INSURANCE TERMS AND CONDITIONS

FOREIGNERS' COMPREHENSIVE MEDICAL INSURANCE

EXCLUSIVE

KZPCE 1/21

effective as of 1July 2021

POJIŠŤOVNA VZP, a. s.

Contents:

SECTION A
JOINT PROVISIONS

Art. 1
Introductory provisions

1. The rights and responsibilities of parties to this **Foreigners' Comprehensive Medical Insurance PLUS** (hereinafter in this section also merely as "Insurance") is governed by the laws of the Czech Republic, particularly by Act No. 89/2012 Coll., the Civil Code, as amended (hereinafter the "Code"), these Insurance terms and conditions, the provisions contained in the insurance policy and its annexes and in other documents which make up an integral part thereof.
2. Arrangements in the insurance policy that deviate from the Code or these Insurance terms and conditions shall prevail.
3. The contracting parties are on the one hand the Policyholder and on the other the Insurer

Art. 2
Definition of Terms

The following definitions of terms shall apply for the purposes of this insurance:

1. **Acute Healthcare** is care designed to prevent a serious deterioration in the state of health or to reduce the risk of a serious deterioration in the state of health so that the facts necessary for determining or changing the individual treatment process are ascertained in time or so that the Insured Person does not get into a state that would endanger him or his surroundings.
2. **Without undue delay** is a very short period, up to a maximum ranging in days, which means urgent, immediate, imminent, or direct action leading to the fulfil of an obligation or to the execution of a legal act or other manifestation of will, given that the period of its duration will depend on the circumstances of the individual case.
3. **The Qualifying Period** is the period in which the Insurer has no obligation to provide Insurance Benefits for events which would otherwise be Insured Events. The Qualifying Period is counted from the start of the agreed Term of Insurance.
4. **The Duration of the Insurance** is the actual period of time within the agreed Term of Insurance for which the personal Insurance was in effect.
5. **Hospitalisation** is understood to mean the state of the Insured Person caused by an Insured Peril, when he/she is provided with the necessary hospital diagnosis and curative care connected with his/her stay in bed.
6. **Chronic Illness** is a long-standing and developing illness (including post-traumatic states) that existed prior to the commencement of the insurance and was in a stable state during the previous 6 months and did not call for hospitalisation or a deteriorate or a change in the treatment procedures or medicine.
7. **One Insured Event** is an Insured Event arising from the Insurance of one person and from one and the same cause, at the same place and the same time, comprising all the facts and their consequences, amongst which there is a causal, territorial, chronological or other direct connection.
8. A **Single Premium** is a premium determined for the entire period for which the Insurance has been agreed.
9. **Comprehensive Healthcare Services** is understood to mean medical services provided to the Insured Person in Contractual Healthcare Facilities of the Insurer without direct reimbursement of the treatment costs in order to maintain his/her state of health from the time prior to the conclusion of the insurance policy. Comprehensive Healthcare Services include outpatient as well as inpatient healthcare services, including diagnostic, preventative and dispensary services, as well as emergency and rescue services, provision of medicines and transport of patients, eventual repatriation of the Insured Person or transportation of his/her remains. The insurance also includes healthcare services related to the pregnancy of an insured mother and the birth of her child.
10. **Period** given in days is always understood to be the number of calendar days.
11. A **Random Event** is an event that is possible and in respect of which it is uncertain whether it will even occur within the Duration of the Insurance, or the time of its occurrence is unknown.
12. A **Sudden Illness** is such a sudden and unexpected health disorder that directly threatens the health or the life of the Insured Person, independent of his own will, and which requires acute and urgent healthcare.
13. **Illness**, for the purpose of this Insurance, is the medically documented onset of the illness, the given that the is, for the purposes of this Insurance, a state which threatens the health or the life of the Insured Person and requires the provision of medical care.
14. **Urgent Healthcare** is care, the purpose of which is to prevent or reduce the occurrence of sudden conditions that are imminently life threatening or could lead to sudden death or serious endangerment to health, or cause sudden or intensive pain or sudden changes in the patient's behaviour, who endangers himself or his surroundings.
15. A **Newborn Baby** is understood for the purpose of this Insurance to be a child from the time of his/her birth to the end of the 3rd month of this child's age.
16. A **Beneficiary** is a party with a right to an Insurance Benefit as a result of an Insured Event.
17. An **Insurance Certificate** is a written confirmation that an insurance policy has been concluded, which the insurer issues to the Policyholder.
18. The **Term of Insurance** is the period for which the personal Insurance was agreed.
19. An **Insured Event** is an accidental state of affairs brought about by the Insured Peril, associated with the establishment of an obligation on the part of the Insurer to provide an Insurance Benefit.
20. An **Insured Peri**l is the possible cause of an Insured Event (the "cause").
21. An **Insurance Risk** is a measure of the probability of the occurrence of the Insured Event caused by an Insured Peril.
22. The **Policyholder** is the party which has concluded the insurance policy with the Insurer.
23. The **Insurer** is a legal entity entitled to carry on insurance activity according to special legislation.
24. The **Insured Person** is a person in respect to whose life or health the insurance relates.
25. **Postnatal Care** for a Newborn Baby is healthcare for a Newborn immediately following upon its birth and without interruption to the continuity of hospitalisation.
26. A **professional athlete** is a person who has concluded a professional contract with a sports club or other entity in this field and/or engages in sporting activity for remuneration, which is this person's main or predominant income, and/or engages in sporting activity for a duration of at least 20 hours per week (including weekend), including training.
27. A **professional sporting activity** is a sporting activity carried out by a person who is a professional athlete as defined in this Article.
28. The **Insured Person's Card** comprises written confirmation of the establishment and continuation of the medical insurance, which the Insurer issues always with the duration being limited to a period for which the premium was paid, unless agreed otherwise in the insurance policy. The card serves the Insured Person for exercising the right to Insurance Benefit.
29. **Contractual Healthcare Service Provider (Contractual Healthcare Facility)** is such a Healthcare Service Provider with which the Insurer has concluded a contract for these purposes.
30. A **Loss Event** is an event resulting in damage which may constitute grounds for the establishment of a right to an Insurance Benefit.
31. **Loss Insurance** s insurance the purpose of which is to provide compensation for a loss arising from an Insured Event.
32. **Damage** refers to reasonable costs demonstrably spent on healthcare services provided to the Insured Person at the Place of Insurance.
33. A **Party to the Insurance** is the Insurer and the Policyholder, as the contracting parties, as well as the Insured Person and every other person to whom a right or obligation arose under the private insurance.
34. An **Accident** is understood, for the purpose of this Insurance, to be the unexpected and sudden action of external forces or one's own strength independent of the insured person's will, which occurs during the Duration of the Insurance and results in damage to the insured person's health or his/her death, including work Accidents. An Accident is deemed to occur the moment that the external forces or influences damaging the health or causing the death of the insured person came to bear.
    Damage to the health of an Insured Person caused by:
    a) localised festering following invasion of pathogens into an open wound caused by an Accident,
    b) tetanus or rabies infection in the course of an Accident, diagnostic, therapeutic and preventive interventions carried out to treat the consequences of an Accident,
    c) unexpected and uninterrupted exposure to high or low outdoor temperatures, gases, vapours, electric current (including lightning), radiation, toxic substances and poisons ((with the exception of microbial poisons and immunotoxic substances),
    d) drowning and death by drowning,
    e) bite, sting, or stabbing by an insect

    is also considered to be an Accident.
35. **Multiple Insurance** arises when two or more private insurance policies relate to the same insurance peril covered for the same period, if the sum of the Insurance Benefit limits exceeds the actual amount of the damage caused.
36. An **Interested Party** is a party interested in concluding an insurance policy with the Insurer.
37. A **Healthcare Service Provider (healthcare facility)** is a registered facility providing outpatient, or outpatient and inpatient, diagnostic and medical care, which may also include necessary preventive measures (hospitals, outpatient doctors). A Healthcare Service Provider may be a natural person or a legal entity.

Art. 3
Extent and Place of Insurance

1. The extent of the agreed Insurance is determined by the Insurance terms and conditions and electable parameters stipulated in the insurance policy. These parameters are elected by the Policyholder upon concluding the insurance policy based on knowledge of the insurable interest of the Insured Persons.
2. The Policyholder shall choose which types of insurance cover shall be arranged for which persons and, if applicable, their type, any supplementary insurance, period insured, and the upper limit of the Insurance Benefit.
3. Insurance is effective only at the agreed Place of Insurance, which is stipulated for individual types of Insurance in the other sections of these Insurance terms and conditions.

Art. 4

Extent and Due Payment of the Insurance Benefit

1. The amount and extent of the Insurance Benefit is determined by the Insurer in accordance with the Insurance terms and conditions.
2. The payment of an Insurance Benefit is conditional on the occurrence of an Insured Event and the meeting of all the conditions and obligations ensuing from the insurance policy and parts thereof, namely the payment of the premium.
3. Unless otherwise agreed by the contracting parties, the Insurance Benefit shall be payable in the currency of the Czech Republic and its territory and the Insurer shall pay it to the Beneficiary by transfer to this person's bank account or by postal order to his name and address.
4. If the Insured Person was entitled to receive the Insurance Benefit, that he/she did not receive whilst alive, this unpaid Insurance Benefit shall become the subject of inheritance proceedings.
5. In cases of the conversion of a foreign currency, the Insurer shall use the exchange rate of the Czech National Bank valid at the time the Insured Event occurred.
6. An Insurance Benefit is payable within 15 days from the end of investigations of the notified event, with which the claim for the Insurance Benefit is connected. The investigations conclude upon there porting of its results to the person who exercised the claim to the Insurance Benefit.
7. If it is not possible to conclude the investigations necessary to ascertain the Insured Event, the extent of the Insurance Benefit or to ascertain the person entitled to receive the Insurance Benefit within three months of the notification date, the Insurer shall inform the notifier why the investigations cannot be concluded; if requested by the notifier, the Insurer shall inform the notifier of the reasons in writing. The Insurer shall provide the person who exercised the claim to the Insurance Benefit with an appropriate advance on the Insurance Benefit on the basis of this person's request; this shall not apply if there are reasonable grounds to deny the provision of such an advance.
8. The Insurer is entitled to reduce the Insurance Benefit:
   a) as a consequence of the compensation which the Beneficiary has already received in another manner,
   b) if a lower premium was agreed as a consequence of a breach of a duty of the Policyholder or the Insured Person when negotiating the conclusion of the policy or its amendment, the Insurer shall be entitled to reduce the Insurance Benefit by an amount equal to the ratio of the premium it received to the premium it ought to have received,
   c) if the breach of the duty of the Policyholder, Insured Person or another party entitled to the Insurance Benefit had a material effect on the occurrence of the Insured Event, its course, on increasing the extent of its consequences or on ascertaining or determining the amount of the Insurance Benefit, the Insurer shall be entitled to reduce the Insurance Benefit proportionally to the effect that this breach had on the extent of the Insurer's duty to render benefits,
   d) in the event of the thwarting of the passing of the right to the Insurer pursuant to Article 18,
   e) if it paid the Insurance Benefit in the unreduced amount and has subsequently acquired a claim to reduce the Insurance Benefit. The Insurer is entitled to exercise a claim to the difference between the paid-out and the reduced Insured Benefit from the person in whose favour it was paid.
   f) if the Policyholder or the Insured Person fails to supply the insurer with the required medical documentation.
9. If the Policyholder or the Insured Person breaches any of the obligations set forth in these Insurance terms and conditions, the Insurer may reduce the Insurance Benefit with respect to the seriousness and nature of the breach of this obligation.
10. The Insurer may refuse to pay the Insurance Benefit if the Insured Event was caused by a fact
    a) of which it learned only after the occurrence of the Insured Event,
    b) which it was unable to ascertain during the conclusion of the policy or its amendment as a consequence of the culpable breach of the obligation stipulated in paragraph 1 or 2 of Article 14 of this section,
    c) the awareness of which at the time of the conclusion of the insurance policy would result in it not concluding it or concluding it under different terms and conditions.
11. The Insurance Benefit is limited to insurance benefit limits. The insurance benefit limits for individual types of Insurance are stipulated in the insurance policy.
12. A more detailed extent and manner of the Insurance Benefit for individual types of Insurance is stipulated in the other sections of these Insurance terms and conditions.

Art. 5

Insurable Interest

1. Insurable interest is a legitimate need for protection from the consequences of the Insured Event.
2. The Policyholder has an insurable interest in his own life and health. It is understood that the Policyholder also has an insurable interest in the life and health of another person, if he/she demonstrates an interest conditional on his relationship to this person, whether resulting from a family relationship or being conditional on the benefit or advantage he/she gains from a continuation of this person's life or preservation of this person's health.
3. If the Insured Person consented to the Insurance it is understood that the Policyholder's insurable interest was demonstrated.
4. The insurance policy shall be invalid if the Interested Party did not have an insurable interest and the Insurer knew or ought to have known this when concluding the insurance policy.
5. The insurance policy shall be invalid if the Policyholder has knowingly insured a non-existent insurable interest, but the Insurer did not or could not have known this; however, the Insurer shall be entitled to remuneration corresponding to the premiums until the time it learned of the insurance policy being invalid.
6. The insurable interest does not terminate upon the absence of Insured Person at the Place of Insurance, the taking up of similar private insurance or for reason of plain disinterest.
7. The termination of the insurable interest must always be proven to the Insurer.

