, procedural and/or substantive choice of law, personal jurisdiction, or subject matter jurisdiction in any forum other than the Circuit or Superior Courts of Marion County, Indiana, or the United States District Court for the Southern District of Indiana, Indianapolis Division (assuming that federal jurisdiction is otherwise appropriate and lawful), (ii) commence an action in any court of competent jurisdiction in or outside of the United States, (iii) remove an action to a United States District Court, or (iv) seek transfer of a case to another court or forum as permitted by the laws of such forum or the laws of the United States or of any State in the United States, as applicable; all of which rights are expressly reserved and retained.

Subject to and without limiting, expanding, superceding, modifying or waiving any of the foregoing Terms contained in this Section B(6), pursuant to any statute of any State, territory or district of the United States which makes provision thereof, the Company hereby designates the Superintendent, Commissioner, or Director of Insurance (or such other officer specified for that purpose in the statute), or his successor or successors in office, as its true and lawful attorney, under a special power of attorney, upon whom may be served any lawful process issued in connection with the initiation of any action, suit or proceeding instituted by or on behalf of the Insured Person arising out of this insurance, including specifically the Commissioner of Insurance for the Indiana Department of Insurance, 311 West Washington Street, Suite 300, Indianapolis, IN 46204, and hereby designates and appoints John P. Dearie, Jr., Esq., Edwards & Angell, LLP, 750 Lexington Avenue, New York, New York 10022, as its attorney-in-fact and agent for service of process to whom said officer or Commissioner is authorized to mail or serve any such process or a true copy thereof.

For Florida residents only: If any dispute shall arise as under the terms and conditions of this Certificate, such dispute may be referred to arbitration in accordance with the procedures of the American Arbitration Association. Any such arbitration shall be held within 50 miles of the Insured Person’s residence, with the Company to pay costs and fees (not including any attorney fees) of the proceeding in excess of $500.00.

(7) MISREPRESENTATION - Any misstatement, omission, concealment or fraud, either in the Insured Person's Application which forms a part of the Master Policy and this Certificate, or in relation to any statement, certification or warranty made by the Insured Person or his/her representatives, agents or proxies, whether in writing or otherwise, to the Company or the Plan Administrator or their respective agents, employees or representatives, or in connection with the making of any claim under this insurance, shall render the Declaration and this Certificate null and void and all claims and benefits under this insurance shall be forfeited and waived.

(8) INSOLVENCY - The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors or dissolution of the Assured or any Insured Person shall not impose upon the Company any liability or obligation other than that specifically included in this insurance.

(9) SUBROGATION CLAUSE - The Insured Person shall undertake to pursue in his/her own name and stead, and to fully cooperate with the Company in the pursuit and prosecution of, any and all valid claims that the Insured Person may have against any third party who may be liable or responsible for any loss or damage arising out of any act, omission or occurrence which results or may result in a loss payment, provision of benefits, or coverage of claim by the Company under this insurance, and to fully account to the Company for any amounts recovered or recoverable in connection therewith, on the basis that the Company shall be reimbursed and entitled to recover first in full for any sums paid or to be paid by it before the Insured Person shares in any amount so recovered. Should the Insured Person fail to so cooperate, account, or to prosecute any valid claims against any such third party or parties, and the Company thereupon or otherwise becomes liable or otherwise obligated to make payment under the Terms of this insurance, then the Company shall be fully subrogated to all rights and interests of the Insured Person with respect thereto and may prosecute such claims in its own name as subrogee. The Insured Person's submission of Proof of Claim or acceptance of coverage or benefits under this insurance shall be deemed to constitute an authorization, consent and assignment of such subrogation rights by the Insured Person to the Company. Any amount recovered by the Company in accordance with the foregoing shall first be used to pay in full the costs and expenses of collection incurred by the Company, including reasonable attorneys' fees, and for reimbursement to the Company for any amount that it may have paid or become liable to pay under this insurance. Any remaining amounts recovered shall be paid to the Insured Person or other persons lawfully entitled thereto, as applicable.

(10) OTHER INSURANCE - The Company shall not be liable or obligated to provide any coverage or benefits or to pay or reimburse any claim under this insurance if there is any other insurance, membership benefit, workers' or workplace compensation coverage program or other government program, reimbursement or indemnification coverage, right of contribution, recoupment or recovery, contract, or any other third-party obligation or liability for provision of benefits ("Other Coverage") which would, or would but for the existence of this insurance, be available or obligated to provide such benefit or to pay or reimburse or provide indemnity for such claim, except in respect of any excess beyond the amount payable or provided under such Other Coverage had this insurance not been effected. The Company shall not be liable or obligated to provide any benefit or to pay or reimburse any claim in respect to Treatment or supplies furnished by any program or agency funded by any government or governmental authority.

(11) CANCELLATION BY INSURED PERSON - The Insured Person may request cancellation of the Declaration and this Certificate, and full return of Premium, by giving the Company written notice thereof prior to the Effective Date of Coverage, whereupon all coverages and benefits under this insurance shall be cancelled, void and without effect. After the Effective Date of Coverage, the Premium is fully earned and is non-refundable.

(12) APPLICABLE CURRENCY - All benefit amounts, coverages, monetary limits and sub-limits, and other amounts stated in the Master Policy, the Application, the Declaration, this Certificate, and in any Riders, including Premium, are in U.S. dollars.

(13) COOPERATION - The Insured Person and his/her Physicians, Hospitals and other healthcare and medical service providers and suppliers shall undertake to cooperate fully with the Company and the Plan Administrator in reviewing, investigating, adjudicating, considering an appeal of, and/or administering any claim for benefits under this insurance, including granting full right of access to all relevant or related medical documentation, medical histories, reports, lab or test results, x-rays, and all other available evidence relating to or affecting the review, investigation, adjudication or administration of the claim. The Company at its option may suspend or pend adjudication of a claim, and/or may deny benefits and/or coverage for a claim, when there has been: (i) a refusal to so cooperate, (ii) an unreasonable delay in such cooperation, and/or (iii) any other act or omission on the part of the Insured Person and/or his/her healthcare providers which hinders, delays, impairs, or otherwise prejudices the performance of the Company's obligations under this insurance.

(14) CLAIM SETTLEMENT - Eligible and covered claims for Eligible Medical Expenses or other benefits under this insurance that have previously been paid by or on behalf of the Insured Person at the time of the Company's favorable adjudication thereof will be reimbursed by the Company directly to the Insured Person, by check, at his/her last known residence or mailing address. While this insurance is in effect, in order to effectuate proper administration the Insured Person shall undertake to promptly notify the Company of any change in such addresses. Eligible and covered claims for Eligible Medical Expenses or other benefits under this insurance that have not been paid by or on behalf of the Insured Person at the time of adjudication will be paid by the Company by check or wire transfer to the Insured Person at his/her last known residence or mailing address, or, at the sole option and discretion of the Company (but without obligation to do so), and as an accommodation to the Insured Person, directly to the provider(s), as applicable. All claim settlements, payments and reimbursements are subject to the applicable Deductible and Coinsurance, if any, and to the benefit limits and sub-limits and all other Terms of this insurance. No healthcare or medical service provider or supplier, or any other third-party, shall have any direct or indirect claim or right of action against the Company under this Certificate, the Declaration or the Master Policy, whether by purported assignment of benefits, subrogation of interests or otherwise, unless first expressly agreed and consented to in writing by the Company, and notwithstanding the Company's exercise or failure to exercise any option or discretion under this Section regarding the method of claim payment. No such provider, supplier or other third-party is intended to have or shall have any rights as a third-party beneficiary under this Certificate, the Declaration, or the Master Policy.

(15) FRAUDULENT CLAIMS - If any claim or request for benefits under this insurance shall be in any respect fraudulent or deceitful, or if the Insured Person or anyone acting for or on his/her behalf under this insurance uses any fraudulent or deceitful means or devices, all past, present and future benefits, coverages and claims under this insurance shall be forfeited and waived by the Insured Person and may be cancelled, voided, rescinded and terminated by the Company in its sole and absolute discretion, and the Company shall have no obligation or liability for any such benefits, coverages or claims.

(16) ARBITRATION - With the exception of Florida residents' option to refer to arbitration, no claim for benefits for which liability, eligibility, or coverage under this insurance has been denied in whole or in part by the Company nor any other dispute or controversy arising under or related to this insurance shall be arbitrable or subject to arbitration under any circumstances or for any reason.

(17) TERMINATION OF MASTER POLICY - The Master Policy can be terminated at any time by either the Company or the Assured by giving at least thirty (30) days written notice to the other and to the Insured Person. Such termination will have no effect on this Certificate prior to the date of the termination, or on eligible coverages or benefits under this insurance accrued prior thereto. No additional Certificates will be issued or further Applications accepted for the plan after the date the Master Policy is terminated.

(18) TERMINATION OF COVERAGE FOR INSURED PERSONS - Coverage and benefits for the Insured Person under this insurance will terminate effective at 12:01 AM, EST, on the earliest of the following dates:

(a) the next day following the end of the coverage period for which Premium has been fully and timely paid; or

(b) the date that the Insured Person no longer is insured under either a group or individual medical insurance plan for medical expenses incurred in Home Country; or

(c) the termination date as shown on the Declaration for this Certificate; or

(d) the date the Master Policy is terminated pursuant to Section B(17), above; or

(e) the date specified by the Company in any notice of cancellation, forfeiture or rescission issued pursuant to or as a result of the circumstances set forth in Sections B(7) or B(15), above, or B(20), below.

Coverage for the Insured Person shall remain in full force and effect unless terminated pursuant to the provisions of this Section B(18), except as otherwise provided in the Master Policy, the Declaration, or this Certificate.