Art. 6

Group Insurance

1. Group Insurance is Insurance pertaining to a group of Insured Persons, as further defined in the insurance policy, whose identity need not be known at the time of the insurance policy being concluded.
2. If the Insurance applies to members of a certain group, the insurance policy need not specify the names of the Insured Persons, on the condition that the Insured Persons can be identified beyond doubt at least at the time of the Insured Event.
3. In the case of group insurance, a breach of the duty to give truthful and complete answers to the Insurer's questions only impacts the Insurance of those persons to whom a breach of this duty applies.

Art. 7

Conclusion of the Insurance Policy

1. The insurance policy is concluded upon acceptance of the Insurer's Insurance offer. The offer is accepted upon its signing by the contracting parties, unless another manner of acceptance is expressly stated therein. If the Policyholder accepted the offer by the timely payment of the premium, it shall be deemed that the written form of the insurance policy has been duly observed.
2. The insurance policy is concluded for a definite time period.
3. An integral part of the insurance policy, apart from the Insurance terms and conditions, are also all agreements, supplements and annexes to the insurance policy and all documents defining the terms and conditions of the establishment, duration, alteration and expiration of the Insurance (e.g. applications, questionnaires, reports, medical examinations and checks, notices, records of the course of concluding the Insurance, the Insurer's information for the Interested Party on the conclusion of the insurance policy).

Art. 8

Commencement and Duration of the Insurance. Term of Insurance

1. The Insurance is concluded for a fixed Term of Insurance from the commencement of the Term of Insurance to the end of the Term of Insurance. The Term of Insurance is agreed in the insurance policy.
2. The Insurance commences at 0:00 hours on the day agreed as the commencement of the Term of Insurance, but no earlier than on the day following the day on which Insurance premium is paid, unless agreed otherwise in the insurance policy.
3. The Insurance lasts from its commencement until the actual expiration of the Insurance.
4. The Insurance cannot be suspended for reason of the non-payment of the premium.

Art. 9

Amendments to and Termination of the Insurance Policy. Expiry of the Insurance

1. All amendments to the insurance policy are made in writing upon the mutual agreement of the contracting parties.
2. The personal Insurance expires upon the lapsing of the Term of Insurance, i.e. at 24:00 hours on the day agreed as the date of the termination of the Term of Insurance.
3. The personal Insurance expires upon the termination of the insurable interest, on the date when the Insured Person dies, on the date that the legal entity is wound up without a legal successor or on the date when the Insurer's notification of the refusal to pay the Insurance Benefit is received.
4. The termination of the insurable interest terminates all of the insured person's insurance in the following cases:
   a) rejection of a visa application by the Department of Asylum and Migration Policy of the Ministry of the Interior of the Czech Republic,
   b) expiration of a visa's validity on the territory of the Czech Republic.
5. The termination of the insurance by the termination of the insurable interest does not occur at the end of the stay of the insured person in the Czech Republic, if this person still has a valid visa after the end of his or her stay.
6. All personal insurance expire as at the date of the Insurer receiving notification by the Policyholder of the Insured Person passing to the public medical insurance of the Czech Republic within the Duration of the Insurance, on the condition that this notification includes a copy of the Insured Person's valid ID card that he/she is a participant of public medical insurance of the Czech Republic. If the insured

person has an insured interest, the insurer will offer the insured person insurance of a different scope and for a different premium.

7. The Insurer or the Policyholder may terminate the Insurance in writing:
   a) within two months of the conclusion of the insurance policy. An eight day notice period shall commence running upon the serving of the termination, with the Insurance terminating upon the expiry of this period,
   b) within three months of the serving of the notification of the Insured Event. A one month notice period shall commence running upon the serving of the termination, with the Insurance terminating upon the expiry of this period.
8. The Policyholder may terminate the Insurance subject to an eight day notice period:
   a) within two months of learning that the Insurer applied a viewpoint contrary to the principle of equal treatment in determining the amount of the premium or for calculating the Insurance Benefit,
   b) within one month of receiving notification of the transfer of the insurance portfolio or part thereof or the transformation of the Insurer,
   c) within one month of the publishing of the notification that the licence enabling the Insurer to carry on its insurance business has been withdrawn.
9. If the Policyholder or the Insured Person breaches the duty stipulated in paragraph 1 or 2 of Article 14, either intentionally or through negligence, the Insurer shall be entitled to withdraw from the insurance policy if it can prove that it would not have concluded the insurance policy had the questions been answered truthfully and completely. The Policyholder shall be entitled to withdraw from the insurance policy if the Insurer breached the duty stipulated in paragraph 7 or 8 of Article 11. The right to withdraw from the insurance policy shall expire if not exercised by a party within two months of the day that it learned or ought to have learned of a breach of the duty stipulated in paragraph 1 or 2 of Article 14 or in paragraph 7 or 8 of Article 11.
10. If the insurance policy was concluded by means of a remote transaction, the Policyholder shall be entitled to withdraw from the policy, without giving any reason, within 14 days of its conclusion or of the date on which the terms and conditions were communicated to him, if such communication first occurs only upon his request after the conclusion of the policy.
11. Exceptionally, in justified cases (e.g. due to a pandemic), the insurance contract may be terminated by a written agreement of the contracting parties under agreed conditions.
12. The insurance policy may be assigned only with the Insurer's consent.
13. If Insurance of another party's insurable risk is concluded, then the Insured Person shall take the place of the Policyholder on the date of the Policyholder's death or the date of it being wound up without a legal successor; however, if the Insured Person gives written notice to the Insurer within thirty days of the Policyholder's death or winding up that he/she is not interested in the Insurance, the Insurance shall expire on the date of the Policyholder's death or winding up. The effects of a delay shall not impact the Insured Person before the expiration of 15 days from the date that the Insured Person learned of his entry into the Insurance.
    However, if there is more than one Insured Person, the Insurance of all such parties shall terminate upon the expiry of the period in respect of which a premium was paid.
14. If the Insurer issues the Policyholder with a notice reminding it to pay the premium and, as part of this reminder notice, and instructs the Policyholder that the Insurance shall expire if the premium is not paid during the additional period, the Insurance shall expire upon the futile passing of this period.
15. The Insurance does not expire due to the termination of the Insured Person's residence at the Place of Insurance prior to the expiry of the Term of Insurance.
16. The insurance policy terminates upon the expiry of all Insurances of all persons.

Art. 10

Premium

1. The Premium is the consideration for the Insurance cover provided. The amount of the premium is determined by the Insurer for the insurance policy. The premium is arranged as a Single Premium.
2. The Premium is payable on the date of the conclusion of the insurance policy in the currency and the amount stated in the insurance policy.
3. The premium shall be considered as duly paid if demonstrably received by the Insurer's agent or credited to the Insurer's bank account.
4. The Insurer is entitled to the premium for the entire Duration of the Insurance. The Insurer acquires this right on the date on which the insurance policy is concluded.
5. If the Insurance is terminated due to a refusal of a visa application or the expiration of a visa's validity, the Insurer shall return to the Policyholder, after calculating the total Insurance Benefit paid,but not later than 3 months from the date of the Insurance expiring, part of the premiumcorresponding to the unearned premium as at the expiry of the Insurance, after deducting:
   a) the costs associated with the Insurance Benefits, and
   b) amount corresponding to the proportional part of the Premium (Section B, Article 4, paragraph 6) by which the Insured Person has overdrawn the earned part of the Premium corresponding to the actual Duration of the Insurance.
6. If the Insurance is terminated as a consequence of the Policyholder's termination or as a consequence of a notification by the Policyholder of the Insured Person passing to the public medical insurance of the Czech Republic within the Duration of the Insurance, the Insurer shall return to the Policyholder, after calculating the total Insurance Benefit paid, but not later than 3 months from the date of the Insurance expiring, part of the premium corresponding to the unearned premium as at the expiry of the Insurance, after deducting:
   a) the costs associated with taking out and administering the Insurance and
   b) the costs associated with the Insurance Benefits, and
   c) amount corresponding to the proportional part of the Premium (Section B, Article 4, paragraph 6) by which the Insured Person has overdrawn the earned part of the Premium corresponding to the actual Duration of the Insurance.
7. If the Insurance is terminated as a consequence of an Insured Event, the Insurer shall be entitled to the whole Single Premium.
8. If the insurance policy is terminated **by agreement** before the date of the commencement of the Insurance, the Insurer shall return all received premiums to the Policyholder minus the costs associated with taking out and administering the Insurance, upon the return of the Insured Person's Card.
9. The Insurer's costs associated with taking out and administering the insurance policy come to 20% of the unearned premium.
10. The Insurer is entitled to the premium until the time it learned of the expiry of the insurable interest.
11. If the Policyholder withdraws from the insurance policy, the Insurer shall return to the Policyholder the received premiums within 30 days of the date of the withdrawal taking effect less any Insurance Benefits it may have paid under the Insurance; if the Insurer withdraws from the insurance policy, it shall be entitled to also set off the costs associated with taking out and administering the Insurance. If the Insurer withdraws from the Insurance, the Policyholder, Insured Person or another party who had already received an Insurance Benefit shall reimburse the Insurer within this same time period the amount of the Insurance Benefit received that is surplus to the received premiums.
12. If the Policyholder withdraws from the insurance policy according to Article 9(10) of this section, the Insurer shall return to the Policyholder the received premiums without undue delay, but not later than 30 days from the date of the withdrawal taking effect; in so doing, the Insurer shall be entitled to deduct any Insurance Benefit it had already paid under the Insurance. However, if the amount of Insurance Benefit paid exceeds the amount of premiums received, the Policyholder, or the Insured Person or the beneficiary in the event of the Insured Person's death, as the case may be, shall be obliged to pay the Insurer the amount of the Insurance Benefit paid that is surplus to the premiums received.
13. The Insurer will set off its outstanding premiums in the order in which they were created rather than in the order in which reminder letters were sent.

Art. 11

Rights and Obligations of the Insurer

1. The Insurer is entitled to verify the submitted documents, to demand the submission of expert reports and/or to consult complicated Loss Events with healthcare providers or other competent entities, even abroad.
2. The Insurer shall issue the Insurance Certificate and the Insured Person's Card for every Insured Person to the Policyholder after the conclusion of the insurance policy and payment of the premium. The validity of every Insured Person's Card shall always be for the period for which the premium was paid.
3. If the event of the loss, damage or destruction of a valid Insurance Certificate, the Insurer shall issue a duplicate thereof to the Policyholder at the Policyholder's request; the same applies to the issue of a copy of the insurance policy concluded in writing and the Insured Person's Card. The Insurer may make the issue of such a duplicate conditional on the payment of the costs it has incurred to do so.
4. The Insurer shall notify the Interested Party information about the Insurer and the Insurance taken out prior to the conclusion of the insurance policy.
5. The Insurer is also obliged to accept the payment of outstanding premiums and other outstanding receivables under the Insurance from the Policyholder's pledgee, from a Beneficiary or from the Insured Person.
6. Within the Duration of the Insurance, the Insurer shall provide information to the Policyholder at his address stipulated in the insurance policy or via the Insurer's web site. If the correspondence address is different from the address of the registered office or residential address, then it is designated as the correspondence address. The address may also be an address designated for electronic communication.
7. If the Insurer ought to be aware of the inconsistencies between the Insurance being offered and the Interested Party's requirements when concluding the insurance policy, it shall alert the Interested Party of them. In so doing, the circumstances and the manner in which the insurance policy is concluded, as well as whether the other contracting party is being assisted in the conclusion of the policy by an agent independent of the insurer shall be taken into account.
8. If the Insurer asks the Interested Party or the Policyholder in writing whilst negotiating the conclusion of the insurance policy about facts pertaining to the Insurance, the Insurer shall answer these questions truthfully and completely.
9. If the Policyholder asks the Insurer in writing to provide him with information that is material for rendering benefits under the policy, the Insurer shall provide such information in writing without undue delay.

Art. 12

Obligations of the Policyholder

The Policyholder has the following obligations:

1. To pay the Insurance premium to the Insurer.
2. To inform all Insured Persons, in a timely manner, of the contents of the insurance policy, including all annexes and parts thereof, and provide them with all materials and information which it has received on their behalf from the Insurer.
3. To inform every Insurer without undue delay in the event of Multiple Insurance occurring, providing details of the other insurers and the Insurance Benefit limits agreed in the other insurance policies.
4. To inform the Insurer without undue delay of a change in correspondence address.
5. Always return the Insured Person's Card to the Insurer within five calendar days of the expiration of the Insurance, if the Insurance expires before the end of the agreed Insurance Period.
6. If the Policyholder is also the Insured Person, all the obligations of the Insured Person shall apply to the Policyholder as well.

Art. 13

Obligations of the Insured Person

The Insured Person has the following obligations:

1. To do everything to avert the occurrence of an Insured Event and to reduce the extent of their consequences,
2. To release the healthcare provider in writing from its obligation to maintain confidentiality and provide the Insurer with written authorisation to obtain information from healthcare staff which is subject to the obligation to maintain confidentiality and which is required for the Insurer's investigations if any Loss Event has occurred,
3. To always follow the instructions of the attending doctor,
4. To abide by the safety measures for the Duration of the Insurance,
5. To use suitable protective aids and equipment required for the maximum safe performance of all activities performed,
6. To have the appropriate valid licence for the performance of all activities carried out at the Place of Insurance,
7. To arrange for proper supervision or escort, should this be usual for the performed activity,
8. To refrain from standing in places designated as inappropriate by the organiser,
9. To comply with the legislation in force at the Place of insurance,
10. To seek out medical treatment, should the need arise,
11. To comply with the obligations prescribed in the other sections for the types of Insurance taken out.

Art. 14

Other Rights and Obligations of the Parties to the Insurance

1. If the Insurer asks the Interested Party in writing whilst negotiating the conclusion of the insurance policy or asks the Policyholder in writing whilst negotiating the amendment of the insurance policy about facts that are relevant to the Insurer's decision on evaluating the insurance risk, whether it will insure them and under what conditions, the Interested Party or the Policyholder shall answer these questions truthfully and completely. The duty shall be deemed to have been duly met if nothing material had been concealed as part of the answer.
2. The provisions contained in paragraph 1 of this article regarding to the duty of the Policyholder shall also apply to the Insured Person.
3. Should an event occur with which the person who considers him/herself to be a Beneficiary links his/her claim to an Insurance Benefit, he/she shall notify this fact to the Insurer without undue delay, give the Insurer a truthful explanation of the cause, the origin and the extent of the consequences of such an event, the rights of third parties and any Multiple Insurance; at the same time, he/she shall also submit to the Insurer the required documents (e.g. the Insured Person's medical documentation) and proceed in the manner agreed in the insurance policy. If this person is not simultaneously the Policyholder or the Insured Person, the Policyholder and the Insured Person shall also have these duties.
4. The same notification may be made by any person with a legal interest in the Insurance Benefit.
5. The notification under paragraph 3 and 4 of this article shall be deemed as having been received after the Insurer:
   I.) was notified of the event via the Insurer's form, which has been duly completed and delivered to the Insurer,
   II.) was handed all the required documents or documents requested by the Insurer.
   The required documents are:
   A) documents demonstrating:
      a) the cause, time, place and circumstances of the occurrence of the Insured Event, its extent and the direct connection of the Insured Event with the Insured Person, at least detailing the first name, surname and date of birth of the Insured Person,
      b) a detailed specification of the subject of compensation (e.g. a medical report with the diagnosis, description and date of the procedures performed and the medicine administered,
      c) the subject of the requested payment (e.g. bills or invoices issued by a doctor or bills issued by a pharmacy on the basis of a prescription issued by the attending doctor) and detailing the date and amount of the payment (e.g. receipts on a cash payment, account statements),
   B) in the case of Insurance Benefits for Outpatient Medicine prescribed by a doctor, also copies of the prescriptions made out in the name of the Insured Person, specifying the date of issue, the quantity and description of the medicine and healthcare aids, and the signature and stamp of the issuer,
   C) for an Insured Event investigated by the police, also a police report or confirmation of the investigation of an accident,
   D) in the case of the death of the Insured Person, also a copy of an official death certificate and medical certification of the cause of death.
6. The parties to the Insurance submit copies of documents to the Insurer, or originals upon the Insurer's request.
   All documents must be made out in the name of the Insured Person and must contain the date of issue and also the signature and stamp of the issuer, if prescribed on the document.
7. The Insurer shall commence investigations necessary to ascertain the existence and extent of its duty to perform without undue delay of the receipt of the notification under paragraph 5 of this article. The investigations shall be deemed as duly concluded upon the reporting of their outcome to the person who exercised the claim to the Insurance Benefit; at the request of this person, the Insurer shall justify the amount of the Insurance Benefit in writing, or the reason for this claim being refused, as the case may be.
8. If the notification contains knowingly false or grossly distorted material information pertaining to the extent of the notified event, or if information pertaining to this event has been knowingly concealed therein, the Insurer shall be entitled to compensation for the costs it purposefully incurred in investigating the facts in regards to which this information was given to or concealed from him. It is understood that the demonstrable costs of the Insurer were incurred purposefully.
9. If the Policyholder, the Insured Person or another party exercising a claim to the Insurance Benefit causes investigation costs or an increase therein by breaching a duty, the Insurer shall be entitled to claim reasonable compensation from such a person.
10. The Policyholder and the Insured Person are obliged:
    a) to notify the Insurer in writing without undue delay at any time within the Duration of the Insurance of a change of any and all particulars made in the insurance policy,
    b) to enable the Insurer to conduct investigations into the causes of the Loss Event and the extent of their consequences and to co-operate with the Insurer as required,
    c) to notify the Insurer the details of all insurance policies valid at the time of the Loss Event occurring, the subject of which is insurance of the same Insured Peril.
11. The parties to the Insurance must not assign a claim for Insurance Benefit under the Insurance without the Insurer‘s consent.

Art. 15

Delivery of Documents

1. Correspondence delivered via the holder of a postal licence (hereinafter the "post office") shall be sent:
   a) to the Insurer at the address of the registered office stated in the insurance policy, or another address that is communicated to the Policyholder by the Insurer;
   b) by the Insurer to the correspondence address of the relevant person (addressee) stated in the insurance policy or otherwise notified to the Insurer. If the correspondence address is not stated in the insurance policy or subsequently notified to the Insurer, the correspondence will be sent to the address stated in the policy or notified to the Insurer as the residence or permanent residence, or the registered office of such a person.
2. Unless agreed otherwise, correspondence may also be delivered electronically (for example, via a data box, the Insurer's internet app, by e-mail) to the contact information provided for the purpose of electronic communication. Correspondence sent by the Insurer electronically to the last contact address provided by the addressee shall be deemed as delivered on the third business day after its sending, if the date of its delivery cannot be ascertained or if the relevant legal regulations do not stipulate otherwise.
3. Correspondence may also be delivered by an employee of the Insurer or another person authorised by the Insurer, especially to the addresses pursuant to paragraph 1 b), but also to any other place where the addressee will be willing to accept the correspondence. The correspondence thus delivered shall be deemed as delivered on the day of its receipt.
4. The parties to the Insurance are obliged to notify the Insurer without undue delay of any change in the facts relevant to the delivery and to notify each other of their new postal address, e-mail address or data box or telephone number.
5. If not a case of the delivery pursuant to paragraphs 6 to 8, correspondence sent by the Insurer by registered post with an advice of delivery shall be deemed as delivered on the day specified as the day of receipt of the correspondence on the advice of delivery, with correspondence sent by the Insurer by registered post without an advice of delivery, or sent by regular mail, being deemed as delivered

on the third business day after dispatch, and in the case of delivery to an address in a country other than the Czech Republic, on the 15th business day after dispatch.

6. If the addressee deliberately thwarts the delivery of correspondence, it shall be deemed to have been duly delivered on the day that its receipt was thwarted by the addressee.
7. If the addressee thwarts the delivery of correspondence by failing to take delivery of the correspondence.
8. If the addressee thwarts the receipt of correspondence in another manner, e.g. by failing to take delivery of this correspondence or by failing to mark his/her/its letter box by his/her first name and surname or company name, it shall be deemed to have been duly delivered on the date on which it was returned to the insurer.
9. Correspondence sent by the Insurer by registered post or registered post with an advice of delivery shall be deemed duly delivered even in the case that they are received by another person in place of the addressee (e.g. a family member), to whom the post office delivered the correspondence in accordance with the legal regulations pertaining to postal services.

Art. 16

Form of Legal Acts

1. The insurance policy must be concluded in writing, unless the Civil Code provides otherwise.
2. In the event that the Policyholder's acceptance of the offer is found to be invalid due to a failure to accept the offer in writing or for any other reason, and the Policyholder pays the first premium or an instalment thereof in the amount and within the time period specified in the offer (if no time period is stated in the offer, then within one month of the delivery of the offer), the offer shall be deemed to have been received by virtue of the payment of this first premium or an instalment thereof.
3. Legal acts, notices, and requests must be made in writing if they have an affect on:
   a) the duration and termination of the insurance,
   b) changes in the premium,
   c) changes in the scope of the insurance.
4. A legal act, for which a written form is required, shall be valid, in particular, where it is personally signed by the acting person, or where the signature is replaced by a mechanical means, where this is usual, if made by means of a data box, if provided with a guaranteed electronic signature pursuant to a special law, or if it is made via the Insurer's protected internet client portal.
5. Legal acts, notices, and requests, not mentioned in paragraph 3. may be made in writing, over the telephone, by e-mail, via the Insurer's internet application or via a data box, if the Insurer permits delivery to a data box. This applies namely to the reporting of an Insured Event, notification by the Policyholder or the Insured Person pertaining to a change in the surname, residential address, correspondence address, and other contact details, as specified in the policy. Legal acts, notices, and requests pursuant to this paragraph, made other than in writing must be subsequently supplemented in written form, if the Insurer so requests.
6. The insurer is entitled, as regards matters relating to the insurance relationship, namely in connection with the administration of the Insurance and the settlement of Insured Events, to contact other parties to the Insurance by electronic or other technical means (e.g. via telephone, SMS, e-mail, fax, data box), unless agreed otherwise. In electing the form of communication, the Insurer shall take into account the obligations stipulated by the relevant legal regulations and the nature of the information communicated.
7. Legal acts, notices, and requests shall be effective against the other contracting party as soon as they have been received by this party.

Art. 17

Rescue Costs

1. If the Policyholder purposefully incurs costs in averting the immediate threat of an Insured Event or to mitigate the consequences of an Insured Event that has already occurred, it shall be entitled to compensation for these costs from the Insurer, as well as compensation for the loss suffered by the Policyholder in connection with this activity.
2. Compensation for rescue costs incurred in order to save lives or the health of persons is limited to 30% of the agreed insured amount or Insurance Benefit limit. The amount of compensation for rescue costs for the Period of Validity of the insurance policy is limited to CZK 100,000, with the exception of costs incurred by the Policyholder with the Insurer's consent.
3. Compensation for rescue costs is in excess of the framework of the agreed Insurance Benefit limit.
4. If the Insured Person or another person incurred rescue costs in excess of the framework of duties stipulated by law, they shall have the same right to compensation against the Insurer as the Policyholder.

Art. 18

Assignment of Rights to the Insurer

1. If a person entitled to the Insurance Benefit, the Insured or a person incurring rescue costs, became entitled to compensation from another party for a loss or another similar right in connection with an Insured Event which is imminent or has already occurred, this claim, including appurtenances, security and other rights connected therewith, shall pass to the Insurer upon the payment of the Insurance Benefit, up to the amount of the benefits rendered by the Insurer to the Beneficiary. The above shall not apply if this person became entitled to this right against someone with whom he/she lives in a joint household or is dependent on him/her, unless he/she caused the Insured Event intentionally.
2. The person whose right passed to the Insurer shall release the required documents to the Insurer and disclose it all that is necessary in order to exercise the claim. Should this person thwart the passing of this right to the Insurer, the Insurer shall be entitled to reduce the benefits under the Insurance by the amount it could otherwise have received. If the Insurer has already rendered benefits, it shall be entitled to compensation up to this amount.
3. The Beneficiary is obliged to take measures to ensure that the right to compensation which pass to the Insurer under the law do not expire or become stature-barred.
4. The Beneficiary must not enter into an agreement with a third party to relinquish a claim for compensation against this third party if such claims pass to the Insurer.
5. The Beneficiary is obliged to confirm the assignment of rights to the Insurer in writing upon the Insurer's request.
6. If, in connection with the exercise of the claim, the Insurer incurs additional costs due to the fault of the Beneficiary, then the Insurer is entitled to require the Beneficiary to pay such costs

Art. 19

Final Provisions

1. Representations and notifications with respect to the Insurer are only valid if submitted in writing.
2. The language of communication is Czech.
3. Persons with restricted legal capacity shall be represented by their guardian. It is understood that persons who have yet to attain full legal capacity act with the consent of their statutory representative or that this statutory representative acts on their behalf.
4. If payment is made in cash, the date of payment is the date the sum is deposited in favour of the recipient. If the payment is not made in cash, the date of payment is the date the sum is credited to the account of the recipient.
5. All disputes arising out of or in connection with this Insurance which are not resolved by agreement or out-of-court settlement shall be dealt with by any court having jurisdiction in the Czech Republic in compliance with Czech law.

SECTION B
MEDICAL INSURANCE

Aside from the Joint Provisions of Section A, the medical insurance (hereinafter in this section merely as "Insurance"") is also governed by the provisions of this section.

Art. 1

Purpose and Subject of the Insurance

1. The Insurer shall, in the event of the occurrence of an Insured Event, provide the Beneficiary with an Insurance Benefit to the extent of the loss affecting the subject of the Insurance up to the agreed Insurance Benefit limit.
2. The Beneficiary is the Insured Person.
3. The subject of the Insurance is the health of the Insured Person. Supplementary insurance can also be taken out to cover the health of the insured mother's Newborn Baby.
4. The Insurance is concluded as Loss Insurance.

Art. 2

Insured Event

1. With the exception of the agreed exclusions, an Insured Event is a change in the state of health of the Insured Person or other operations related to the state of health of the Insured Person caused by Illness or Injury, which occurred within the Duration of the Insurance and following the expiry of the waiting period and at the Place of Insurance to the extent and under the conditions stipulated in the provisions of these Insurance terms and conditions..
2. In the event of the occurrence of the Insured Event, the Insurer shall provide an Insurance Benefit within the scope of Article 4 of this section.

Art. 3

Extent and Place of Insurance

1. Insurance is effective only in the agreed Place of Insurance, which is the territory of the **Czech Republic**.
2. The Qualifying Period applied in cases of healthcare services for reason of:
   - pregnancy is **three months,**
   - childbirth is **eight months**.