(19) PATIENT ADVOCACY - Neither the Company nor the Plan Administrator shall have any right, obligation, or authority of any kind to ultimately select Physicians, Hospitals, or other healthcare or health service providers for the Insured Person or to make any medical Treatment decisions for or on behalf of the Insured Person, and all such decisions shall be made solely and exclusively by the Insured Person and/or his/her guardians, family members and treating Physicians and other healthcare providers. Subject to the foregoing, the Company may determine that a particular claim, benefit, Treatment, or diagnosis occurring under or relating to this insurance may be placed under the Company's "Patient Advocacy" program to ensure that Medically Necessary Treatment and supplies are provided in the most cost effective manner. In the event the Company determines that a claim, benefit, Treatment, or diagnosis meets the Company's Patient Advocacy program guidelines, the Company will notify the Insured Person as soon as reasonably practicable, and a Patient Advocate will be assigned to the Insured Person. Thereafter, the Company's Patient Advocate may make evaluations and/or recommendations of Treatment settings and/or procedures and/or supplies that may be more cost effective for the Company and/or the Insured Person. Such recommendations will be made with input from the Insured Person and/or the Insured Person's guardians, family members and treating Physicians and other healthcare providers, and will be made only when it can be reasonably demonstrated that the Medically Necessary Treatment and/or supplies can be provided in a more cost effective manner to the Company and/or the Insured Person. The Company will use its best efforts to evaluate and recommend Treatment settings and/or procedures and/or supplies that can reasonably be expected to result in the same or better care of the Insured Person. The Insured Person is under no obligation to accept or follow any of the Company's recommendations. However, if the Insured Person accepts and follows any of the Company's recommendations, the Insured Person agrees to hold the Company and the Company's agents and representatives, including the Patient Advocate, harmless from same, and the Company shall not be held liable or otherwise responsible for any Treatment or supply provided to the Insured Person except for the payment of claims and benefits eligible for coverage under the Terms of this insurance. After the Insured Person has been notified that the claim, Treatment, benefit or diagnosis meets the Company's Patient Advocacy program guidelines, the Company reserves the right, at its option and in its sole discretion without liability, to:

(a) make payment for Treatment and/or supplies which, although not expressly covered under this insurance, may be beneficial to the Insured Person and cost effective to the Company; and/or

(b) deny coverage and/or benefits for any charges, including Eligible Medical Expenses otherwise eligible for coverage but for the Terms of this Section, which exceed the amount the Company would have covered had the Insured Person accepted and followed the recommendations of the Patient Advocacy program.

(20) RIGHT OF RECOVERY - In the event of overpayment by the Company of any claim for benefits under this insurance, for any reason, including without limitation because:

(a) all or part of the claim was not incurred by or paid by or on behalf of the Insured Person; or

(b) the Insured Person or any member of the Insured Person's family, whether or not the family member is or was an insured person under this insurance plan, is repaid or is entitled to be repaid for all or part of the claim by Other Coverage or by or from a source other than the Company; or

(c) all or part of the claim was not eligible for payment or coverage under the Terms of this insurance; or

(d) all or part of the claim was paid or reimbursed based on an incorrect or mistaken application of benefits under this insurance; or

(e) all or part of the claim has been excused, waived, abandoned, forfeited, discounted or released by the provider or supplier; or

(f) the Insured Person is not liable or responsible as a matter of law for all or part of a claim;

the Company shall have the right to a refund of and to recover the amount of overpayment from the Insured Person and/or the Hospital, Physician, or other provider of services or supplies, as the case may be. For overpayment of claims under subparagraphs B(20)(c) and (d), above, the amount of the refund and recovery shall be the difference between: (i) the amount actually paid by the Company; and (ii) the amount, if any, that should have been paid by the Company under the Terms of this insurance. For all other overpayments, the amount of the refund and recovery shall be the amount overpaid. If the Insured Person or the Hospital, Physician or other provider of services or supplies does not promptly make any such refund to the Company, the Company may, in addition to any other rights or remedies available to it (all of which are reserved): (i) reduce or deduct from the amount of any future claim that is otherwise eligible for coverage or payment under this insurance, to the full extent of the refund due to the Company; and/or (ii) cancel this Certificate and all further coverage of the Insured Person under the Master Policy by giving thirty (30) days advance written notice by mail to the Insured Person at his/her last known residence or mailing address, and offset against the amount of any pro-rata refund of Premium due the Insured Person to the full extent of the refund due to the Company.

(21) RENEWAL/AMENDMENT- Coverage under Access HMO Gold International plan may be renewed for extended periods of coverage in increments of 12 months up to a maximum total of thirty-six (36) continuous months. Any one Period of Coverage may not exceed twelve (12) months. If any Period of Coverage under this insurance has lapsed or terminated for any reason, coverage under the Access HMO Gold International plan cannot be renewed, but may be separately written under a new Certificate (only after all applicable eligibility guidelines are met). A new Application with premium must be received by the Company in order to affect newly written coverage, and upon acceptance, a new Certificate will be issued and a new initial Period of Coverage will be established. New deductibles, scheduled benefit limits and sub-limits, conditions of coverage, eligibility requirements, and Pre-existing Condition exclusions will apply to any separately written and non-continuous coverage periods.

(a) At the time of any request for renewal, the Insured Person must satisfy all of the then-current eligibility requirements for this insurance, as established by the Company at its sole discretions (see e.g., Section D); and

(b) The maximum period of continuous coverage under this insurance, including the initial Period of Coverage and any renewed Period(s) of Coverage, may not exceed a total of thirty-six (36) continuous months; and

(a) Upon the Company's acceptance of a renewal Application, a new Declaration of Insurance and the then-current form of Certificate of Insurance for this insurance plan will be issued to the Insured Person by the Company.

The Company's commitment and the Insured Person's ability to renew is also subject to termination upon thirty (30) days written notice to the other party prior to the expiration date of the then existing Period of Coverage. The Company reserves the right in its sole discretion to make changes, additions and/or deletions to the Terms of the Master Policy, this Certificate, renewals or replacements of either, and/or to the Access HMO Gold International insurance plan (including the issuance of Riders to effectuate same) at any time or from time to time after the Effective Date of Coverage of this Certificate, upon no less than ninety (90) days prior written notice to the Assured and the Insured Person (Notice of Amendment). The Notice of Amendment shall include a complete description of the changes, additions and/or deletions to be made, the effective date thereof (the Change Date), and notice of the Insured Person's cancellation rights as set forth below, and shall be sent first class mail, postage pre-paid, to the last known residence or mailing address of the Insured Person. Upon issuance of the Notice of Amendment, the Assured and/or the Insured Person shall have the right to request cancellation of this Certificate, above, at any time prior to the Change Date; provided, however that cancellation under this Section B(21) shall be at the option of the Insured Person, and coverage under this insurance shall terminate with effect from the cancellation date specified by the Insured Person (subject to the provisions of Sections B(18)(a)-(d)). If the Insured Person does not elect to cancel this Certificate in accordance with the foregoing, the changes, additions and/or deletions as made by the Company and specified in said Notice of Amendment shall take effect as of the Change Date specified in the Company's Notice, and this insurance shall thereafter continue in effect in accordance with its Terms, as so amended and modified.

(22) EXPLANATION OR VERIFICATION OF BENEFITS - In the event of any verbal or telephone inquiry, every attempt will be made to help the Insured Person and his/her healthcare providers and suppliers understand the status, scope and extent of available benefits and coverages under this insurance; provided, however, that no statement made by any agent, employee or representative of the Company or the Plan Administrator will be deemed or construed as an actionable representation, promise, or an estoppel, or will create any liability against the Company or the Plan Administrator or be deemed or construed to bind the Company or to modify, replace, waive, extend or amend any of the Terms of the Master Policy or this Certificate, unless expressly set forth in writing and signed by an authorized agent or representative of the Company. Actual eligibility determinations, benefit verifications, final coverage decisions and claim adjudications, and final payments and/or reimbursements of benefits or claims shall be determined and adjudicated only after or at the time a proper and complete Application and/or Proof of Claim is submitted (as the case may be), an opportunity for reasonable investigation and/or review is provided, cooperation required hereunder received, and all facts and supporting information, including relevant medical records when deemed necessary or appropriate by the Company, are presented in writing. Appealed claims may be further investigated and/or reviewed. The Terms of the Master Policy govern all available coverages and payments made or to be made. If a definite answer to a specific benefits or coverage question is required for any reason, the Insured Person or his/her healthcare providers may submit a written request to the Company, including all pertinent medical information and a statement from the attending Physician (if applicable), and a written

reply will be sent by the Company and kept on file. If the Company elects to verify generally and/or preliminarily to a provider or the Insured Person that an Injury, Illness, diagnosis or proposed Treatment is or may be covered under this insurance, or that benefits for same are or may be available as outlined in this Certificate, any such verification of benefits does not guaranty either payment of benefits or the amount or eligibility of benefits. Final eligibility determinations, coverage decisions, claim appeals, and actual reimbursement or payment of claims or benefits are subject to all Terms of this insurance, including without limitation filing a proper and complete Proof of Claim under Section B(3) and cooperation under Section B(13).

C. SCHEDULE OF BENEFITS/LIMITS - Subject to the Terms of this insurance, including without limitation the Deductible and Coinsurance (unless otherwise expressly set forth to the contrary), the Exclusions set forth in Section U. of the Master Policy and this Certificate, and the various limits and sub-limits set forth below, the Company promises to provide the Insured Person the following summary of benefits and coverages arising out of Injury or Illness incurred while this Certificate is in effect:

Benefit/Other	**Limit/Sub-limit**
Maximum Limit	Age 15 days to 69 years: US$1,000,000 per Period of Coverage Age 70-75 years: US$ 50,000 per Period of Coverage
Maximum Trip Duration	As shown on the Declaration of Insurance
Deductible	US$250 per Insured Person per covered Illness. The Deductible shall be waived for claims incurred as the result of a covered Accident.
Emergency Room Deductible	An additional Deductible of $250 will be applied for each Emergency Room visit for treatment of an Illness which does not result in a direct Hospital admission.
Coinsurance	For Treatment received outside the US & Canada: No Coinsurance For Treatment received with the US & Canada: In the PPO Network: The plan pays 90% of Eligible Medical Expenses up to US$5000, then 100% up to Maximum Limit Outside of the PPO Network: The plan pays 80% of Eligible Medical Expenses up to US$5000, then 100% up to Maximum Limit
Benefit Period	30 days to a maximum of $5000. See Section V, "Definitions; Benefit Period" for further Terms.
Accidental Death & Dismemberment Benefit	US$25,000 (Not subject to Deductible and Coinsurance). See Section L for further Terms.
Common Carrier Accidental Death Benefit	US$50,000 per Insured Person, maximum of $250,000 per Family involved in the same Accident. See Section M for further Terms.
Sudden and Unexpected Recurrence of a Pre-existing Condition	Subject to the Deductible, up to US$5,000 per Period of Coverage. See Section Q for further Terms.
Dental Emergency	Subject to the Deductible, up to US$100 for the necessary Treatment of Unexpected pain to sound natural teeth.
Emergency Medical Evacuation	Subject to the Deductible, up to US$25,000 for Eligible Medical Expenses for an Emergency Medical Evacuation arising or resulting from a sudden and Unexpected recurrence of a Pre-existing Condition eligible for coverage under Section Q. For Eligible Medical Expenses for an Emergency Evacuation resulting from all other covered incidents, if under the age of 66, up to Maximum Limit, if age 66 to 75, up to US$50,000. All evacuations must be approved in advance and coordinated by the Company. See Sections H and Q for further Terms.
Emergency Reunion	Subject to the Deductible, up to a US$50,000 lifetime maximum and limited to a maximum of 15 days. Must be approved in advance and coordinated by the Company. See Section I for further Terms.
Return of Minor Children	Subject to Deductible, up to US$50,000. Must be approved in advance and coordinated by the Company. See Section R for further Terms.
Return of Mortal Remains	Subject to Deductible, up to US$50,000 per Insured Person. Must be approved in advance and coordinated by the Company. See Section J for further Terms.