   The Qualifying Period **shall not be applied** in the event of the conclusion of "Newborn Baby" cover in the insurance policy.
3. Should an event occur that could have been or was an Insured Event under a medical expenses insurance in the Schengen Area agreed under Section C of these Insurance terms and conditions or under another medical expenses

insurance with the Insurer (e.g. travel insurance) and that requires healthcare upon return to the Czech Republic, the condition of a change in the state of health during the Insured Person's stay in the Czech Republic shall not be applied to this event.

4. The Policyholder shall elect the period insured, the upper limit of the Insurance Benefit (limits of the Insurance Benefit) for healthcare services, including repatriation and transaction, or for agreed supplementary insurance, as the case may be, and the type of insurance, in the following extent:
   "***Standard***" insurance encompasses comprehensive healthcare services provided to the Insured Person; the insurance does not relate to events for which the Insurance Benefit is conditional on the arrangement of the Newborn or Professional Sports insurance type,
   "***Newborn***" insurance beyond the scope of the "Standard" insurance type also relates to events specified under letter d) para. 5. of Article 4 of this section,
   "***Professional Sports***" insurance beyond the scope of the "Standard" insurance type also relates to events specified under letter e) para. 5. of Article 4 of this section.

Art. 4
Extent of the Insurance Benefit

1. The right to Insurance Benefit by way of drawing on healthcare services provided by the Insurer is conditional on the presentation at all times of a valid Insured Person's Card to the provider of these services prior to drawing on these services. This obligation may also be fulfilled by another person.
2. Insurance Benefits for healthcare services drawn in connection with pregnancy or childbirth shall be rendered by the Insurer only after the expiry of the Qualifying Period, if agreed.
3. The Insurer shall not render Insurance Benefits for services drawn outsider of the Duration of the Insurance.
4. The Insurance Benefit is limited by Insurance Benefit limits.
5. The Insurer renders Insurance Benefits up to the limits pursuant to paragraph 11. of this article to the extent of:
   a) healthcare services to the extent akin to the list of healthcare procedures reimbursed to the Insured Persons of public medical insurance of the Czech Republic (hereinafter merely as "healthcare") but with agreed exclusions from the insurance and with arranged Insurance Benefit limits.
      This healthcare shall only be rendered by the Insurer at contractual Healthcare Service Providers. Only in the event of a sudden deterioration in the state of health of the Insured Person, where a delay may result in serious damage to health or a threat to life, shall the Insurer render his healthcare in a non-contractual healthcare facility on the territory of the Czech Republic. Necessary and reasonable costs demonstrably incurred for healthcare services shall be defrayed, but only until such time as it was possible to arrange health services by the Insurer's contractual healthcare provider.
   b) repatriation of a sick Insured Person with the approval of the attending doctor, should his/her state of health allow it, by a medical transportation service organisation approved by the Insurer or by the Insurer's assistance service provider, to the state whose passport the Insured Person holds or to another state in which the Insured Person has been permitted residence. The Insurer may, upon prior approval, also cover the transportation costs of another person required to accompany the Insured Person in justified cases. The Insurer renders these services via its contractual provider without direct payment to the provider by the Insured Person,
   c) transportation of the physical remains of the Insured Person to the state whose passport the Insured Person holds or to another state in which the Insured Person has been permitted residence, performed by a specialist organisation approved by the Insurer or the Insurer's assistance service provider. The Insurer may, upon prior approval, also cover other related costs in justified cases. The Insurer renders these services via its contractual provider without direct payment to the provider by the Insured Person
   d) if, at the time of the occurrence of the Insured Event, the "***Newborn Baby***" cover is in effect, the Insurer shall provide an Insurance Benefit even in the case of the Postnatal Care of a Newborn Baby of an insured mother born within the Duration of the Insurance.
   e) if, at the time of the occurrence of the Insured Event, the "***Professional Sports***" cover is in effect, the Insurer shall provide an Insurance Benefit even in the case of the operation of professional sporting activity and during preparation for such activity,
   f) dental care of the Insured Person in order to eliminate sudden pain or the consequences of an accident within the scope of public medical insurance, preventative examination (hereinafter referred to as „Dental care"),
   g) medicines and medical devices prescribed by a doctor on an outpatient basis in the name of the Insured Person (hereinafter the "*Outpatient-Prescribed Medicines*")
   h) assistance services to the extent of Article 6 of this section. The Insurer renders these services via its contractual provider without direct payment to the provider by the Insured Person.
6. The Insurer shall reimburse the Insured Person in excess of the framework of the Insurance Benefit to the extent of para. 5. of this article for the costs he/she had incurred for premium healthcare services (hereinafter the "Premium") stated below, up to the amount of the limit for the Premium stated in the insurance policy:
   a) vaccination (vaccine, including its application), which is not covered under this Insurance as standard (e.g. against tick-borne encephalitis),
   b) over-the-counter medicines and medical devices purchased from pharmacies (without prescription) and from stores selling medical devices,
   c) plastic immobilisation (lightweight plaster),
   d) hormonal contraceptives,
   e) earpieces, spectacles, and contact lenses,
   f) walkers and wheelchairs for the disabled (as well as those electrically powered),
   g) reimbursement of the costs of transporting the Insured Person to the healthcare facility for the purpose of treatment or hospitalisation; besides the submission of documents proving that the transport costs have actually been incurred, reimbursement of these costs is also conditional on the submission of a medical report confirming the occurrence of the Insured Event to the extent of para. 5 of this article; this benefit is limited to CZK 500 per event,
   h) preventative examinations, tests, and consultations to detect a specific disease (e.g. laboratory tests of blood, prostate; examination for malignant melanoma), including the issue of a extract from the medical documentation, and other examinations not covered under public medical insurance (for the purpose of driver's licence confirmation, for sporting activities, etc.),
   i) dental hygiene and premium stomatological material (white fillings, etc.),
   j) premium hospital room or meals during the hospitalisation of an Insured Person.

   Premium can also be drawn during the course of the Duration of the Insurance in partial amounts of at least CZK 100.
7. The costs of the healthcare services detailed in paragraph 5 of this article shall be paid by the Insurer directly or via the assistance service provider to the healthcare provider, the Insured person or another party that has demonstrably incurred these costs.
8. The Insurer shall reimburse the costs of premium healthcare and other services pursuant to paragraph 6 of this article to the Insured Person or a person who demonstrably incurred these costs, following the submission of proof of their payment.
9. Direct reimbursement of the costs of healthcare and other services:
   a) If the Insured Person or another person made a direct payment of the costs of healthcare services pursuant to paragraph 5 of this article, which represent an Insured Event and were rendered to the Insured Person in a healthcare facility located in the Czech Republic, the Insurer shall subsequently reimburse the Insured Person or another person who incurred these costs the reasonable healthcare costs demonstrably incurred.
   b) The Insurer shall provide an Insurance Benefit for an Outpatient Medicine prescribed by a doctor or a voucher for medical devices if the amount of these costs for each prescription or voucher exceeds CZK 100. An Insurance Benefit is understood to mean the amount specified in the Code List of VZP CR for mass- produced medicinal products, medical devices, and individually prepared medicinal products marked as MAX and valid at the time of the Insured Event occurring.
10. If an Insured Event occurred and the continuous hospitalisation of the Insured Person exceeds the Duration of the Insurance, the Insurer shall decide on the subsequent procedure as follows:
    a) If the state of health of the Insured Person does not allow for his/her repatriation, he/she shall be treated at a healthcare facility designated by the Insurer until such time as his/her state of health improves to such a degree as to allow for his/her repatriation,
    b) If the state of health of the Insured Person allows for his/her repatriation, his/her repatriation may be carried out with the consent of the attending doctor.
11. The upper limit for the Insurance Benefit is determined by the benefit limits specified in the insurance policy:
    a) The benefit limit for costs under letters a) to c) of paragraph 5 of this article (*Healthcare services, including repatriation and transportation*) applies to the Insurance Benefit for every single Insured Event.
    b) The benefit limit for costs under letter d) of paragraph 5 of this article (*Postnatal care of a newborn baby of an insured mother*), which further applies to the Insurance Benefit for the sum of all Insured Events occurring within the Duration of the Insurance.
    c) The benefit limit for costs under letter f) of paragraph 5 of this article (*Dental care),* limits the Insurance Benefit for all Insured Events occurring in one year of the Duration of the Insurance or for the Insurance Period, if the Duration of the Insurance is shorter than one year.
    d) The benefit limit for costs under letter g) of paragraph 5 of this article (*Outpatient Prescribed Insurance*) limits the Insurance Benefit for all Insured Events occurring in one year of the Duration of the Insurance or for the Insurance Period, if the Duration of the Insurance is shorter than one year.
    e) The benefit limit for costs pursuant to letters a) to j) of paragraph 6 of this article (*Premium*) limits the benefit for all premium healthcare and other services for the Duration of the Insurance. The Insurer shall render this Premium benefit in excess of the framework of limits stated in paragraph 5 of this article.

Art. 5
Exclusions from the Insurance

1. Unless it is otherwise agreed in writing by the contracting parties, the Insurer shall not, except for preventative, dispensary healthcare, and related to the pregnancy of the insured mother and the birth of her child, provide Insurance Benefits for the following cases:
   A. costs of:
      a) balneology care, homeopathy, and acupuncture,
      b) regulatory fees and additional charges,
   B. if the Loss Event occurred as a result of or in connection with the Insured Person's active participation:
      a) in events of war and other armed conflicts, acts of violence, or civil war,
      b) in handling a weapon or explosive,

C. if the Loss Event occurred as a result of or in connection with:
   a) riots or criminal activity caused or committed by the Insured Person; this exclusion does not apply in the event of an Accident;
   b) ingestion or in connection with the consequences of the Insured Person's consumption of alcohol, drugs, narcotics, or other psychotropic or addictive substances by the Insured Person; this exclusion does not apply in the event of an Accident,

2. The Insurer does not provide an Insurance Benefit:
   a) in cases where the medical care is provided as a result of illness, accident, or other conditions for which the Insured Person was treated before the Insurance was taken out;
      or
      in cases where the medical care is provided in connection with the treatment of iillness, accident, or other conditions, the cause or symptoms of which occurred prior to the Insurance being taken out or during the waiting period,
   b) for healthcare services that are not covered under public medical insurance in the Czech Republic,
   c) if the Insured Person refuses to undergo repatriation, treatment, or necessary medical examinations, or does not follow the treatment regime recommended by the doctor,
   d) for examinations, check-ups and other medical interventions in the personal interest or at the Insured Person's request, including laboratory examinations (concerning, for example, cosmetic procedures, abortion, infertility, contraception, drawing up a medical certificate),
   e) for drugs and medical devices not prescribed by a doctor, i.e. freely purchased without a doctor's prescription, or whose administration had commenced before the commencement of the Insurance,
   f) optional vaccinations,
   g) for complications that arise in connection with the provision of healthcare for Illnesses, conditions or Injuries not covered by the Insurance,
   h) for post-natal care of the Newborn of the insured mother, if "**Newborn**" Insurance is not effective at the time of the occurrence of the Loss Event; the agreed type of Insurance is specified in the insurance policy,
   i) for events occurring during the course of, and in the preparation for, professional sporting activity, if "**Professional Sports**" Insurance is not effective at the time of the occurrence of the Loss Event; the agreed type of Insurance is specified in the insurance policy.

   The exclusions stipulated in this paragraph do not apply to payments under paragraph 6 of Article 4 of this Section.

Art. 6
Obligations of the Insured Person

Besides the obligations contained in Section A, the Insured Person has the following obligations:

1. To **turn to the** Insurer's **assistance service provider** in a Loss Event, **always and without dela**y, **if his/her state of health permits, and follow its instructions**. This obligation may also be fulfilled by another person.
2. To always identify himself by showing a **valid Insured Person's Card** to the healthcare provider. This obligation may also be fulfilled by another person.
3. To undergo treatment or necessary medical examinations by a doctor designated by the Insurer or by the Insurer's assistance service provider.
4. In the event that he/she is required to participate directly in the settlement of the loss that is the Insured Event:
   a) pay reasonable and demonstrable costs to the authorised recipient (the healthcare provider),
   b) collect the originals of the required documents and to store them safely until their submission to the Insurer,
   c) submit the required documents to the Insurer without undue delay.
5. If the state of health of the Insured Person permits, undergo repatriation at the proposal of the Insurer or the Insurer's assistance s service provider.

Art. 7
Assistance Services

1. The assistance services are services provided to the Insured Person in connection with the Medical Insurance taken out and are arranged for by the Insurer's contractual organisation. Assistance services are provided 24 hours a day 7 days a week. Contact details for the provider of the assistance services are contained in the Insured Person's Card.
2. The assistance services are provided to the following extent:
   - recommendation of a contractual healthcare provider,
   - arranging admission at a contractual healthcare provider for treatment during office hours,
   - recommendation of an appropriate procedure in the case of a Loss Event,
   - monitoring developments in the state of health during the course of hospitalisation,
   - provision of a liquidity guarantee to the contractual healthcare provider in the event of a claim for an Insurance Benefit,
   - arranging for the repatriation of a client in a medically justified event,
   - arranging for a professional companion as part of the repatriation,
   - arranging for the transportation of the physical remains in the event of death.

SECTION C
MEDICAL EXPENSES INSURANCE IN THE SCHENGEN AREA

If medical expenses insurance in the Schengen Area (hereinafter in this section merely as "Insurance") is concluded as part of the insurance policy, the Insurance shall, besides the Joint Provisions of Section A, also be governed by the provisions of this section.