Political Evacuation And Repatriation	Limited to a US$10,000 lifetime maximum. Must be approved in advance and coordinated by the Company. See Section K for further Terms.
Local Ambulance Expense	Subject to Deductible, Usual, Reasonable and Customary. See Section G(4)(k)and (l) for further Terms.
Hospital Room & Board	Subject to Deductible, the average semi-private room rate, including nursing service. See Section G(1)(a) for further Terms.
Intensive Care Unit	Subject to Deductible, Usual, Reasonable and Customary. See Section G(1)(b) for further Terms.
Eligible Medical Expenses	Subject to Deductible, Usual, Reasonable and Customary. See Section G for further Terms.
Pre-certification	50% reduction of Eligible Medical Expenses if Pre-certification provisions are not met. See Section E for further Terms.
Hospital Indemnity	US$100 per day paid directly to the Insured Person for each night of a required hospital stay that is covered under all terms and conditions of this plan up to a maximum of 10 nights per Period of Coverage. Not subject to Deductible or Coinsurance. See Section T for further Terms.
Trip Interruption	Not subject to Deductible, up to US$5,000 per Insured Person per Period of Coverage. See Section N for further Terms.
Lost Luggage	Not subject to Deductible, up to US$50 per item of luggage, $250 maximum per Insured Person per Period of Coverage. See Section O for further Terms.
Identity Theft	Up to US$500 per Period of Coverage Not subject to Deductible or Coinsurance. See Section S for further Terms.

D. ELIGIBILITY - If an Insured Person is not eligible, this Certificate is void *ab initio* and all premium paid will be refunded. In order to be eligible and qualified for coverage under this insurance, a person must:

(1) complete and sign an Application as the Insured Person (or be listed thereon by proxy as an applicant and proposed Insured Person), and/or as the Insured Person's spouse and/or Dependent Child; and

(2) be at least 15 days old and under the age of 76; and

(3) intend to legally depart the Home Country and legally enter the Host Country one or more times during the Period of Coverage; and

(4) not be a citizen of the Host Country; and

(5) pay the required Premium on or before the Effective Date of Coverage; and

(6) must be a citizen of the United States of America; and

(7) must be covered by an individual or group medical plan for expenses incurred in Home Country, which is in effect on the Effective Date of this plan and remains in effect during the duration of this plan.

E. PRE-CERTIFICATION PROVISIONS/REQUIREMENTS - Pre-certification is a general determination of Medical Necessity, only, and all such determinations are made by the Company (acting through its authorized agents and representatives) in reliance and based upon the completeness and accuracy of the information provided by the Insured Person and/or his/her relatives, guardians and/or healthcare providers at the time of Pre-certification. The Company reserves the right to challenge, dispute and/or revoke a prior determination of Medical Necessity based upon subsequent information obtained. Pre-certification is **not** an assurance, authorization, preauthorization, or verification of Treatment or coverage, a verification of benefits, or a guarantee of payment. The fact that Treatment or supplies are Pre-certified by the Company does not guarantee the payment of benefits, the availability of coverages, or the amount of or eligibility for benefits. The Company's consideration and determination of a Pre-certification request, as well as any subsequent review or adjudication of all medical claims submitted in connection therewith, shall remain subject to all of the Terms of the Master Policy and this Certificate, including exclusions for Pre-existing Conditions and other designated exclusions, benefit limitations and sub-limitations, and the requirement that claims be Usual, Reasonable and Customary. Also, any consideration or determination of a Pre-certification request shall not be deemed or considered as the Company's approval, authorization or ratification of, recommendation for, or consent to any diagnosis or proposed course of Treatment. Neither the Company nor the Plan Administrator (nor anyone acting on their respective behalves) has any authority or obligation to select Physicians, Hospitals, or other healthcare providers for the Insured Person, or to make any diagnosis or medical Treatment decisions on behalf of the Insured Person, and all such decisions must be made solely and exclusively by the Insured Person and/or his/her family members or guardians, treating Physicians and other healthcare providers. If the Insured Person and his/her healthcare providers comply with the Pre-certification requirements of the Master Policy and this Certificate, and the Treatment or supplies are Pre-certified as Medically Necessary, the Company will reimburse the Insured Person for

Eligible Medical Expenses incurred in relation thereto, subject to all Terms of this insurance, including the Deductible and Coinsurance. Eligibility for and payment of benefits are subject to all of the Terms of this insurance.

(1) SPECIFIC REQUIREMENTS - The following Treatments and/or supplies must always be Pre-certified for Medical Necessity by the Company through the Plan Administrator:

(a) Inpatient Treatment and/or supplies of any kind.

(b) any Surgery or Surgical procedure.

(c) any Treatment in an Extended Care Facility.

(d) any Home Nursing Care.

(e) Durable Medical Equipment.

(f) artificial limbs.

(g) Computerized Axial Tomography (CAT Scan).

(h) Magnetic Resonance Imaging (MRI).

(2) GENERAL REQUIREMENTS - To comply with the Pre-certification requirements of this insurance for the Treatments and/or supplies listed in Section E(1), above, the Insured Person or his/her Physician or healthcare provider must:

(a) contact the Company through the Plan Administrator at the telephone numbers printed on the Insured Person's ID card, **as soon as possible before the Treatment or supply is to be obtained,** as follows:

Inside the United States:	+1-616-855-7670
Outside the United States:	+420.776 162 499
E-mail:	claims@accesshmo.com
Website:	www.accesshmo.com

(b) comply with the instructions of the Company and submit any information or documents required by the Company; and

(c) notify all Physicians, Hospitals and other healthcare providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Company.

(3) LOSS OF COVERAGE/BENEFITS FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS - If the Insured Person or his/her healthcare providers do not comply with the foregoing Pre-certification requirements, all Eligible Medical Expenses incurred with respect to said Treatments and/or supplies will first be reduced by fifty percent (50%), the applicable Deductible will be subtracted from the reduced amount, the Coinsurance will then be applied to the remainder of the reduced amount as applicable, and further benefits, if any, will be available only for the remaining balance of the reduced amount thereafter.

(4) EMERGENCY PRE-CERTIFICATION - In the event of an Emergency Hospital admission, Pre-certification must be completed within forty-eight (48) hours after the admission, or as soon as is reasonably possible.

(5) CONCURRENT REVIEW - For Inpatient Treatment of any kind, the Company will Pre-certify a limited number of days of confinement based upon the disclosed medical condition. Thereafter, Pre-certification must again be requested and approved if additional days of Inpatient Treatment are necessary.

(6) APPEAL PROCESS - If the Insured Person disagrees with a Pre-certification decision of the Company, the Insured Person may in writing ask the Company to reconsider the decision and may supply additional documentation to support the appeal. The Company may reconsider its decision based on review of the additional documentation and facts, if any. The Company will advise the Insured Person of its decision.

F. UNITED STATES PREFERRED PROVIDER ORGANIZATION (PPO)

PPO Information: The Company, through the Plan Administrator, endeavors to maintain a contractual arrangement with one or more independent Preferred Provider Organizations (PPO) that has established and maintains a network of U.S.-based Physicians, Hospitals and other healthcare and health service providers who are contracted separately and directly with the PPO and who may provide re-pricings, discounts or reduced charges for Treatment or supplies provided to the Insured Person. Neither the Company nor the Plan Administrator has any authority or control over the operations or business of the PPO, or over the operations or business of any provider within the independent PPO network. Neither the PPO nor any provider within the PPO network nor any of their respective agents, employees or representatives has or shall have any power or authority whatsoever to act for or on behalf of the Company or the Plan Administrator in any respect, including without limitation no power or authority to: (i) approve Applications or enrollments for initial, renewal or reinstated coverage under this insurance plan or to accept Premium payments, (ii) accept risks for or on behalf of the Company, (iii) act for, speak for, or bind the Company or the Plan Administrator in

any way, (iv) waive, alter or amend any of the Terms of the Master Policy or this Certificate or waive, release, compromise or settle any of the Company's rights, remedies, or interests thereunder or hereunder, or (v) determine Pre-certification, eligibility for coverage, verification of benefits, or make any coverage, benefit or claim adjudications or decisions of any kind. It is not a requirement of this insurance that the Insured Person seek Treatment or supplies exclusively from a provider within the independent PPO network. However, the Insured Person's use or non-use of the PPO network may affect the scope and extent of benefits available under this insurance, including without limitation the applicable Deductible, Coinsurance and Extra Deductible, as set forth above. An Insured Person may contact the Company through the Plan Administrator and request a PPO Directory for the area where the Insured Person will be receiving Treatment (therein listing the Physicians, Hospitals and other healthcare providers within the PPO network by location and specialty), or may visit the Plan Administrator's website at https://www.accesshmo.com to obtain such information.

G. ELIGIBLE MEDICAL EXPENSES - Subject to the Terms of this insurance, including without limitation the Deductible, and the various limits and sub-limits set forth in the Schedule of Benefits/Limits contained in Section C, above, and the Exclusions set forth in Section U, below, the Company will reimburse the Insured Person for the following costs, charges and expenses ("Charges") incurred by the Insured Person during the Period of Coverage or any applicable Benefit Period with respect to an Illness or Injury suffered or sustained by the Insured Person during the Period of Coverage and while this Certificate is in effect, so long as the Charges are Usual, Reasonable and Customary and are incurred for Treatment or supplies that are Medically Necessary ("Eligible Medical Expenses"):

(1) Charges incurred at a Hospital for:

(a) daily room and board and nursing services not to exceed the average semi-private room rate; and

(b) daily room and board and nursing services in an Intensive Care Unit; and

(c) use of operating, Treatment or recovery room; and

(d) services and supplies which are routinely provided by the Hospital to persons for use while Inpatient; and

(e) Emergency Room Treatment of an Injury, even if Hospital confinement is not required; and

(f) Emergency Room Treatment of an Illness; however an additional $250 deductible will be required unless the Insured Person is directly admitted to the Hospital as Inpatient for further Treatment of that Illness;

(2) Charges incurred for Surgery at an Outpatient Surgical facility, including services and supplies; and

(3) Charges by a Physician for professional services rendered, including Surgery; provided, however, that charges by or for an assistant surgeon will be limited and covered at the rate of twenty percent (20%) of the Usual, Reasonable and Customary charge of the primary surgeon; and provided, further, that standby availability of a Physician or surgeon will not be deemed to be a professional service and is not eligible for coverage; and

(4) Charges incurred for:

(a) dressings, sutures, casts or other supplies that are Medically Necessary; and

(b) diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, behavioral and educational testing are not included); and

(c) Implant devices that are Medically Necessary; however any Implants provided by a non-PPO provider are limited to payment of no more than 150% of the established invoice price and/or list price for that item.; and

(d) subject to the Terms of Sections T(10)(b), (c) and (d), basic functional artificial limbs, eye or larynx or breast prostheses, but not the replacement or repair thereof; and

(e) hemodialysis and the Charges by a Hospital for processing and administration of blood or blood components, but not the cost of the actual blood or blood components; and

(f) oxygen and other gasses and their administration; and

(g) anesthetics and their administration by a Physician; and

(h) drugs which require prescription by a Physician for Treatment of Illness or Injury, but not for the replacement of lost, stolen, damaged, expired or otherwise compromised drugs, and for a maximum supply of ninety (90) days of any one prescription; and

(i) care in a licensed Extended Care Facility upon direct transfer from an acute care Hospital; and

(j) Home Nursing Care in bed by a qualified licensed professional, provided by a Home Health Care Agency upon direct transfer from an acute care Hospital; and

(k) Emergency Local Ambulance Transport necessarily incurred in connection with Injury; and

(l) Emergency Local Ambulance Transport necessarily incurred in connection with an Illness resulting in Hospitalization; and

(m) Accident-related Dental Treatment and Dental Surgery, as necessary to restore or replace sound natural teeth lost or damaged in an Accident leading to an Injury that is covered under this insurance; and

(n) physical therapy prescribed by a Physician and performed by a professional physical therapist, and necessarily incurred to continue recovery from a covered Injury or covered Illness; and

(o) Medically Necessary rental of Durable Medical Equipment, up to the purchase price.

(5) Subject to the Terms of Section U, Exclusions, subsection 1 (e) "War; Military Action" and Section T, subsection 2. "Terrorism", below, and subject also to the Deductible, Coinsurance and limits and sublimits set forth in Section C of the Certificate "Schedule of Benefits/Limits," the Company will pay and/or reimburse the Insured Person up to $50,000 for the Eligible Medical Expenses described in Sections G. 1-4, a-o of the Certificate arising out of Injury or Illness incurred by the Insured Person as a result of or in connection with an act of Terrorism while this insurance is in effect.

H. EMERGENCY MEDICAL EVACUATION BENEFIT - Subject to the applicable Maximum Limit set forth in the Schedule of Benefits/Limits set forth in Section C, above, and the other Terms of this insurance, including the Exclusions set forth in Section T and the Conditions and Restrictions set forth below, the Company will reimburse the Insured Person for the following transportation costs, when the Company or Plan Administrator arranges such transportation, and expenses incurred by the Insured Person arising out of or in connection with an Emergency Medical Evacuation occurring while this Certificate is in effect and during the Period of Coverage:

(1) Emergency air transportation to a suitable airport nearest to the Hospital where the Insured Person will receive Treatment or to their Home Country; and

(2) Emergency ground transportation necessarily preceding Emergency air transportation and from the destination airport to the Hospital where the Insured Person will receive Treatment or to their Home Country; and

(3) Return ground and air transportation, upon medical release by the attending Physician, to the country where the evacuation initially occurred or to the Insured Person's Home Country, at the Insured Person's option.

Conditions and Restrictions - To be eligible for coverage for Emergency Medical Evacuation benefits the Insured Person must be in compliance with all Terms of this insurance. The Company will provide Emergency Medical Evacuation benefits only when the condition, Illness, Injury or occurrence giving rise to the Emergency Medical Evacuation is covered under the Terms of this insurance, subject to the provisions of subparagraph (f)(ii), below. The Company will provide Emergency Medical Evacuation benefits only when all of the following conditions and restrictions are met:

(a) Medically Necessary Treatment cannot be provided locally; and

(b) transportation by any other means or methods would result in loss of the Insured Person's life or limb based upon a reasonable medical certainty; and

(c) Emergency Medical Evacuation is recommended by the attending Physician who certifies to the matters in subparagraphs (a) and (b), above; and

(d) Emergency Medical Evacuation is agreed to by the Insured Person or a Relative of the Insured Person; and

(e) Emergency Medical Evacuation is approved in advance and all arrangements are coordinated by the Company; and

(f) the condition, Illness, Injury or occurrence giving rise to the need for the Emergency Medical Evacuation:

(i) occurred suddenly, Unexpectedly, and spontaneously, and without: (1) advance warning, (2) advance Treatment, diagnosis or recommendation for Treatment by a Physician, and (3) prior manifestation of symptoms or conditions which would have caused a reasonably prudent person to seek medical attention prior to the onset of the Emergency, and

(ii) was not a Pre-existing Condition; provided, however that if such condition, Illness or Injury *is* a Pre-existing Condition that is eligible for coverage under the Terms of Section Q, below, Emergency Medical Evacuation benefits will be provided up to US $25,000 so long as each and all of other Terms, Conditions and Restrictions set forth in this Section H have been satisfied; and

(g) The Company will cover reimbursement for the above-described costs and expenses and will arrange Emergency Medical Evacuation only to the nearest Hospital that is qualified to provide the Medically Necessary Treatment to prevent the Insured Person's loss of life or limb. The Insured Person may select a different Hospital in his/her Home Country at his/her option, but in such event shall retain for the Insured Person's own account and responsibility all costs and expenses in excess of the amounts that would have been incurred to the nearest qualified Hospital. If a Hospital other than the nearest qualified Hospital is selected by the Insured Person, the attending physician, Insured Person, or a relative of the Insured Person shall certify to the Company the Insured Person's understanding and acknowledgement of such responsibility for excess costs and expenses in addition to the matters set forth in subsections (a) and (b) of the Conditions and Restrictions, above. In all cases the Company will make the necessary arrangements for the Emergency Medical Evacuation, and will use its best efforts to arrange with independent, third-

party contractors any Emergency Medical Evacuation within the least amount of time reasonably possible. By acceptance of this Certificate and request for Emergency Medical Evacuation benefits hereunder, the Insured Person understands, acknowledges and agrees that the timeliness, duration, occurrences during, and outcome of an Emergency Medical Evacuation can be directly and indirectly affected by events and/or circumstances which are not within the supervision or control of the Company, including but not limited to: the availability, limitations, physical condition, reliability, maintenance and training schedules and procedures, and performance or non-performance of competent transportation equipment, supplies and/or staff of such third-party contractors; delays or restrictions on flights or other modes or means of transportation caused by mechanical problems, government officials, telecommunications problems, non-availability of routes, and/or other travel, geographical or weather conditions; and other acts of God and unforeseeable and/or uncontrollable occurrences. The Insured Person agrees to release and to hold the Company, the Plan Administrator and their agents and representatives harmless from, and agrees that the Company, the Plan Administrator and their agents and representatives shall not be held liable or responsible for, any delays, losses, damages, further injuries or illnesses, or any other claims that arise from or are caused in whole or in part by the acts or omissions of such independent third-party contractors or their agents, employees or representatives, or that arise from or are caused in whole or in part by any acts, omissions, events or circumstances that are not within the direct and immediate supervision and control of the Company, the Plan Administrator and/or their authorized agents and representatives, including without limitation the events and circumstances set forth above. The Insured Person further agrees that upon seeking an Emergency Medical Evacuation, he or she will cooperate fully as required by Section (B)(13). Failure to so cooperate and/or failure to use or accept Emergency Medical Evacuation once it has been arranged by the Company or Plan Administrator will require the Insured Person to reimburse the Company for costs incurred for any Emergency Medical Evacuation that was arranged, but not used, by the Insured Person. Furthermore, the Insured Person may be required to arrange for payment of any subsequent Emergency Medical Evacuation and seek reimbursement thereafter for eligible costs associated with that subsequent Emergency Medical Evacuation.

I. EMERGENCY REUNION - Subject to the Terms of this insurance, including without limitation the Conditions and Restrictions set forth below, Emergency Reunion expenses up to $50,000 per Period of Coverage (and also not to exceed $50,000 lifetime maximum) will be reimbursed to an Insured Person as outlined in the Schedule of Benefits/Limits set forth in Section C, above, in cases where there has been an Emergency Medical Evacuation covered under the Terms of this insurance. Subject to the applicable Deductible and Coinsurance and other limits and sub-limits as specified in the Schedule of Benefits/Limits, and subject to the Conditions and Restrictions set forth below, the following costs and expenses incurred in respect of travel by a Relative or friend of the Insured Person will be reimbursable to the Insured Person upon the recommendation and prior approval of the Company:

(1) the cost of a round-trip economy air ticket for one Relative or friend from the airport nearest to the location of the Relative or friend at the time of the Emergency to the airport serving the area where the Insured Person is Hospitalized as a result of the Emergency or is to be Hospitalized as a result of the Emergency Medical Evacuation (to be determined pursuant to the Terms of subsection (c) of the Conditions and Restrictions, below), and return from whichever of such locations is actually selected to the point of the original departure; and

(2) reasonable and necessary travel costs, meals (maximum of $25 per day), transportation and accommodation expenses incurred in relation to the Emergency Reunion (but excluding entertainment).

Conditions and Restrictions:

(a) The allowable period of coverage for the Emergency Reunion shall not exceed fifteen (15) days, including travel days, and all costs and expenses incurred beyond such period of coverage shall be retained for the sole account and responsibility of the Insured Person, Relative, or friend; and

(b) the Emergency Reunion must be due to an Emergency Medical Evacuation covered under the Terms of this insurance; and

(c) the Insured Person must be so seriously ill that the attending Physician deems it necessary and recommends the presence of a Relative or friend at either the location where the Insured Person is being evacuated from or the destination of the evacuation, whichever is considered by the attending Physician and the Company to be the more reasonable; and

(d) all Emergency Reunion travel, transportation and accommodation arrangements and benefits must be coordinated and approved in advance by the Company in order to be eligible for coverage under this insurance; and

(e) The Insured Person, Relative and/or friend must submit to the Company upon completion of the Emergency Reunion travel legible and verifiable copies of all paid receipts for the travel and transportation costs and expenses so incurred for which reimbursement is sought.

J. RETURN OF MORTAL REMAINS - In the event of the death of the Insured Person during the Period of Coverage as a result of an Illness or Injury covered under this insurance while the Insured Person is outside of his/her Home Country, the Company will reimburse the estate of the Insured Person up to US $50,000 for the costs and expenses incurred to return the Insured Person's Mortal Remains to his/her Home Country and thereafter to the place of burial or other final disposition (but not including any costs of burial or other disposition); provided, however, that the Company must coordinate and approve all costs and expenses related to the return of the Insured Person's Mortal Remains in advance as a condition to the availability of this benefit.

K. POLITICAL EVACUATION AND REPATRIATION – If the United States Department of State, Bureau of Consular Affairs or similar government organization of the Insured Person's Home Country orders the evacuation of all non-emergency government personnel from the Host Country, due to political unrest, that becomes effective on or after the Insured Person's date of arrival in

the Host Country, the Company will pay up to US$10,000 lifetime maximum for transportation to the nearest place of safety or for repatriation to the Insured Person's home country or country of residence provided that:

(1) the Insured Person contacts the Company within 10 days of the United States Department of State, Bureau of Consular affairs or similar government organization of the Insured Person's Home Country issuing the evacuation order; and

(2) the evacuation order pertains to persons from the same Home Country as the Insured Person; and

(3) Political Evacuation and Repatriation is approved and coordinated by the Company;

In no event will the Company pay for a Political Evacuation if there is a Travel Warning in effect on or within six (6) months prior to the Insured Person's date of arrival in the Host Country. This coverage will provide the most appropriate and economical means of travel consistent under the circumstances with the Insured Person's health and safety.

L. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

(1) Accidental Death - Subject to the Terms of this insurance, including all of the Exclusions contained in Section U, in the event of the Unexpected death of an Insured Person during the Period of Coverage as a result of covered Injury that was suffered due to an Accident that occurred during the Period of Coverage, regardless of whether or not a claim for medical expenses is submitted, the Company will pay to the Insured Person's estate or to the Insured Person's designated beneficiary an Accidental Death benefit in the amount of $25,000.

(2) Dismemberment - Subject to the Terms of this insurance, including all of the Exclusions contained in Section U ,in the event of an Unexpected dismemberment/loss suffered by an Insured Person, as detailed below, during the Period of Coverage as a result of a covered Injury or Illness that was suffered due to an Accident that occurred during the Period of Coverage, the Company will pay to the Insured Person the applicable loss/dismemberment benefit as specified below.

Loss	Benefit
Sight of one Eye	$12,500
One hand or one foot	$12,500
One hand and the loss of sight of one eye	$25,000
One foot and the loss of sight of one eye	$25,000
One hand and one foot	$25,000
Both hands or both feet	$25,000
Sight of both eyes	$25,000

The maximum benefit payable for all dismemberment or losses resulting from any one Accident or Injury shall not exceed $25,000. The loss of a hand or foot means the complete severance at or above the wrist or ankle joint. The loss of sight means the entire and irrecoverable loss of sight.

The Accidental Death and Dismemberment benefits will be paid to the Insured Person or to the Insured Person's estate or designated beneficiary, as the case may be, upon proper application therefor.

M. COMMON CARRIER ACCIDENTAL DEATH BENEFIT - Subject to the Terms of this insurance, including the Pre-Existing Conditions exclusion as defined herein, in the event of the Unexpected death of an Insured Person during the Period of Coverage as a result of an Injury that was suffered due to an Accident that occurred during the Period of Coverage and while the Insured Person was traveling on a Common Carrier, the Company will pay to the Insured Person's estate or to the Insured Person's designated beneficiary a Common Carrier Accidental Death benefit in the amount of $50,000; provided, however, that such Common Carrier Accidental Death benefits shall not exceed a maximum of $250,000 per Family involved in the same Accident.

N. TRIP INTERRUPTION - Subject to the limits set forth in the Schedule of Benefits/Limits, in the event of the Unexpected death of a Relative of the Insured Person, or in the event the Insured Person's trip or travel plans must be cancelled or interrupted as a result of a break-in or substantial destruction due to a fire or Natural Disaster of an Insured Person's principal residence in his/her Home Country, the Company will reimburse the Insured Person's actual expense up to US $5,000 for the costs of a one-way air or ground transportation ticket of the same class as the unused travel ticket to return an Insured Person from the International airport nearest to where the Insured Person was located at the time of learning of such death or destruction to the International airport nearest to: (i) the location of the funeral or place of burial in the case of the Unexpected death of a Relative, or (ii) the Insured Person's principal residence in the case of substantial destruction thereof; subject to the following conditions and limitations:

(1) The Insured Person must be outside of his/her Home Country at the time of the Unexpected death of the Relative or the substantial destruction of the principal residence; and

(2) The Unexpected death of the Relative or the substantial destruction of the residence must have occurred during the Period of Coverage; and

(3) The Company will deduct from the Trip Interruption benefits payable hereunder the value, if any, of the unused return ticket held by the Insured Person at the time of the death or destruction, which value the Insured Person must attempt to receive credit for or apply towards the costs of the return trip.

The Company will not provide any benefits, reimbursements or coverage for any of the costs or expenses incurred by the Insured Person for a re-return trip, if any, to the original location of the Insured Person at the time of learning of such death or destruction.

O. LOST LUGGAGE - Subject to the limits set forth in the Schedule of Benefits/Limits, the Company will reimburse the Insured Person for the cost of lost checked luggage when such luggage was permanently lost in transit by a Common Carrier during the Period of Coverage, subject to the following conditions:

(1) The Insured Person must submit to the Company a copy of the Common Carrier's claim form and such other documentation as the Company may reasonably require to prove that the Insured Person's luggage was permanently lost; and

(2) The Common Carrier must have first reimbursed the Insured Person the full amount that it is legally required to pay for lost checked luggage, and proof of such reimbursement shall be provided to the Company by the Insured Person. Lost Luggage benefits under this insurance will be provided only if and to the extent the amount of the Insured Person's loss suffered as a result of lost checked baggage exceeds any such reimbursement by the Common Carrier (and subject to the limits set forth in the Schedule of Benefits/Limits).

P. DENTAL EMERGENCY – Subject to the limits set forth in the Schedule of Benefits/Limits, the Company will pay up to US$100 for the Treatment and relief of Unexpected pain to sound natural teeth.

Q. SUDDEN AND UNEXPECTED RECURRENCE OF A PRE-EXISTING CONDITION. Subject to the Terms of this insurance, including without limitation the Exclusions set forth in Section U, the Conditions and Restrictions set forth below and the applicable Deductible and Coinsurance and other limits and sub-limits as specified in the Schedule of Benefits/Limits set forth in Section C, above, in the event the Insured Person suffers or experiences an Unexpected recurrence of a Pre-existing Condition during the Period of Coverage for which immediate Treatment is essential and necessary to stabilize the Pre-existing Condition, the Insured Person will be reimbursed up to US$5,000 for Eligible Medical Expenses incurred during the Period of Coverage with respect to the Unexpected recurrence of the Pre-existing Condition.

Conditions and Restrictions - To be eligible for the foregoing limited coverage and benefits for an Unexpected recurrence of a Pre-existing Condition, the Insured Person must be in compliance with all Terms of this insurance. The Company will provide such coverage and benefits only when all of the following conditions and restrictions have been met. At the time of the Unexpected recurrence of the Pre-existing Condition:

(1) The Insured Person must not be traveling against or in disregard of the recommendations, established Treatment programs, or medical advice of a Physician or other healthcare provider; and

(2) The Insured Person must not be traveling with the intent or purpose to seek or obtain Treatment for the Pre-existing Condition; and

(3) The Insured Person must not be traveling during a period of time when the Insured Person is preparing or waiting for, involved in, or undertaking a new, changed or modified Treatment program with respect to the Pre-existing Condition, and is not traveling subsequent to any such new, changed or modified Treatment program having been advised or recommended; and

(4) The Pre-existing Condition must have been stabilized for at least thirty (30) days prior to the Effective Date without change in Treatment; and

(5) The Insured Person must be traveling outside their Home Country.

R. RETURN OF MINOR DEPENDENT CHILDREN - Subject to the Terms of this insurance, in the event the Insured Person is hospitalized as an Inpatient during the Period of Coverage due to an Injury or Illness suffered during the Period of Coverage and eligible for coverage under the Terms of the plan, and at the time of such hospitalization the Insured Person is traveling alone with a Dependent Child or Children, the Company will reimburse the Insured Person's actual expense up to U.S. $50,000 for the costs of one-way economy airfare to return the Dependent Child or Children to their Home Country, including such costs for a chaperone if necessary for the safety of the Dependent Child or Children, subject to the following conditions and limitations:

(1) The Insured Person must be outside the Home Country at the time of the hospitalization as an Inpatient; and

(2) The return of the Dependent Child or Children must occur during the hospitalization; and

(3) Reimbursable costs are only for one-way economy airfares from the International airport nearest to where the Dependent Child or Children were located at the time of the Insured Person's hospitalization, to the International airport nearest to the Dependent Child's or Children's principal residence in the Home Country; and

(4) All travel and transportation arrangements for the Dependent Child or Children must be coordinated and approved in advance by the Company in order to be eligible for coverage under this insurance; and

(5) The Company will deduct from the return transportation benefits payable hereunder the value, if any, of the unused return ticket(s) held by or for the benefit of the Dependent Child or Children at the time of the Insured Person's hospitalization, which value the Insured Person and/or the Dependent Child or Children must attempt to receive credit for or apply towards the costs of the return trip.

The Company will not provide any benefits, reimbursements or coverage for any costs or expenses incurred by the Insured Person and/or by the Dependent Child or Children for a re-return trip, if any, to the original location of the Dependent Child or Children at the time of the hospitalization.

S. IDENTITY THEFT - The reasonable, customary and necessary costs incurred by the insured for re-filing loan or other credit applications that are rejected solely as a result of the stolen identity event; the reasonable, customary and necessary costs incurred by the insured for notarization of legal documents, long distance telephone calls, and postage that has resulted solely as a result of reporting, amending and/or rectifying records as a result of the stolen identity event; the reasonable, customary and necessary costs incurred by the insured for up to three credit reports obtained within one year of the insured person's knowledge of the stolen identity event; the reasonable, customary and necessary costs incurred by the insured for stop payment orders placed on missing or unauthorized checks as a result of the stolen identity event.

T. HOSPITAL INDEMNITY - Subject to the Terms of this insurance, in the event the Insured Person is a U.S. citizen who has been hospitalized as an Inpatient during the Period of Coverage or an applicable Benefit Period, the Company will indemnify the Insured Person U.S. $100 for each night of a required overnight stay in the Hospital, so long as the stay and the Treatment received during the stay are eligible, in whole or in part, for coverage under the Terms of the plan up to a maximum of 10 nights per Period of Coverage.

U. EXCLUSIONS - All charges, costs, expenses and/or claims (collectively "Charges") incurred by the Insured Person and directly or indirectly relating to or arising or resulting from or in connection with any of the following acts, omissions, events, conditions, charges, consequences, claims, Treatment (including diagnoses, consultations, tests, examinations and evaluations related thereto), services and/or supplies are expressly excluded from coverage under this insurance, and the Company shall provide no benefits or reimbursements and shall have no liability or obligation for any coverage thereof or therefor:

(1) War; Military Action – Subject to the Terms of Section G. 5, above, and Section U. 2, below, the Company shall not be liable for and will not provide coverage or benefits for any claim or Charges incurred with respect to any Illness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising or incurred in connection with or as a result of any of the following acts or events (collectively, "Occurrences"):

(a) war, invasion, act of foreign enemy hostilities, warlike operations (whether war be declared or not), or civil war;

(b) mutiny, riot, strike, military or popular uprising, insurrection, rebellion, revolution, military or usurped power;

(c) any act of any person acting on behalf of or in connection with any organization with activities directed towards the overthrow by force of the Government de jure or de facto or to the influencing of it by violence of any type;

(d) martial law or state of siege or any events or causes which determine the proclamation or maintenance of martial law or state of siege; and

(e) any use of radiological, chemical, nuclear or biological weapons or any other radiological, chemical, nuclear or biological events of any type (including in connection with an act of Terrorism).