Art. 1
Purpose and Subject of the Insurance

1. The Insurer shall, in the event of the occurrence of an Insured Event, provide the Beneficiary with an Insurance Benefit to the extent of the loss affecting the subject of the Insurance up to the agreed Insurance Benefit limit.
2. The Beneficiary is the Insured Person.
3. The subject of the Insurance is the health of the Insured Person.
4. The Insurance is concluded as Loss Insurance.

Art. 2
Insured Event

With the exception of the agreed exclusions, an Insured Event is a change in the state of health (including a sudden change in a long-term stabilised chronic disease) of the Insured Person caused by Sudden Illness or Injury, which occurred within the Duration of the Insurance and at the Place of Insurance and which requires the subsequent provision of Acute and Urgent Healthcare at the Place of Insurance.

Art. 3
Extent and Place of Insurance

1. The Insurance is only effective in the agreed place of Insurance, which is the territory of the states of the Schengen area, with the exception of the territory of the Czech Republic. The territory of the states is understood to also include the Exclusive Economic Zone (EEZ).
2. No differentiation is made in the Insurance as regards the type of stay (trip). The Insurance is effective as regards stays (trips) taken for the purposes of tourism as well as business.
3. The Insurance applies to recreational trips and stays taken whilst undertaking common recreational and relaxation sports, which are specified in the List of Activities and Sports (hereinafter referred to as the "List") as sports Not Requiring Supplementary Insurance and sports which are specified in the List of sports requiring supplementary insurance – Dangerous sports . The Insurance does not apply to sports specified in the List as Extreme Sports and for Uninsurable Sports.

Art. 4
Extent of the Insurance Benefit

1. Unless stipulated below that the Insurer realises the Insurance Benefit via the provision of services without direct payment by the Insured Person, the Insurer shall reimburse the Beneficiary, (Insured Person or person who actually incurred the costs) the costs of the damage that had actually been incurred.
2. The Insurance Benefit up to the limits set out in paragraph 5 of this article to the following extent:
   a) acute and Urgent Healthcare of the Insured Person including:
      - the essential examination required in order to determine the diagnosis and the medical procedure to be taken,
      - the essential standard treatment,
      - the essential hospitalisation for the patient in a multi-bed hospital room with standard equipment,
      - a necessary operation with associated necessary expenses,
      - the essential medicine and healthcare aids prescribed by the doctor of the quantity required until the patient returns to the Czech Republic,
      - transportation necessary from a healthcare standpoint from the location where the Insured Event took place to the nearest medical first aid facility or hospital and back,
   b) repatriation of a sick Insured Person, with the consent of the attending doctor, if his/her state of health allows it, by a medical transport organisation approved by the Insurer or by the Insurer's assistance service provider, to a healthcare facility in the Czech Republic designated in the same manner, or to the place of residence of the Insured Person in the Czech Republic. The Insurer renders these services via its contractual provider without direct payment to the provider by the Insured Person,
   c) the Insurer may, upon prior approval and in justified cases, also cover the costs of another person required to accompany the Insured Person,
   d) transportation of the bodily remains of the Insured Person to his place of residence in the Czech Republic performed by a specialist organization approved by the Insurer or the Insurer's assistance service provider. Upon prior approval and in justified cases the insurer may also cover additional associated costs. The Insurer renders these services via its contractual provider without direct payment to the provider by the Insured Person,
   e) urgent dental care of the Insured Person to alleviate sudden pain with the exception of the production and repair of dentures, fixed dentures and orthodontic aids,
   f) assistance services to the extent of Article 7 of this section. The Insurer renders these services via its contractual provider without direct payment to the provider by the Insured Person.
3. Direct payment of the costs of healthcare and other services:
   If the Insured Person or another person made a direct payment of the costs of healthcare services pursuant to paragraph 2 of this article, which represent an Insured Event and were rendered to the Insured Person in a healthcare facility located in the Schengen Area, the Insurer shall subsequently reimburse the Insured Person or another person who incurred these costs the reasonable

healthcare costs demonstrably incurred upon the receipt of at least a copy of the required documents.

4. If an Insured Event occurred and the continuous hospitalisation of the Insured Person exceeds the Duration of the Insurance, the Insurer shall decide on the subsequent procedure as follows:
   a) if the state of health of the Insured Person does not allow for his repatriation, the Insured Person shall be treated in a healthcare facility designated by the Insurer until such time as his state of health improves to such an extent as to allow for his repatriation,
   b) if the state of health of the Insured Person allows for his repatriation, the repatriation can proceed after the consent of the attending doctor is obtained and also, if necessary, final treatment in a healthcare facility in the Czech Republic designated by the Insurer.
5. The upper limit for the Insurance Benefit is determined by these limits:
   a) The limit for expenses pursuant to items a) to e) of paragraph 2 of this article (*Healthcare, including repatriation and transportation*) is specified in the insurance policy and limits the Insurance Benefit for all of the Insured Person's Insured Events for the Duration of the Insurance.
   b) The partial limit detailed in letter a) of this paragraph is the benefit limit for costs pursuant to letter e) of paragraph 2 of this article (*Urgent dental* care) stipulated in the insurance policy and limits the Insurance Benefit for all of the Insured Person's Insured Events arising in one year for Duration of the Insurance.

Art. 5

Exclusions from the Insurance

Besides the exclusions stipulated in Section A, Insured Events are not deemed to be:

1. events where medical treatment is provided as a result of illness, accident or other conditions for which the Insured Person was treated prior to the Insurance being taken out, or events where medical treatment is provided in connection with the treatment of illness, accident, or other conditions, the cause or symptoms of which occurred prior to the Insurance being taken out or during the waiting period,
2. childbirth, including premature and puerperium, abortion, artificial fertilisation, infertility treatment and tests or tests (including laboratory and ultrasound) to ascertain and monitor pregnancy, tests involving contraception and payment of contraception,
3. cases of travel abroad for the purposes of utilizing healthcare,
4. dental treatment and associated services, with the exception of the treatment of the consequences of an injury and urgent simple dental treatment to eliminate sudden pain,
5. preventative examinations, vaccination, medical tests,
6. treatments not associated with the sudden onset of Illness or Injury,
7. rehabilitation, physical therapy, chiropractic operations, exercise therapy and self-reliance training,
8. organ transplants, haemophilia treatment, interferon treatment, insulin therapy except during the provision of first aid, chronic haemodialysis,
9. replacements for spectacles, contact lenses and hearing aids and the production and repair of orthopaedic prostheses,
10. costs connected with contacting the Insurer or the assistance service (telephone call charges, etc.),
11. examination and treatment of psychiatric disorders not associated with any other sudden onset of illness or injury, psychological tests and psychotherapy,
12. procedures and diagnostic methods that are not medically recognised or performed by a qualified healthcare professional, including hospitalisation provided at such facilities,
13. cosmetic measures,
14. spa and convalescent treatment and stays, treatment at specialist facilities (including long-term care facilities, sanatoria and hospices) and at facilities for subsequent ward treatment care,
15. acupuncture and homeopathy,
16. complications that may arise during the treatment of illnesses, conditions or injuries not covered by the Insurance,
17. examinations and treatment of venereal and sexually transmitted diseases and AIDS from the determination of a diagnosis,
18. coverage of medicine and healthcare aids not prescribed by a doctor, i.e. freely available without a doctor's prescription or medicine whose administration started before the commencement of the Insurance,
19. treatment of illnesses and states of health where healthcare is appropriate, useful and necessary, but may be postponed and need not be provided until one returns to the Czech Republic,
20. events after the Insured Person refuses to undergo repatriation, treatment or necessary medical examinations by a doctor assigned by the Insurer or the Insurer's assistance service provider,
21. transportation, searching, probing and rescue operations, if an Insured Event has not occurred at the same time impacting on the health of the Insured Person,
22. events which the Policyholder, Insured Person or Beneficiary could foresee or which they knew of at the time the insurance policy was taken out,
23. events which the Insured Person brought about intentionally (including suicide or attempted suicide) or which were caused by the intentional conduct of the Policyholder or the Beneficiary,
24. events which were caused to the Insured Person by another person at the instigation of the Insured Person, the Policyholder or the Beneficiary,
25. events arising in connection with a riot which the Insured Person provoked, or in connection with criminal activity which the Insured Person committed or attempted to commit,
26. events which have occurred as a result of or in connection with the usage of, or the consequences of the usage of, alcohol, drugs, narcotics or other psychotropic or addictive substances by the Insured Person,
27. events which have occurred during test trials of Transport Means,
28. events which have occurred during stunt activities and the taming of beasts of prey,
29. events which have occurred during activities at locations not designated for that purpose,
30. events which have occurred in an area that a state administration body has designated as a war zone or as an area that is otherwise dangerous to life and health, or has not recommended for travel or a stay in this area if the journey or the stay commenced or the insurance policy was taken out after this declaration was made,
31. events which have occurred as a consequence of or in connection with:
    a) the effects of released nuclear energy, or of chemical or biological weapons,
    b) wartime events or civil war,
    c) acts of violence (including civil disturbances and terrorist activities), in which the Insured Person took an active part,
    d) handling of a firearm or explosive by the Insured Person.
32. events occurring and healthcare services provided on the territory of the Czech Republic,
33. events occurring during the preparation and performance of extreme and uninsurable sports stated in the Activities and Sports List 1/20,
34. events arising during the preparation and performance of professional sports activities; this exclusion does not apply if professional insurance of the "Professional Sports" cover for Medical Insurance pursuant to Section B of these Insurance terms and conditions is in effect at the time of the occurrence of the Insured Event; the agreed type of Insurance is specified in the insurance policy.

Art. 6

Obligations of the Insured Person

Besides the obligations contained in Section A, the Insured Person has the following obligations:

1. To **contact the Insurer's assistance service provider** in a Loss Event, **always and without delay**, if his state of health permits, **and follow its instructions**. This obligation may also be fulfilled by another person.
2. To always identify himself by showing **a valid Insured Person's Card** to the healthcare provider. This obligation may also be fulfilled by another person,
3. Undergo treatment or necessary medical examinations by a doctor designated by the Insurer or by the Insurer's assistance service provider,
4. In the event that he/she is required, on rare occasions, to participate directly in the settlement of the loss that is the Insured Event:
   a) pay reasonable and demonstrable costs to the authorised recipient (the healthcare provider),
   b) collect the originals of the required documents and to store them safely until their submission to the Insurer,
   c) submit the required documents to the Insurer without undue delay.
5. If the state of health of the Insured Person permits, undergo repatriation at the proposal of the Insurer or the Insurer's assistance service provider.

Art. 7

Assistance Services

1. Assistance services are provided to the Insured Person in connection with the Medical Expenses Insurance taken out and are arranged for by the Insurer's contractual organisation. Contact details for the provider of the assistance services are contained in the Insured Person's Card.
2. Assistance services are provided 24 hours a day 7 days a week to the following extent:
   - provision of a liquidity guarantee to the contractual healthcare provider in the event of a claim for an Insurance Benefit,
   - medical assistance in the event of outpatient healthcare,
   - medical assistance in the event of hospitalisation,
   - arranging for the repatriation of a client in a medically justified event,
   - arranging for a professional companion as part of the repatriation,
   - arranging for the transportation of the physical remains in the event of death,
   - accompaniment by a family member.

Art. 8

Duration of the Insurance

Should a situation occur within the Duration of the Insurance where the Insured Person cannot, independently of his own will, return to the Czech Republic prior to the expiry of the Term of Insurance agreed in the insurance policy, the Term of Insurance shall be automatically extended, without an increase in the premium, for the time until the reasons stated hereinafter pass, but no more than seven days immediately following the initial Term of Insurance. The reasons for an extension are objective facts, which may be forces of nature (e.g. earthquakes, volcanic eruptions, floods and spates, storms), transport strikes, technical defect in a means of transport or terrorist acts preventing the Insured Person from returning to the Czech Republic.

INSURANCE TERMS AND CONDITIONS OF **DAILY ALLOWANCE INSURANCE DURING HOSPITALISATION AS A CONSEQUENCE OF AN ACCIDENT**

HOSP CIZ 1/21

effective as of 15 September 2021

POJIŠŤOVNA VZP, a. s.

Contents:

Art. 1

Introductory provisions

1. The rights and responsibilities of parties to this **Insurance of Daily Allowance During Hospitalization** (hereinafter in this section also merely as "Insurance") is governed by the laws of the Czech Republic, particularly by Act No. 89/2012 Coll., the Civil Code, as amended (hereinafter the "Code"), these Insurance terms and conditions, the provisions contained in the insurance policy and its annexes and in other documents which make up an integral part thereof.
2. Arrangements in the insurance policy that deviate from the Code or these Insurance terms and conditions shall prevail.
3. The contracting parties are on the one hand the Policyholder and on the other the Insurer

Art. 2

Definition of Terms

The following definitions of terms shall apply for the purposes of this insurance:

1. **Without undue delay** is a very short period, up to a maximum ranging in days, which means urgent, immediate, imminent, or direct action leading to the fulfil of an obligation or to the execution of a legal act or other manifestation of will, given that the period of its duration will depend on the circumstances of the individual case.
2. **The Duration of the Insurance** is the actual period of time within the agreed Term of Insurance for which the Insurance was in effect.
3. **Hospitalisation** is understood to mean the state of the Insured Person caused by an Insured Peril, when he/she is provided with the necessary hospital diagnosis and curative care connected with his/her stay in bed.
4. **One Hospitalisation Day** is every full 24 hours of continuous stay in hospital.
5. **One Insured Event** is an Insured Event arising from the Insurance of one person and from one and the same cause, at the same place and the same time, comprising all the facts and their consequences, amongst which there is a causal, territorial, chronological or other direct connection.
6. A **Single Premium** is a premium determined for the entire period for which the Insurance has been agreed.
7. **Period** given in days is always understood to be the number of calendar days**.**
8. A **Random Event** is an event that is possible and in respect of which it is uncertain whether it will even occur within the Duration of the Insurance, or the time of its occurrence is unknown.
9. **Agreed Sum Insurance** is Insurance the purpose of which is to obtain a sum, i.e. an agreed financial amount, as a consequence of an Insured Event in an amount that is independent of the occurrence or extent of the loss.
10. A **Beneficiary** is a party with a right to an Insurance Benefit as a result of an Insured Event.
11. An **Insurance Certificate** is a written confirmation that an insurance policy has been concluded, which the insurer issues to the Policyholder.
12. The **Term of Insurance** is the period for which the Insurance was agreed.
13. An **Insured Event** is an accidental state of affairs brought about by the Insured Peril, associated with the establishment of an obligation on the part of the Insurer to provide an Insurance Benefit.
14. An **Insured Peri**l is the possible cause of an Insured Event (the "cause").
15. The **Insurance Period** is the period of time agreed in the insurance policy for which the premium was paid. The first day of the first Insurance Period is the day of the commencement of the Term of Insurance. In the case of this Insurance, the Insurance Period is equal to the Term of Insurance.
16. An **Insurance Risk** is a measure of the probability of the occurrence of the Insured Event caused by an Insured Peril.
17. The **Policyholder** is the party which has concluded the insurance policy with the Insurer.
18. The **Insurer** is a legal entity entitled to carry on insurance activity according to special legislation.
19. The **Insured Person** is a person in respect to whose life or health the insurance relates.
20. A **professional athlete** is a person who has concluded a professional contract with a sports club or other entity in this field and/or engages in sporting activity for remuneration, which is this person's main or predominant income, and/or engages in sporting activity for a duration of at least 20 hours per week (including weekend), including training.
21. A **professional sporting activity** is a sporting activity carried out by a person who is a professional athlete as defined in this Article.
22. A **Loss Event** is an event resulting in damage which may constitute grounds for the establishment of a right to an Insurance Benefit.
23. A **Party to the Insurance** is the Insurer and the Policyholder, as the contracting parties, as well as the Insured Person and every other person to whom a right or obligation arose under the private insurance.
24. An **Accident** is understood, for the purpose of this Insurance, to be the unexpected and sudden action of external forces or one's own strength independent of the insured person's will, which occurs during the Duration of the Insurance and results in damage to the insured person's health or his/her death, including work Accidents. An Accident is deemed to occur the moment that the external forces or influences damaging the health or causing the death of the insured person came to bear.
    Damage to the health of an Insured Person caused by:
    a) localised festering following invasion of pathogens into an open wound caused by an Accident,
    b) tetanus or rabies infection in the course of an Accident, diagnostic, therapeutic and preventive interventions carried out to treat the consequences of an Accident,
    c) unexpected and uninterrupted exposure to high or low outdoor temperatures, gases, vapours, electric current (including lightning), radiation, toxic substances and poisons ((with the exception of microbial poisons and immunotoxic substances),
    d) drowning and death by drowning,
    e) bite, sting, or stabbing by an insect
    is also considered to be an Accident.
25. An **Interested Party** is a party interested in concluding an insurance policy with the Insurer.

Art. 3

Purpose and Subject of the Insurance

1. In the event of the occurrence of an Insured Event the Insurer shall provide the Beneficiary with a lump-sum insurance benefit in the agreed amount.
2. The Beneficiary is the Insured Person.
3. The subject of the Insurance is the health of the Insured Person.
4. The Insurance is concluded as Agreed Sum Insurance.

Art. 4

Insured Event

1. With the exception of the agreed exclusions, an Insured Event is the hospitalisation of the Insured Person in a healthcare facility at the place of Insurance commenced within the Duration of the Insurance due to Insured Perils occurring within the Duration of the Insurance after the expiry of the agreed Qualifying Period and during the Insured Person's stay at the place of Insurance
2. Insured Perils is Injury.

Art. 5

Extent and Place of Insurance

1. The extent of the agreed Insurance is determined by the Insurance terms and conditions and electable parameters stipulated in the insurance policy. These parameters are elected by the Policyholder upon concluding the insurance policy based on knowledge of the needs of the Insured Persons.
2. The Insurance is only effective in the agreed place of Insurance, which is the **territory of the states of the Schengen area, including the Czech Republic**.
3. The Policyholder shall elect the period insured and the upper limit of the Insurance Benefit (insured amount), which is stipulated in the other sections of these Insurance terms and conditions.
4. **Insurance of activities and sports**
    The Insurance covers the conducting of recreational and leisure activities and sports stipulated in the List of Activities and Sports (hereinafter referred to as the "List") as **activities and sports without the need for supplementary insurance**, which forms an annex to these Insurance terms and conditions. This Insurance does not cover the other activities and sports stipulated in the List **as activities and sports with the need for supplementary insurance (hazardous, extreme) or uninsurable**.

Art. 6

Extent and Due Payment of the Insurance Benefit

1. The insurer shall provide an insurance benefit to the extent contractually agreed as at the date of the insured event occurring.
2. The amount and extent of the Insurance Benefit is determined by the Insurer in accordance with the Insurance terms and conditions.
3. The payment of an Insurance Benefit is conditional on the occurrence of an Insured Event and the meeting of all the conditions and obligations ensuing from the insurance policy and parts thereof, namely the payment of the premium.
4. The Insurer renders an Insurance Benefit to the Beneficiary in the manner specified in subsequent sections for individual types of Insurance.
5. Unless otherwise agreed by the contracting parties, the Insurance Benefit shall be payable in the currency of the Czech Republic and its territory and the Insurer shall pay it to the Beneficiary by transfer to this person's bank account or by postal order to his name and address.
6. If the Insured Person was entitled to receive the Insurance Benefit, that he/she did not receive whilst alive, and his/her death was not an Insured Event this unpaid Insurance Benefit shall become the subject of inheritance proceedings.
7. The Insurance Benefit has an upper limit. The upper limit for the Insurance Benefit is the insured amount stipulated for individual types of Insurance in the insurance policy.
8. An Insurance Benefit is payable within 15 days from the end of investigations of the notified event, with which the claim for the Insurance Benefit is connected. The investigations conclude upon there porting of its results to the person who exercised the claim to the Insurance Benefit.

9. If it is not possible to conclude the investigations necessary to ascertain the Insured Event, the extent of the Insurance Benefit or to ascertain the person entitled to receive the Insurance Benefit within three months of the notification date, the Insurer shall inform the notifier why the investigations cannot be concluded; if requested by the notifier, the Insurer shall inform the notifier of the reasons in writing. The Insurer shall provide the person who exercised the claim to the Insurance Benefit with an appropriate advance on the Insurance Benefit on the basis of this person's request; this shall not apply if there are reasonable grounds to deny the provision of such an advance.
10. The Insurer is entitled to reduce the Insurance Benefit:
    a) if a lower premium was agreed as a consequence of a breach of a duty of the Policyholder or the Insured Person when negotiating the conclusion of the policy or its amendment, the Insurer shall be entitled to reduce the Insurance Benefit by an amount equal to the ratio of the premium it received to the premium it ought to have received,
    b) if the breach of the duty of the Policyholder, Insured Person or another party entitled to the Insurance Benefit had a material effect on the occurrence of the Insured Event, its course, on increasing the extent of its consequences or on ascertaining or determining the amount of the Insurance Benefit, the Insurer shall be entitled to reduce the Insurance Benefit proportionally to the effect that this breach had on the extent of the Insurer's duty to render benefits,
    c) in the event of the thwarting of the passing of the right to the Insurer pursuant to Article 18,
    d) if it paid the Insurance Benefit in the unreduced amount and has subsequently acquired a claim to reduce the Insurance Benefit. The Insurer is entitled to exercise a claim to the difference between the paid-out and the reduced Insured Benefit from the person in whose favour it was paid.
11. The Insurer is entitled refuse to pay the Insurance Benefit if the Insured Event was caused by a fact
    a) of which it learned only after the occurrence of the Insured Event,
    b) which it was unable to ascertain during the conclusion of the policy or its amendment as a consequence of the culpable breach of the obligation stipulated in paragraph 1 or 2 of Article 17 of this section,
    c) the awareness of which at the time of the conclusion of the insurance policy would result in it not concluding it or concluding it under different terms and conditions.
12. If the Policyholder or the Insured Person breaches any of the obligations set forth in these Insurance terms and conditions, the Insurer may reduce the Insurance Benefit with respect to the seriousness and nature of the breach of this obligation.
13. The Insurer shall, in the event of the occurrence of an Insured Event, provide the Beneficiary with a lump-sum Insurance Benefit in an amount corresponding to the product of the insured amount stipulated in the insurance policy for this Insurance and the number of days of hospitalisation. The number of days of hospitalisation is limited to the maximum hospitalisation period.
14. The insurance benefit is determined by the insured amount. Its concrete amount is elected by the Policy and stated in the insurance policy.
15. The maximum hospitalisation period is, in the case of injury, 365 days for the Duration of the Insurance (Term of Insurance).
16. The hospitalisation period is always counted from the first day of hospitalisation.
17. The first and last day of hospitalisation is counted as one day.
18. The Insurer does not provide an Insurance Benefit for hospitalisation lasting less than 24 hours.
19. Investigations of an event may be concluded not earlier than the end of hospitalisation or the expiry of the maximum hospitalisation period. Should rthe hospitalisation last longer than three months, the Insurer may, upon a written request and following the submission of all the required documents, provide the Beneficiary an appropriate advance.

Art. 7

Exclusions from the Insurance

An Insured Event does not include:

1. events where medical treatment is provided as a result of accident for which the Insured Person was treated prior to the Insurance being taken out,
   or events where medical treatment is provided in connection with the treatment of accident, the cause or symptoms of which occurred prior to the Insurance being taken out,
2. events associated with:
   a) performances and diagnostic methods that are not medically recognised or performed by a qualified healthcare professional,
   b) cosmetic measures,
   c) spa and convalescent treatment and stays, treatment at specialist treatment facilities (including long-term care facilities, sanatoria and hospices) and at facilities for subsequent ward treatment care,homeopathy and acupuncture,
3. psychiatric disorders, psychological tests and psychotherapy,
4. homeopathy and acupuncture,
5. complications that arise in connection with the provision of healthcare for injuries to which the Insurance does not apply,
6. events which the Policyholder, Insured Person or Beneficiary could foresee or which they knew of at the time the insurance policy was taken out,
7. events which the Insured Person brought about intentionally (including suicide or attempted suicide) or which were caused by the intentional conduct of the Policyholder or the Beneficiary,
8. events which were caused to the Insured Person by another person at the instigation of the Insured Person, the Policyholder or the Beneficiary,
9. events arising in connection with a riot which the Insured Person provoked, or in connection with criminal activity which the Insured Person committed or attempted to commit,
10. events which have occurred as a result of or in connection with the usage of, or the consequences of the usage of, alcohol, drugs, narcotics or other psychotropic or addictive substances by the Insured Person, even in the case of the voluntarily as well as proven treatment of additions to alcohol, addictive substances or gambling addiction, including stay in a detoxication facility or in a treatment facility for the other said addictions,
11. events which have occurred during test trials of Transport Means and during stunt activities,
12. events occurring during the preparation for and conducting of activities and sports not covered by this Insurance under the scope set out in Article 5(5) of this Section,
13. events occurring during the conducting of a sport performed by a Professional Athlete,
14. events associated with driving a motor vehicle, when the Insured Person refuses to undergo a test to determine the content of alcohol, toxic or narcotic substances in his blood,
15. events which the Insurer Person failed to document by providing proof of their duration, or failed to provide documentation that the Insurer requested or demanded of him in the course of the investigation of the Insured Event,
16. events which have occurred as a consequence of or in connection with:
    - the effects of released nuclear energy, or of chemical or biological weapons,
    - wartime events or civil war,
    - acts of violence (including civil disturbances and terrorist activities), in which the Insured Person took an active part,
    - handling of a firearm or explosive by the Insured Person.
17. hospitalisation related solely to the need for care providing by a nurse or a guardian,
18. events whereby the Insured Person failed to comply with the legislation in force in the country of his/her stay,
19. that part of hospitalisation surpassing the maximum hospitalisation period.

Art. 8

Insurable Interest

1. Insurable interest is a legitimate need for protection from the consequences of the Insured Event.
2. The Policyholder has an insurable interest in his own life and health. It is understood that the Policyholder also has an insurable interest in the life and health of another person, if he/she demonstrates an interest conditional on his relationship to this person, whether resulting from a family relationship or being conditional on the benefit or advantage he/she gains from a continuation of this person's life or preservation of this person's health.
3. If the Insured Person consented to the Insurance it is understood that the Policyholder's insurable interest was demonstrated.
4. The insurance policy shall be invalid if the Interested Party did not have an insurable interest and the Insurer knew or ought to have known this when concluding the insurance policy.
5. The insurance policy shall be invalid if the Policyholder has knowingly insured a non-existent insurable interest, but the Insurer did not or could not have known this; however, the Insurer shall be entitled to remuneration corresponding to the premiums until the time it learned of the insurance policy being invalid.
6. The insurable interest does not terminate upon the taking up of similar private insurance or for reason of plain disinterest.
7. The termination of the insurable interest must always be proven to the Insurer.