Any claim, Charges, Illness, Injury or other consequence happening or arising during the existence of abnormal conditions (whether physical or otherwise), whether or not directly or indirectly, proximately or remotely occasioned by, or contributed to by, traceable to, or arising in connection with, any of the said Occurrences shall be deemed and considered to be consequences for which the Company shall not be liable under the Master Policy or this Certificate, except to the extent that the Insured Person shall prove that such claim, Charges, Illness, Injury or other consequence happened independently of the existence of such abnormal conditions and/or Occurrences.

(2) Terrorism – The Company shall not be liable for and will not provide coverage or benefits in excess of a $50,000 lifetime maximum benefit for any claim or charges, Illness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising in connection with any act of Terrorism; and provided, further, the Company shall not be liable for and will not provide any coverage or benefits for any claim, charges, Illness, Injury or other consequence, whether directly or indirectly, proximately or remotely occasioned by, contributed to by, or traceable to or arising in connection with the following:

(a) the Insured Person's active and voluntary planning or coordination of or participation in any act of Terrorism; and/or

(b) any act of Terrorism that takes place in a location, post, area, territory or country for which the United States Department of State, Bureau of Consular Affairs issued a Travel Warning that was in effect on or within six (6) months prior to the Insured Person's date of arrival in said location, post, area, territory or country; and/or

(c) any act of Terrorism that takes place in a location, post, area, territory or country for which the United States Department of State, Bureau of Consular Affairs issues a Travel Warning that becomes effective or is in effect on or after the Insured Person's date of arrival in said location, post, area, territory or country, and the Insured Person unreasonably fails or refuses to heed such warning and thereafter remains in said location, post, area, territory or country.

(3) Pre-existing Conditions - Charges arising or resulting directly or indirectly from or relating to any Pre-existing Condition, as herein defined, except for as provided for in Section Q, above; and

(4) Maternity and Newborn Care - Charges for pre-natal care, delivery, post-natal care, and care of Newborns, including complications of Pregnancy, miscarriage, complications of delivery and/or complications of Newborns; and

(5) Charges for Treatment of Mental or Nervous Disorders; and

(6) Charges for any Treatment or supplies that are:

(a) not incurred, obtained or received by an Insured Person during the Period of Coverage; and/or

(b) not presented to the Company for payment by way of a complete Proof of Claim within ninety (90) days of the date such Charges are incurred; and/or

(c) not administered or ordered by a Physician; and/or

(d) not Medically Necessary; and/or

(e) provided at no cost to the Insured Person or for which the Insured Person is not otherwise liable; and/or

(f) in excess of Usual, Reasonable, and Customary; and/or

(g) incurred by an Insured Person who was HIV + on or before the Effective Date of this insurance relating to or arising or resulting directly or indirectly from HIV, AIDS virus, AIDS related Illness, ARC Syndrome, AIDS and/or any other Illness arising or resulting from any complications or consequences of any of the foregoing conditions; whether or not the Insured Person had knowledge of his/her HIV status prior to the Effective Date, and whether or not the Charges are incurred in relation to or as a result of said status; and/or

(h) provided by or at the direction or recommendation of a chiropractor, unless ordered in advance by a Physician; and/or

(i) performed or provided by a Relative of the Insured Person; and/or

(j) not expressly included as Eligible Medical Expenses as defined in Section F, above; and/or

(k) provided by a person who resides or has resided with the Insured Person or in the Insured Person's home; and/or

(l) required or recommended as a result of complications or consequences arising from or related to any Treatment, Illness, Injury, or supply excluded from coverage or which is otherwise not covered under this insurance; and

(m) for Congenital Disorders and conditions arising out of or resulting there from; and

(7) Charges incurred for telephone consultations except Telemedicine consultations through an established Telemedicine protocol system will be considered individually based on medical necessity and appropriateness as determined by the Company under the plan; and

(8) Charges incurred due to a failure to keep a scheduled appointment; and

(9) Charges incurred for Surgeries or Treatment or supplies which are:

(a) Investigational, Experimental, or for research purposes, and/or

(b) related to genetic medicine, genetic testing, surveillance testing and/or wellness screening procedures for genetically predisposed conditions indicated by genetic medicine or genetic testing, including, but not limited to amniocentesis, genetic screening, risk assessment, preventive and prophylactic surgeries recommended by genetic testing, and/or any procedures used to determine pre-disposition, provide genetic counseling, or administration of gene therapy; and

(10) Charges incurred while confined primarily to receive Custodial Care, Educational or Rehabilitative Care; and

(11) Charges incurred for any surgery, Treatment or supplies relating to, arising from or in connection with, for, or as a result of:

(a) weight modification or any Inpatient, Outpatient, Surgical or other Treatment of obesity (including without limitation morbid obesity), including without limitation wiring of the teeth and all forms or procedures of bariatric Surgery by whatever name called, or reversal thereof, including without limitation intestinal bypass, gastric bypass, gastric banding, vertical banded gastroplasty, biliopancreatic diversion, duodenal switch, or stomach reduction or stapling; and/or

(b) modification of the physical body in order to change or improve or attempt to change or improve the physical appearance or psychological, mental or emotional well-being of the Insured Person (such as but not limited to sex-change Surgery or Surgery relating to sexual performance or enhancement thereof); and/or

(c) elective Surgery or Treatment of any kind; and/or

(d) cosmetic or aesthetic reasons, except for reconstructive Surgery when such Surgery is Medically Necessary and is directly related to and follows a Surgery which was covered under this insurance; and/or

(e) any Illness or Injury sustained while taking part in: Amateur Athletics, Professional Athletics and adventure sports and activities, including, without limitation the following (including any combination or derivative of the following): abseiling; mountaineering activities where specialised climbing equipment, ropes or guides are normally or reasonably should have been used; athletic or sporting activities (except for activities that are non-contact, non-professional, and engaged in by *You* solely for recreational, entertainment or fitness purposes); aviation (except when travelling solely as a passenger in a commercial aircraft); motocross (MOTO-X); BMX; BASE jumping; bobsledding; bungee jumping; canyoning;, caving; hang gliding; heli-skiing; high diving; hot air ballooning; inline skating; jet skiing; jungle zip lining; kiteboarding; kayaking; luge; mountain biking; parachuting; paragliding; parascending; rappelling; racing of any kind including by horse, motor vehicle (of any type) or motorcycle; rock climbing; any rodeo activity; ski jumping; sky diving; snow skiing except for recreational downhill and/or cross country snow skiing (no cover provided whilst skiing in violation of applicable laws, rules or regulations; away from prepared and marked in-bound territories; and/or against the advice of the local ski school or local authoritative body; snowboarding; snowmobiling; spelunking; surfing; trekking; whitewater rafting; windsurfing; wildlife safaris; and subaqua pursuits involving underwater breathing apparatus below a depth of 10 meters. Practice or training in preparation for any excluded activity which results in Injury will be considered as activity while taking part in such activity and/or

(f) any Illness or Injury sustained while participating in any sporting, recreational or adventure activity where such activity is undertaken against the advice or direction of any local authority or any qualified instructor or contrary to the rules, recommendations and procedures of a recognized governing body for the sport or activity; and/or

(g) any Illness or Injury sustained while participating in any activity where such activity is undertaken in disregard of or against the recommendations, Treatment programs, or medical advice of a Physician or other healthcare provider; and/or

(h) any Injury or Illness sustained as a result of being under the influence of or due wholly or partly to the effects of intoxicating liquor or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician but not for the Treatment of Substance Abuse; and/or

(i) any Injury or Illness sustained while operating a moving vehicle after consumption of intoxicating liquor or drugs other than drugs taken in accordance with Treatment prescribed and directed by a Physician. For purposes of this exclusion, "vehicle" shall include motorized devices regardless of whether or not a driver or operator license is required (including watercraft and aircraft) and non-motorized bicycles and scooters for which no permit or license is required; and/or

(j) any willfully Self-Inflicted Injury or Illness; and/or

(k) any venereal disease; and/or

(l) any testing for the following: HIV, seropositivity to the AIDS virus, AIDS related Illnesses, ARC Syndrome, AIDS; and/or

(m) any Illness or Injury resulting from or occurring during the commission of a violation of law by the Insured Person, including, without limitation, the engaging in an illegal occupation or act, but excluding minor traffic violations; and/or

(n) any Substance Abuse; and/or

(o) speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy; and/or

(p) orthoptics, visual therapy or visual eye training; and/or

(q) any Illness or Treatment of the feet, including without limitation: orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; Treatment of weak, strained, flat, unstable or unbalanced feet; metatarsalgia, bone spurs, hammer toes or bunions; and any Treatment or supplies for corns, calluses or toenails; provided, however, that claims for Treatment or supplies for the feet may be eligible for coverage under this insurance at the sole option of the Company and subject to all other Terms of this insurance when related to:

(i) an Injury to the foot arising from an Accident covered hereunder; or

(ii) an Illness for which foot Surgery is Medically Necessary and determined to be the only appropriate method of Treatment; and/or

(r) hair loss, including without limitation wigs, hair transplants or any drug that promises to promote hair growth, whether or not prescribed by a Physician; and/or

(s) any sleep disorder, including without limitation sleep apnea; and/or

(t) any exercise program, whether or not prescribed or recommended by a Physician; and/or

(u) any exposure to any non-medical nuclear or atomic radiation, and/or radioactive material(s); and/or

(v) any organ or tissue or other transplant or related services, Treatment or supplies; and/or

(w) any artificial or mechanical devices designed to replace human organs temporarily or permanently; and/or

(x) any efforts to keep a donor alive for a transplant procedure; and/or

(12) Charges incurred for any Treatment or supply that either promotes or prevents or attempts to promote or prevent conception or birth; including but not limited to: artificial insemination; oral contraceptives, Treatment for infertility or impotency; vasectomy or reversal of vasectomy; sterilization or reversal of sterilization; surrogacy; or abortion; and

(13) Charges incurred for any Treatment or supply that either promotes, enhances or corrects or attempts to promote, enhance or correct impotency or sexual dysfunction; and

(14) Charges incurred for Dental Treatment, except for Accident-related Dental Treatment and Dental Surgery necessary to repair or replace sound natural teeth lost or damaged in an Accident leading to an Injury covered hereunder, or as necessary treatment of sudden, unexpected pain to sound natural teeth, and subject to the limits set forth in the Schedule of Benefits/Limits; and

(15) Charges incurred for eyeglasses, contact lenses, hearing aids, hearing implants and Charges for any Treatment, supply, examination or fitting related to these devices, or for eye refraction for any reason; and

(16) Charges incurred for eye Surgery, such as but not limited to radial keratotomy, when the primary purpose is to correct or attempt to correct nearsightedness, farsightedness, or astigmatism; and

(17) Charges incurred for Treatment of the temporomandibular joint; and

(18) Charges incurred for any immunizations and/or Routine Physical Exams; and

(19) Charges incurred for any travel, meals, transportation and/or accommodations, except as otherwise expressly provided for in this insurance; and

(20) Any taxes, involuntary or forced contributions, assessments, charges, fees or surcharges imposed by any governmental agency or authority:

(a) arising out of or as a result of any Treatment or supplies received by the Insured Person, or

(b) based upon the Company's election hereunder, if any, to pay benefits directly to providers as an accommodation to the Insured Person, or

(c) for any other reason; and

(21) Charges or expenses incurred for nonprescription drugs, medicines, vitamins, food extracts, or nutritional supplements; IV vitamin or herbal therapy; drugs or medicines not approved by the U.S. Food and Drug Administration or which are considered "off-label" drug use; and for drugs or medicines not prescribed by a Physician.