Art. 9

Group Insurance

1. Group Insurance is insurance pertaining to a group of Insured Persons, as further defined in the insurance policy, whose identity need not be known at the time of the insurance policy being concluded.
2. If the Insurance applies to members of a certain group, the insurance policy need not specify the names of the Insured Persons, on the condition that the Insured Persons can be identified beyond doubt at least at the time of the Insured Event.
3. In the case of group insurance, a breach of the duty to give truthful and complete answers to the Insurer's questions only impacts the Insurance of those persons to whom a breach of this duty applies.

Art. 10

Conclusion of the Insurance Policy

1. The insurance policy is concluded for a definite time period and in writing, otherwise it shall be deemed invalid.
2. The offer is accepted upon its signing by the contracting parties, unless another manner of acceptance is expressly stated therein.
3. If the Policyholder accepted the offer for the conclusion of an insurance policy by the timely payment of the premium in its full amount or of the full amount of the agreed premium instalment, it shall be deemed that the written form of the insurance policy has been duly observed.
4. An integral part of the insurance policy, apart from the Insurance terms and conditions, are also all agreements, supplements and annexes to the insurance policy and all documents defining the terms and conditions of the establishment, duration, alteration and expiration of the Insurance (e.g. testimonies, agent´s records of the course of concluding the insurance, information for the client).

Art. 11

Commencement and Duration of the Insurance – Term of Insurance

1. The Insurance is concluded for a fixed Term of Insurance from the commencement of the Term of Insurance to the end of the Term of Insurance.
2. The Term of Insurance and the Insurance period are agreed in the insurance policy.
3. The Insurance commences at 0:00 hours on the day agreed as the commencement of the Term of Insurance, but no earlier than on the day following the day on which Insurance premium is paid, unless agreed otherwise in the insurance policy.
4. The Insurance lasts from its commencement until the actual expiration of the Insurance.
5. The Insurance cannot be suspended for reason of the non-payment of the premium.

Art. 12

Amendments to and Termination of the Insurance Policy. Expiry of the Insurance

1. All amendments to the insurance policy are made in writing upon the mutual agreement of the contracting parties.
2. The personal Insurance expires upon the lapsing of the Term of Insurance, i.e. at 24:00 hours on the day agreed as the date of the termination of the Term of Insurance.
3. The personal Insurance expires upon the termination of the insurable interest, on the date when the Insured Person dies or on the date when the Insurer's notification of the refusal to pay the Insurance Benefit is received.
4. The Insurer or the Policyholder may terminate the insurance in writing:
   a) within two months of the conclusion of the insurance policy. An eight-day notice period shall commence running upon the serving of the termination notice, with the insurance expiring upon the passing of this period
   b) within three months of the serving of the notification of the occurrence of the insured event. A one-month notice period shall commence running upon the serving of the termination, with the insurance expiring upon the passing of this period.
5. The Policyholder may terminate the Insurance subject to an eight day notice period:
   a. within two months of learning that the Insurer applied a viewpoint contrary to the principle of equal treatment in determining the amount of the premium or for calculating the Insurance Benefit,
   b. within one month of receiving notification of the transfer of the insurance portfolio or part thereof or the transformation of the Insurer,
   c. within one month of the publishing of the notification that the licence enabling the Insurer to carry on its insurance business has been withdrawn.
6. If the policyholder or the insured person breaches, whether intentionally or through negligence, the duty stipulated in paragraph 1 or 2 of Article 17 of this section, the insurer shall be entitled to withdraw from the insurance policy if it can prove that it would not have concluded the insurance policy had the questions been answered truthfully and completely. The policyholder shall be entitled to withdraw from the insurance policy if the insurer breached the duty stipulated in paragraph 7 or 8 of Article 14 of this section. The right to withdraw from the insurance policy shall expire if not exercised by a party within two months of the day that this party had learned or ought to have learned of a breach of the duty stipulated in paragraph 1 or 2 of Article 17 or in paragraph 7 or 8 of Article 14 of this section.
7. If the insurance policy was concluded by means of a remote transaction, the Policyholder shall be entitled to withdraw from the policy, without giving any reason, within 14 days of its conclusion or of the date on which the terms and conditions were communicated to him, if such communication first occurs only upon his request after the conclusion of the policy.
8. The insurance policy may, in exceptional cases, be terminated by a written agreement of the contracting parties under the agreed conditions.
9. The insurance policy may be assigned only with the Insurer's consent.
10. If Insurance of another party's insurable risk is concluded, then the Insured Person shall take the place of the Policyholder on the date of the Policyholder's death or the date of it being wound up without a legal successor; however, if the Insured Person gives written notice to the Insurer within thirty days of the Policyholder's death or winding up that he/she is not interested in the Insurance, the Insurance shall expire on the date of the Policyholder's death or winding up. The effects of a delay shall not impact the Insured Person before the expiration of 15 days from the date that the Insured Person learned of his entry into the Insurance.
    However, if there is more than one Insured Person, the Insurance of all such parties shall terminate upon the expiry of the period in respect of which a premium was paid.
11. If the Insurer issues the Policyholder with a notice reminding it to pay the premium and, as part of this reminder notice, and instructs the Policyholder that the Insurance shall expire if the premium is not paid during the additional period, the Insurance shall expire upon the futile passing of this period.
12. The insurance policy terminates upon the expiry of the insurance of all persons.

Art. 13

Premium

1. The Premium is the consideration for the Insurance cover provided. The amount of the premium is determined by the Insurer and is stated in the insurance policy.
2. The premium is paid as a Single Premium, unless otherwise stated in the policy.
3. The payment of premiums in instalments can be agreed in the insurance policy. If an arrangement for the payment of premiums in instalments has been made and the policyholder fails to pay an instalment, the insurer shall be entitled to the entire insurance premium. The maturity of the entire premium occurs on the day following the due date of the premium instalment, with which the policyholder is in payment default.
4. The Premium is payable on the first day of the insurance period in the currency and the amount stated in the insurance policy.
5. The premium shall be considered as duly paid if demonstrably received by the Insurer's agent or credited to the Insurer's bank account.
6. The Insurer is entitled to the premium for the entire Duration of the Insurance. The Insurer acquires this right on the date on which the insurance policy is concluded.
7. If the Insurance is terminated as a consequence of an Insured Event, the Insurer shall be entitled to the Premium up to the end of the insurance period in which the insured event occurred.
8. If the insurance policy is terminated **by agreement** before the date of the commencement of the Insurance, the Insurer shall return all received premiums to the Policyholder minus the costs associated with taking out and administering the Insurance, upon the return of all documents verifying the validity of the Insurance.
9. The Insurer is entitled to the premium until the time it learned of the expiry of the insurable interest.
10. If the Policyholder withdraws from the insurance policy, the Insurer shall return to the Policyholder the received premiums within 30 days of the date of the withdrawal taking effect less any Insurance Benefits it may have paid under the Insurance; if the Insurer withdraws from the insurance policy, it shall be entitled to also set off the costs associated with taking out and administering the Insurance. If the Insurer withdraws from the Insurance, the Policyholder, Insured Person or another party who had already received an Insurance Benefit shall reimburse the Insurer within this same time period the amount of the Insurance Benefit received that is surplus to the received premiums.
11. If the Policyholder withdraws from the insurance policy according to Article 12(7) of this section, the Insurer shall return to the Policyholder the received premiums without undue delay, but not later than 30 days from the date of the withdrawal taking effect; in so doing, the Insurer shall be entitled to deduct any Insurance Benefit it had already paid under the Insurance. However, if the amount of Insurance Benefit paid exceeds the amount of premiums received, the Policyholder, or the Insured Person or the beneficiary in the event of the Insured Person's death, as the case may be, shall be obliged to pay the Insurer the amount of the Insurance Benefit paid that is surplus to the premiums received.
12. The Insurer will set off its outstanding premiums in the order in which they were created rather than in the order in which reminder letters were sent.

Art. 14

Rights and Obligations of the Insurer

1. The Insurer is entitled to verify the submitted documents, to demand the submission of expert reports and/or to consult complicated Loss Events with healthcare providers (healthcare facilities) or other competent entities, even abroad.
2. The Insurer shall issue the Insurance Certificate to the Policyholder after the conclusion of the insurance policy and payment of the premium.
3. If the event of the loss, damage or destruction of a valid Insurance Certificate, the Insurer shall issue a duplicate thereof to the Policyholder at the Policyholder's request; the same applies to the issue of a copy of the insurance policy concluded in writing.
4. The Insurer shall notify the Interested Party information about the Insurer and the Insurance taken out prior to the conclusion of the insurance policy.
5. The Insurer is also obliged to accept the payment of outstanding premiums and other outstanding receivables under the Insurance from the Policyholder's pledgee, from a Beneficiary or from the Insured Person.
6. Within the Duration of the Insurance, the Insurer shall provide information to the Policyholder at his address stipulated in the insurance policy or via the Insurer's web site. If the correspondence address is different from the address of the registered

office or residential address, then it is designated as the correspondence address. The address may also be an address designated for electronic communication.

7. If the Insurer ought to be aware of the inconsistencies between the Insurance being offered and the Interested Party's requirements when concluding the insurance policy, it shall alert the Interested Party of them. In so doing, the circumstances and the manner in which the insurance policy is concluded, as well as whether the other contracting party is being assisted in the conclusion of the policy by an agent independent of the insurer shall be taken into account.
8. If the Insurer asks the Interested Party or the Policyholder in writing whilst negotiating the conclusion of the insurance policy about facts pertaining to the Insurance, the Insurer shall answer these questions truthfully and completely.
9. If the Policyholder asks the Insurer in writing to provide him with information that is material for rendering benefits under the policy, the Insurer shall provide such information in writing without undue delay.

Art. 15

Obligations of the Policyholder

The Policyholder has the following obligations:

1. To pay the Insurance premium to the Insurer in a timely manner.
2. To inform all Insured Persons, in a timely manner, of the contents of the insurance policy, including all annexes and parts thereof, and provide them with all materials and information which it has received on their behalf from the Insurer.
3. To inform the Insurer without undue delay of a change in correspondence address.
4. If the Policyholder is also the Insured Person, all the obligations of the Insured Person shall apply to the Policyholder as well.

Art. 16

Obligations of the Insured Person

The Insured Person has the following obligations:

1. To do everything to avert the occurrence of an Insured Event and to reduce the extent of their consequences,
2. To take all the necessary and reasonable steps to prevent the extent of the consequences of the Loss Event from increasing and to exclude actions that prevent or hinder healing (e.g. failure to observe the treatment regime, including follow-up examinations, failure to seek medical treatment in the case of the continuation, aggravation, or occurrence of new difficulties); the Insurer is entitled to refuse to pay the Insurance Benefit in the event that this obligation is not observed,
3. To release the healthcare provider in writing from its obligation to maintain confidentiality and provide the Insurer with written authorisation to obtain information from healthcare staff which is subject to the obligation to maintain confidentiality and which is required for the Insurer's investigations if any Loss Event has occurred,
4. To undergo treatment or necessary medical examinations by a doctor designated by the Insurer,
5. To always undergo medical treatment or check-up at a time designated by the attending doctor,
6. To always follow the instructions given by the attending doctor and to abide by the treatment regime prescribed by the attending doctor,
7. To observe safety regulations and measures for the period of the Insurance being in effect (e.g. to respect a warning given by a mountain rescue service, to use seat belts whilst in a motor vehicle, to not enter areas designated as being dangerous to human health, to not move around avalanche areas, etc.),
8. To use suitable protective aids and equipment required for the maximum safe performance of all activities performed (e.g. use of seat belts),
9. To have the appropriate valid licence for the performance of all activities carried out at the Place of Insurance,
10. To arrange for proper supervision or escort, should this be usual for the performed activity,
11. To refrain from standing in places designated as inappropriate by the organiser,
12. To comply with the legislation in force at the Place of insurance,
13. To seek out medical treatment, should the need arise,