(22) Charges incurred for Treatment in the Insured Person's Home Country except as expressly provided for in this insurance.

(23) Charges incurred for Illness or Injury where the trip to the Host Country is undertaken for the purpose of securing medical treatment of advice for such Illness or Injury.

(24) Charges first incurred for Illness or Injury beyond the Maximum Trip Duration.

V. DEFINITIONS - Certain words and phrases used in this Certificate are defined below. Other words and phrases may be defined elsewhere in this Certificate, including where they are first used.

Accident: An Unexpected occurrence caused by external, visible means and resulting in physical Injury to the Insured Person.

AIDS.: Acquired Immune Deficiency Syndrome, as that term is defined by the United States Centers for Disease Control.

Amateur Athletics: An amateur or other non-professional sporting, recreational, or athletic activity that is organized, sponsored and/or sanctioned, and/or involves regular or scheduled practices, games and/or competitions (collectively, "organized athletic activities"). This definition does not include non-organized athletic activities that are non-contact and engaged in by the Insured Person solely for recreational, entertainment or fitness purposes.

Application: The fully answered and signed individual or Family Application/enrollment form submitted by or on behalf of the Insured Person for acceptance into this insurance plan, which Application shall be incorporated in and become part of this Certificate. Any insurance agent/broker or other person or entity assigned to, soliciting, or assisting with the Application is the agent and representative of the applicant/Insured Person and is not and shall not be deemed or considered as an agent or representative for or on behalf of the Company or the Plan Administrator.

ARC: AIDS related complex, as that term is defined by the United States Centers for Disease Control.

Assured: The Global Medical Services Group Insurance Trust, c/o MutualWealth Management Group, Carmel, IN.

Benefit Period: If a covered Injury or Illness requires continuing Treatment after the expiration of the Period of Coverage, a supplemental Benefit Period may provide continuing coverage for the covered Injury or Illness for up to thirty (30) continuous days, not to exceed $5,000, subject to the following: when the Period of Coverage expires while a covered Injury or Illness requires continuing Treatment, the Company will review and determine the date of initial Treatment for the covered Injury or Illness, and if such date is less than thirty (30) days prior to the expiration of the Period of Coverage, benefits for the covered Injury or Illness will continue until there has been at least thirty (30) days of continuous coverage for the covered Injury or Illness, subject to the limits and sub-limits set forth in the Schedule of Benefits/Limits, and subject to all other Terms of the plan.

Certificate: This document, including any Riders, as issued to the Insured Person, which describes and provides an outline and evidence of eligible insurance coverages and benefits payable to or for the benefit of the Insured Person under the Master Policy. The Application and the Declaration are incorporated herein by this reference and made a part hereof.

Coinsurance: The payment by or obligations of the Insured Person for payment of Eligible Medical Expenses at the percentage specified in the Schedule of Benefits/Limits contained herein, and exclusive of the applicable Deductible.

Common Carrier: A company or organization that holds itself out to the public as engaging in the business of transporting persons from place to place by air, rail, bus and/or sea for compensation, offering its scheduled services to the public generally, and is licensed by a recognized and approved government authority to transport fare-paying passengers. The term Common Carrier does not include taxi, motorcar, motorcycle, or limousine services, or transportation by animal or human means (for example, by horse, camel, elephant or rickshaw).

Company: The "Company," as referred to in the Master Policy and this Certificate, is Sirius International Insurance Corporation (publ), headquartered in Stockholm, Sweden. This insurance and its risks are underwritten by the Company as the insurer and carrier, and the Company is solely obligated and liable for the coverages and benefits provided by this insurance.

Congenital Disorder: Physical abnormality that is present at birth.

Custodial Care: Those types of Treatment, care or services, wherever furnished and by whatever name called, that are designed primarily to assist an individual in activities of daily life.

Declaration: The Declaration of Insurance issued by the Plan Administrator for and on behalf of the Company to the Insured Person contemporaneously with this Certificate evidencing the Insured Person's insurance coverage under the Master Policy as evidenced by this Certificate, which Declaration shall be incorporated in and become a part of this Certificate.

Deductible: The dollar amount of Eligible Medical Expenses, as selected on the Application and specified in the Declaration, that the Insured Person must pay per Period of Coverage prior to receiving benefits or coverages under this insurance, and exclusive of Coinsurance.

Dental Treatment: Treatment or supplies relating to the care, maintenance or repair of teeth, gums or bones supporting the teeth, including dentures and preparation for dentures.

Dependent Child: A natural or adopted child of the named Insured Person or the named Insured Person's spouse, who is unmarried and living with the named Insured Person and/or such Spouse, who is under the age of 18 years old but older than 14 days and otherwise eligible for this insurance pursuant to Section D, and who has been properly listed and identified on the Application and for whom the proper Premium has been timely paid.

Disabled: A person who has a congenital or acquired mental or physical defect that interferes with normal functioning of the body system or the ability to be self-sufficient.

Durable Medical Equipment (DME): Durable Medical Equipment shall mean exclusively the following items: a standard basic hospital bed; and/or a standard basic wheel chair.

Educational or Rehabilitative Care: Care for restoration (by education or training) of a person's ability to function in a normal or near normal manner following an Illness or Injury. This type of care includes, but is not limited to, vocational or occupational therapy, and speech therapy.

Effective Date; Effective Date of Coverage: The date coverage for the Insured Person begins under the Terms of the Master Policy as evidenced by this Certificate, as indicated on the Declaration.

Eligible Medical Expenses: As defined in Section F, above.

Emergency: A medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within twenty-four (24) hours, based upon a reasonable medical certainty.

Emergency Medical Evacuation: Emergency transportation from the Hospital or medical facility where the Insured Person is located to a non-local Hospital or medical facility, recommended by the attending Physician who certifies to a reasonable medical certainty that the Insured Person has experienced

- a medical condition manifesting itself by acute signs or symptoms which could reasonably result in placing the Insured Person's life or limb in danger if medical attention is not provided within twenty-four (24) hours; and
- where Medically Necessary Treatment cannot be provided locally, either in the facility of the attending Physician or another local facility.

EST: United States Eastern Standard Time.

Experimental: Any Treatment that includes completely new, untested drugs, procedures, or services, or the use of which is for a purpose other than the use for which they have previously been approved; new drug procedure or service combinations; and/or and/ or alternative therapies which are not generally accepted standards of current medical practice.

Extended Care Facility: An institution, or a distinct part of an institution, which is licensed as a Hospital, Extended Care Facility or rehabilitation facility by the state or country in which it operates; and is regularly engaged in providing 24-hour skilled nursing care under the regular supervision of a Physician and the direct supervision of a Registered Nurse; and maintains a daily record on each patient; and provides each patient with a planned program of observation prescribed by a Physician; and provides each patient with active Treatment of an Illness or Injury. Extended Care Facility does not include a facility primarily for rest, the aged, Substance Abuse, Custodial Care, nursing care, or for care of Mental or Nervous Disorders or the mentally incompetent.

Family: An Insured Person and his/her spouse who is covered as an insured person under this insurance plan and his/her natural Child or Children who are under the age of eighteen (18) and covered as insured persons under this insurance plan.

HIV: Human Immunodeficiency Virus, as that term is defined by the United States Centers of Disease Control.

HIV +: Laboratory evidence defined by the United States Centers for Disease Control as being positive for Human Immunodeficiency Virus infection.

Home Country: For U.S. citizens, the Home Country is the United States. For non-U.S. citizens, the Home Country is the country of which the Insured Person is a citizen or national; including any country where the Insured Person maintains his/her primary residence or usual place of abode and any country of which the Insured Person is the possessor of a validly issued passport. In the event there is more than one home country under the above-listed criteria, the Home Country is the country meeting the above-listed criteria and listed by the Insured as his or her Home Country on the Application.

Home Health Care Agency: A public or private agency or one of its subdivisions, which operates pursuant to law; and is regularly engaged in providing Home Nursing Care under the supervision of a Registered Nurse; and maintains a daily record on each patient; and provides each patient with a planned program of observation and Treatment prescribed by a Physician.

Home Nursing Care: Services and/or Treatment provided by a Home Health Care Agency and supervised by a Registered Nurse, which are directed toward the personal care of a patient, provided always that such care is Medically Necessary and in lieu of Medically Necessary Inpatient care, and not primarily for Custodial Care or rehabilitative purposes.

Hospice: An institution which operates as a hospice; and is licensed by the state or country in which it operates; and operates primarily for the reception, care and palliative control of pain for terminally ill persons who have, as certified by a Physician, a life expectancy of not more than six (6) months.

Hospital: An institution which operates as a hospital pursuant to law; and is licensed by the state or country in which it operates; and operates primarily for the reception, care, and Treatment of sick or injured persons as Inpatients; and provides 24-hour nursing service by Registered Nurses on duty or call; and has a staff of one or more Physicians available at all times; and provides organized facilities and equipment for diagnosis and Treatment of acute medical, surgical or mental/nervous conditions on its premises; and is not primarily a long-term care facility, Extended Care Facility, nursing, rest, Custodial Care, or convalescent home, a place for the aged, drug addicts or abusers, alcoholics or runaways; or similar establishment.

Hospitalization; Hospitalized: Confined and/or treated in a Hospital as an Inpatient.

Host Country: The country or countries other than the Home Country that the Insured Person is traveling to/in.

Illness: A sickness, disorder, illness, pathology, abnormality, malady, morbidity, affliction, disability, defect, handicap, deformity, birth defect, congenital defect, symptomatology, syndrome, malaise, infection, infirmity, ailment, disease of any kind, or any other medical, physical or health condition. Provided, however, that Illness does not include learning disabilities, or attitudinal or disciplinary problems. All Illnesses that exist simultaneously or which arise subsequent to a prior Illness and which directly or

indirectly relate to or result or arise from the same or related causes or as a consequence thereof or from one another are considered to be one Illness. Further, if a subsequent Illness results or arises from causes or consequences that are the same as or related to the causes or consequences of a prior Illness, the subsequent Illness will be deemed to be a continuation of the prior Illness and not a separate Illness.

Injury: Bodily injury resulting or arising directly from an Accident. All Injuries resulting or arising from the same Accident shall be deemed to be one Injury.

Inpatient: A person who is an overnight resident patient of a Hospital, using and being charged for room and board.

Insured Person: The person named as the Insured Person on the Declaration.

Intensive Care Unit: A cardiac care unit or other unit or area of a Hospital that meets the required standards of the Joint Commission on Accreditation of Healthcare Organizations for Special Care Units.

Investigational: Treatment that includes drugs not yet released for distribution by the US Food and Drug Administration and/or procedures or services which are still in the clinical stages of evaluation.

Local Ambulance Transport; Local Ambulance Expense: Transportation and accompanying care provided by designated professional emergency personnel from the location of an accident or acute illness to a Hospital or other appropriate health care facility. Local ambulance transport does not include subsequent inter-facility transfers of admitted patients.

Master Policy: The applicable Master Policy for Access HMO Gold International medical insurance for citizens traveling outside of their Home Country, as issued on an annual basis by the Company to the Assured, and under which insurance coverage and benefits are provided by the Company to the Insured Person, subject to the Terms thereof, and as outlined and evidenced by this Certificate and subject to the Terms hereof. The Company, as insurance carrier and underwriter of the Master Policy, is solely liable and responsible for the coverages and benefits provided thereunder.

Maximum Limit: The cumulative total dollar amount of benefit payments and/or reimbursements available to an Insured Person under this insurance during the Insured Person's Period of Coverage. When the Maximum Limit is reached, no further benefits, reimbursements or payments will be available under this insurance during the Insured Person's Period of Coverage.

Medically Necessary; Medical Necessity: A Treatment, service, medicine or supply which is necessary and appropriate for the diagnosis or Treatment of an Illness or Injury based on generally accepted standards of current medical practice as determined by the Company. By way of example but not limitation, a service, Treatment, medicine or supply will not be considered Medically Necessary or a Medical Necessity if it is provided or obtained only as a convenience to the Insured Person or his/her provider; and/or if it is not necessary or appropriate for the Insured Person's Treatment, diagnosis or symptoms; and/or if it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate, and appropriate diagnosis or Treatment.

Mental or Nervous Disorders: Any mental, nervous, or emotional Illness which generally denotes an Illness of the brain with predominant behavioral symptoms; or an Illness of the mind or personality, evidenced by abnormal behavior; or an Illness or disorder of conduct evidenced by socially deviant behavior. Mental or Nervous Disorders include without limitation: psychosis; depression; schizophrenia; bipolar affective disorder; learning disabilities and attitudinal or disciplinary problems; any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases as published by the U.S. Department of Health and Human Services; and those psychiatric and other mental Illnesses listed in the current edition of the Diagnostic and Statistical Manual for Mental Disorders published by the American Psychiatric Association. For purposes of this insurance, Mental or Nervous Disorder does not include Substance Abuse.

Mortal Remains: The bodily remains or ashes of an Insured Person.

Natural Disaster: Widespread disruption of human lives by disasters such as flood, drought, tidal wave, fire, hurricane, earthquake, windstorm, or other storm, landslide, or other natural catastrophe or event resulting in migration of the population for its safety.

Newborn: An infant from the moment of birth through the first thirty-one (31) days of life.

Other Coverage: As defined in Section B(10), above.

Outpatient: A person who receives Medically Necessary Treatment by a Physician or other healthcare provider that does not require an overnight stay in a Hospital.

Period of Coverage: The period beginning on the Effective Date of Coverage of this Certificate and ending on the earliest of the following dates: (a) the termination date specified in the Declaration, or (b) the termination date as determined in accordance with Section B(18), above. The Period of Coverage can be no more than twelve (12) consecutive months.

Physician: A duly licensed practitioner of the medical arts. A Physician must be currently licensed by the state or country in which the services are provided, and the services must be within the scope of that license.

Plan Administrator: The Plan Administrator for this insurance is Access Health Maintenance Organization, inc. 2885 Sanford Avenue SW Grandville, MI 49418 Telephone Number +1.616-855-7670, or +420.777 322 522, Website:https://www.accesshmo.com, Email: claims@accesshmo.com As the Plan Administrator, International Medical Group, Inc., acts solely as the disclosed and authorized agent and representative for and on behalf of the Company, and does not have, and shall not be deemed, considered or alleged to have any, direct, indirect, joint, several, separate, individual, or independent liability,responsibility or obligation of any kind under the Master Policy, the Declaration, or this Certificate to the Insured Person or to any other person or entity, including without limitation to any Physician, Hospital, Extended Care Facility, Home Health Care Agency, or any other health care or medical service provider or supplier.

Pre-certification; Pre-certify: A general determination of Medical Necessity, only, made by the Company in reliance and based upon the completeness and accuracy of the information provided by the Insured Person and/or the Insured Person's healthcare or medical service providers, guardians, Relatives and/or proxies at the time thereof. Pre-certification is not an assurance, authorization, pre-authorization or verification of coverage, a verification of benefits, or a guarantee of payment. See Section E, above, for further details.

Pre-existing Condition: Any Injury, Illness, sickness, disease, or other physical, medical, Mental or Nervous Disorder, condition or ailment that, with reasonable medical certainty, existed at the time of Application or at any time during the three years prior to the Effective Date of this insurance, whether or not previously manifested, symptomatic or known, diagnosed, Treated, or disclosed to the Company prior to the Effective Date, and including any and all subsequent, chronic or recurring complications or consequences related thereto or resulting or arising therefrom.

Premium: The premium payments required to effectuate and maintain the Insured Person's insurance coverage and benefits under this insurance, in the amounts and at the times ("Due Dates") established by the Company in its sole discretion from time to time.

Pregnancy; Pregnant: The process of growth and development within a woman's reproductive organs of a new individual from the time of conception through the phases where the embryo grows and fetus develops to birth.

Professional Athletics: A sport activity, including practice, preparation, and actual sporting events, for any individual or organized team that is a member of a recognized professional sports organization, is directly supported or sponsored by a professional team or professional sports organization, is a member of a playing league that is directly supported or sponsored by a professional team or professional sports organization; or has any athlete receiving for his or her participation any kind of payment or compensation, directly or indirectly, from a professional team or professional sports organization.

Registered Nurse: A graduate nurse who has been registered or licensed to practice by a State Board of Nurse Examiners or other state authority, and who is legally entitled to place the letters "R.N." after his or her name.

Relative: A parent, legal guardian, spouse, son, daughter, or immediate family member of the Insured Person.

Rider: Any exhibit, schedule, attachment, amendment, endorsement, Rider or other document attached to, issued in connection with, or otherwise expressly made a part of or applicable to, the Master Policy, this Certificate, the Declaration, or the Application, as the case may be.

Routine Physical Exam: Examination of the physical body by a Physician for preventative or informative purposes only, and not for the Treatment of any previously manifested, symptomatic, diagnosed or known Illness or Injury.

Schedule of Benefits/Limits: The summarized schedule of benefits, coverages, limits and sub-limits as set forth for ease of reference in Section C of this Certificate, all of which are subject to the full Terms of this insurance.

Self-inflicted: Action or inaction by the Insured Person that the Insured Person consciously understands will or may cause or contribute, directly or indirectly, to his or her personal Injury or Illness. Self-inflicted specifically includes failure of an Insured Person to follow his or her doctor's orders, complete prescriptions as directed, or follow any health care protocol or procedures designed to return or maintain his or her health.

Substance Abuse: Alcohol, drug or chemical abuse, misuse, illegal use, overuse or dependency.

Surgery or Surgical Procedure: An invasive diagnostic or surgical procedure; or the Treatment of Illness or Injury by manual or instrumental operations performed by a Physician while the patient is under general or local anesthesia.

Telemedicine: Telemedicine is the use of medical information (beyond a verbal history) exchanged from one healthcare provider site to another via electronic communications to improve patients' health status. Videoconferencing, transmission of still images, and remote monitoring of vital signs are all considered part of Telemedicine. Telemedicine services that would be considered for Medical Necessity and appropriateness by the Company under the plan would include without limit:

- Specialist referral services which typically involves of a specialist assisting a general practitioner in rendering a diagnosis to guide Treatment.
- Patient consultations using telecommunications to provide medical data, which may include audio, still or live images, between a patient and a Physician or other healthcare provider for use in rendering a diagnosis and Treatment plan. This might originate from a remote clinic to a Physician's office using a direct transmission link or may include communicating over the internet..

- Remote patient monitoring uses devices to remotely collect and send data from a medical facility to a monitoring station for interpretation. Such applications might include a specific vital sign, such as blood glucose or heart ECG**.**

Terms: Terms, provisions, conditions, definitions, limits, sub-limits, limitations, wordings, restrictions, qualifications and/or exclusions.

Terrorism: Criminal acts, including against civilians, committed with the intent to cause death or serious bodily injury, or taking of hostages, with the purpose to provide a state of terror in the general public or in a group of persons or particular persons, intimidate a population, or compel a government of international organization to do or to abstain from doing an act.

Travel Warning: Published statement or web-site document issued by the United States Department of State, Bureau of Consular Affairs or similar government agency of the Insured Person's Home Country, warning that travel to specific identified countries is hazardous and is not advised.

Treated; Treatment: Any and all undertakings, services and/or procedures rendered or employed with respect to the management and/or care of an Insured Person for the purpose of identifying, testing for, analyzing, diagnosing, treating, curing, resolving, preventing, monitoring, attending to, caring for, controlling and/or combating any Illness or Injury or the symptoms or manifestations thereof, including without limitation: verbal or written advice, consultation, examination, discussion, diagnostic or laboratory testing or evaluation of any kind, pharmacotherapy or other medication, and/or Surgery.

Unexpected: Sudden, unintentional, not expected, and unforeseen.

Usual, Reasonable and Customary: A typical and reasonable amount of reimbursement for similar services, medicines, or supplies within the area in which the charge is incurred. In determining the typical and reasonable amount of reimbursement, the Company may, in its reasonable discretion, consider one or more of the following factors, without limitation: the amount charged by the provider; the amount charged by similar providers or providers in the same or similar locality; the amount reimbursed by other payors for the same or comparable services, medicines or supplies in the same or similar locality; the amount reimbursed by other payors for the same or comparable services, medicines or supplies in other parts of the country; the cost to the provider of providing the service, medicine or supply; the level of skill, extent of training, and experience required to perform the procedure or service; the length of time required to perform the procedure or service as compared to the length of time required to perform other similar services; the length of time required to perform the procedure or service as compared to national standards and/or benchmarks; the severity or nature of the Illness or Injury being treated; and such other factors as the Company, in the reasonable exercise of its discretion, determines are appropriate.