Art. 17

Other Rights and Obligations of the Parties to the Insurance

1. If the Insurer asks the Interested Party in writing whilst negotiating the conclusion of the insurance policy or asks the Policyholder in writing whilst negotiating the amendment of the insurance policy about facts that are relevant to the Insurer's decision on evaluating the insurance risk, whether it will insure them and under what conditions, the Interested Party or the Policyholder shall answer these questions truthfully and completely. The duty shall be deemed to have been duly met if nothing material had been concealed as part of the answer.
2. The provisions contained in paragraph 1 of this article regarding to the duty of the Policyholder shall also apply to the Insured Person.
3. Should an event occur with which the person who considers him/herself to be a Beneficiary links his/her claim to an Insurance Benefit, he/she shall notify this fact to the Insurer without undue delay, give the Insurer a truthful explanation of the cause, the origin and the extent of the consequences of such an event; at the same time, he/she shall also submit to the Insurer the required documents (e.g. the Insured Person's medical documentation) and proceed in the manner agreed in the insurance policy. If this person is not simultaneously the Policyholder or the Insured Person, the Policyholder and the Insured Person shall also have these duties.
4. The same notification may be made by any person with a legal interest in the Insurance Benefit.
5. The notification under paragraph 3 and 4 of this article shall be deemed as having been received after the Insurer:
   I.) was notified of the event via the Insurer's form, which has been duly completed (Notice of Loss Event),
   II.) was handed copies (unless otherwise stipulated below) of all the required documents or documents requested by the Insurer, particularly:
      a) received the Insured Person's medical documentation,
      b) received, for an Insured Event investigated by the police, also a police report or confirmation of the investigation of an accident,
      c) received a copy of the discharge report
6. Handover of documents to the insurer is deemed to constitute consent with the insurer reviewing the medical state.
7. The parties to the Insurance submit copies of documents to the Insurer, or originals upon the Insurer's request.
   All documents must be made out in the name of the Insured Person and must contain the date of issue and also the signature and stamp of the issuer, if prescribed on the document.
8. The Insurer shall commence investigations necessary to ascertain the existence and extent of its duty to perform without undue delay of the receipt of the notification under paragraph 5 of this article. The investigations shall be deemed as duly concluded upon the reporting of their outcome to the person who exercised the claim to the Insurance Benefit; at the request of this person, the Insurer shall justify the amount of the Insurance Benefit in writing, or the reason for this claim being refused, as the case may be.
9. If the notification contains knowingly false or grossly distorted material information pertaining to the extent of the notified event, or if information pertaining to this event has been knowingly concealed therein, the Insurer shall be entitled to compensation for the costs it purposefully incurred in investigating the facts in regards to which this information was given to or concealed from him. It is understood that the demonstrable costs of the Insurer were incurred purposefully.
10. If the Policyholder, the Insured Person or another party exercising a claim to the Insurance Benefit causes investigation costs or an increase therein by breaching a duty, the Insurer shall be entitled to claim reasonable compensation from such a person.
11. The Policyholder and the Insured Person are obliged:
    a) to notify the Insurer in writing at any time within the Duration of the Insurance of a change of any and all particulars made in the insurance policy,
    b) to enable the Insurer to conduct investigations into the causes of the Loss Event and the extent of their consequences and to co-operate with the Insurer as required,
    c) to notify the Insurer the details of all insurance policies valid at the time of the Loss Event occurring, the subject of which is insurance of the same Insured Peril.
12. The parties to the Insurance must not assign a claim for Insurance Benefit under the Insurance without the Insurer's consent.

Art. 18

Delivery of Documents

1. Correspondence delivered via the holder of a postal licence (hereinafter the "post office") shall be sent:
   a) to the Insurer at the address of the registered office stated in the insurance policy, or another address that is communicated to the Policyholder by the Insurer;
   b) by the Insurer to the correspondence address of the relevant person (addressee) stated in the insurance policy or otherwise notified to the Insurer. If the correspondence address is not stated in the insurance policy or subsequently notified to the Insurer, the correspondence will be sent to the address stated in the policy or notified to the Insurer as the residence or permanent residence, or the registered office of such a person.
2. Unless agreed otherwise, correspondence may also be delivered electronically (for example, via a data box, the Insurer's internet app, by e-mail) to the contact information provided for the purpose of electronic communication. Correspondence sent by the Insurer electronically to the last contact address provided by the addressee shall be deemed as delivered on the third business day after its sending, if the date of its delivery cannot be ascertained or if the relevant legal regulations do not stipulate otherwise.
3. Correspondence may also be delivered by an employee of the Insurer or another person authorised by the Insurer, especially to the addresses pursuant to paragraph 1 b), but also to any other place where the addressee will be willing to accept the correspondence. The correspondence thus delivered shall be deemed as delivered on the day of its receipt.

4. The parties to the Insurance are obliged to notify the Insurer without undue delay of any change in the facts relevant to the delivery and to notify each other of their new postal address, e-mail address or data box or telephone number.
5. If not a case of the delivery pursuant to paragraphs 6 to 8, correspondence sent by the Insurer by registered post with an advice of delivery shall be deemed as delivered on the day specified as the day of receipt of the correspondence on the advice of delivery, with correspondence sent by the Insurer by registered post without an advice of delivery, or sent by regular mail, being deemed as delivered on the third business day after dispatch, and in the case of delivery to an address in a country other than the Czech Republic, on the 15th business day after dispatch.
6. If the addressee deliberately thwarts the delivery of correspondence, it shall be deemed to have been duly delivered on the day that its receipt was thwarted by the addressee.
7. If the addressee thwarts the delivery of correspondence by failing to take delivery of the correspondence.
8. If the addressee thwarts the receipt of correspondence in another manner, e.g. by failing to take delivery of this correspondence or by failing to mark his/her/its letter box by his/her first name and surname or company name, it shall be deemed to have been duly delivered on the date on which it was returned to the insurer.
9. Correspondence sent by the Insurer by registered post or registered post with an advice of delivery shall be deemed duly delivered even in the case that they are received by another person in place of the addressee (e.g. a family member), to whom the post office delivered the correspondence in accordance with the legal regulations pertaining to postal services.

Art. 19

Form of Legal Acts

1. The insurance policy must be concluded in writing, unless the Civil Code provides otherwise.
2. In the event that the Policyholder's acceptance of the offer is found to be invalid due to a failure to accept the offer in writing or for any other reason, and the Policyholder pays the first premium or an instalment thereof in the amount and within the time period specified in the offer (if no time period is stated in the offer, then within one month of the delivery of the offer), the offer shall be deemed to have been received by virtue of the payment of this first premium or an instalment thereof.
3. Legal acts, notices, and requests must be made in writing if they have an effect on:
   a. the duration and termination of the insurance,
   b. changes in the premium,
   c. changes in the scope of the insurance.
4. A legal act, for which a written form is required, shall be valid, in particular, where it is personally signed by the acting person, or where the signature is replaced by a mechanical means, where this is usual, if made by means of a data box, if provided with a guaranteed electronic signature pursuant to a special law, or if it is made via the Insurer's protected internet client portal.
5. Legal acts, notices, and requests, not mentioned in paragraph 3. may be made in writing, over the telephone, by e-mail, via the Insurer's internet application or via a data box, if the Insurer permits delivery to a data box. This applies namely to the reporting of an Insured Event, notification by the Policyholder or the Insured Person pertaining to a change in the surname, residential address, correspondence address, and other contact details, as specified in the policy. Legal acts, notices, and requests pursuant to this paragraph, made other than in writing must be subsequently supplemented in written form, if the Insurer so requests.
6. The insurer is entitled, as regards matters relating to the insurance relationship, namely in connection with the administration of the Insurance and the settlement of Insured Events, to contact other parties to the Insurance by electronic or other technical means (e.g. via telephone, SMS, e-mail, fax, data box), unless agreed otherwise. In electing the form of communication, the Insurer shall take into account the obligations stipulated by the relevant legal regulations and the nature of the information communicated.
7. Legal acts, notices, and requests shall be effective against the other contracting party as soon as they have been received by this party.

Art. 20

Rescue Costs

1. If the Policyholder purposefully incurs costs in averting the immediate threat of an Insured Event or to mitigate the consequences of an Insured Event that has already occurred, it shall be entitled to compensation for these costs from the Insurer, as well as compensation for the loss suffered by the Policyholder in connection with this activity.
2. Compensation for rescue costs incurred in order to save lives or the health of persons is limited to 30% of the agreed insured amount or Insurance Benefit limit. The amount of compensation for rescue costs for the Period of Validity of the insurance policy is limited to CZK 100,000, with the exception of costs incurred by the Policyholder with the Insurer's consent.
3. Compensation for rescue costs is in excess of the framework of the Insurance Benefit limit.
4. If the Insured Person or another person incurred rescue costs in excess of the framework of duties stipulated by law, they shall have the same right to compensation against the Insurer as the Policyholder.

Art. 21

Assignment of Rights to the Insurer

1. If a person entitled to the Insurance Benefit, the Insured or a person incurring rescue costs, became entitled to compensation from another party for a loss or another similar right in connection with an Insured Event which is imminent or has already occurred, this claim, including appurtenances, security and other rights connected therewith, shall pass to the Insurer upon the payment of the Insurance Benefit, up to the amount of the benefits rendered by the Insurer to the Beneficiary. The above shall not apply if this person became entitled to this right against someone with whom he/she lives in a joint household or is dependent on him/her, unless he/she caused the Insured Event intentionally.
2. The person whose right passed to the Insurer shall release the required documents to the Insurer and disclose it all that is necessary in order to exercise the claim. Should this person thwart the passing of this right to the Insurer, the Insurer shall be entitled to reduce the benefits under the Insurance by the amount it could otherwise have received. If the Insurer has already rendered benefits, it shall be entitled to compensation up to this amount.
3. The Beneficiary is obliged to take measures to ensure that the right to compensation which pass to the Insurer under the law do not expire or become stature-barred.
4. The Beneficiary must not enter into an agreement with a third party to relinquish a claim for compensation against this third party if such claims pass to the Insurer.
5. The Beneficiary is obliged to confirm the assignment of rights to the Insurer in writing upon the Insurer's request.
6. If, in connection with the exercise of the claim, the Insurer incurs additional costs due to the fault of the Beneficiary, then the Insurer is entitled to require the Beneficiary to pay such costs

Art. 22

Final Provisions

1. Representations and notifications with respect to the Insurer are only valid if submitted in writing.
2. The language of communication is Czech.
3. Persons with restricted legal capacity shall be represented by their guardian. It is understood that persons who have yet to attain full legal capacity act with the consent of their statutory representative or that this statutory representative acts on their behalf.
4. If payment is made in cash, the date of payment is the date the sum is deposited in favour of the recipient. If the payment is not made in cash, the date of payment is the date the sum is credited to the account of the recipient.
5. The Insurer's costs associated with taking out and administering the insurance come to 20% of the unearned premium.
6. All disputes arising out of or in connection with this Insurance which are not resolved by agreement or out-of-court settlement shall be dealt with by any court having jurisdiction in the Czech Republic in compliance with Czech law.

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) promisesand agrees toprovidetheInsured Person with thebenefits described in the Master Policy, as outlinedherein and coverage for which is certified hereunder by the Company. The Company makes thispromise and agreement inconsideration ofthe Assured's Application, the Insured Person's Applicationand paymentofPremium, and subjecttoallofthe Terms ofthe Master Policy and as containedtherein,includingany Riders.The Master Policy is effective as ofJanuary 1, 2013,and shall remaineffect untilterminatedinaccordance withSection B(17), below.This Certificate shall be effective as ofthe Effective Date of Coverage shown onthe Declaration, and shall remainin effect untilterminatedin accordance withSection B(18), below. This Certificate is notpartofthe insurance contract. The contract is the Master Policy,theApplication, the Declaration,and any applicableRiders. This Certificateismerely adescriptionof and evidenceof the Insured Person's rightsand benefitsunderthe contract. The Declarationlikewiseisevidenceofthecoverage underthe contract andastatementofthe Effective Date ofCoverage, subjectalways tothe termsofcoverage containedwithinthe contract. The Company hereby recognizes Access HMO Inc., as the Company's authorizedagentand representative,andasthePlan Administratorofthe Master Policy and thisCertificate. Subject totheprovisionsofSectionB(6), below, all communications,notices and paymentstothe Company thatare requiredorpermittedundertheMasterPolicy and/oras described in this Certificateshould betransmitted throughthePlanAdministrator,and receiptofsame by thePlanAdministrator shallbe consideredreceiptbytheCompany.THISINSURANCE IS ISSUED PURSUANTTOAPP LICABLE SURPLUS LINES LAW.PERSONS INSURED BY SURPLUS LINES CARRIERS DONOTHAVE THE PROTECTIONOF STATEINSURANCE GUARANTY LAWS TO THE EXTENT OF ANY RIGHTOF RECOVERY FOR THE OBLIGATION OF AN INSOLVENT UNLICENSED INSURER.

B. CONDITIONS AND GENERAL PROVISIONS –The followingTermsare conditionsprecedenttotheCompany'sliabilityunder the insurance provided tothe InsuredPerson pursuantto and in accordance with theTerms of the Master Policy, as represented by thisCertificate(such insurance beingsometimesreferredtoherein as "thisinsurance" or "the plan"):

(1) ENTIRE AGREEMENT –The Master Policy, includingthe Application,the Declaration,andanyRiders, shall constitutethe entire agreement amongtheCompany, the Assured, and the Insured Person. This Certificate, includingtheApplication, the Declaration,and anyRiders, is an outlineand evidence of theinsurance providedby theMasterPolicy. This Certificatedoesnot extend orchange thecoverage providedby theMaster Policy. The insurance evidenced by this Certificate is subjectto all Terms of the Master Policy,includingtheApplication, the Declaration,and anyRiders.

(2) PREMIUM –Payment of requiredPremiumshallberemitted totheCompany on or beforetheEff ectiveDateofCoverage.

(3) PROOF OF CLAIM –When the Company receives noticeofaclaim forbenefitsunderthisinsurancefromor on behalfofan Insured Person it will provide the InsuredPerson with Claimant's Statement and AuthorizationForms ("Claim Forms") for filing Proof ofClaim.The followingitemsmustbe submittedbyor onbehalfof theInsuredPerson tobeconsidered acompleteProofof Claim eligible forconsiderationof coverage under this insurance ("Proof ofClaim"):

(a) aduly completed, timelysubmitted,and signed Claim Form; and

(b) all original itemizedbills and statements of services rendered fromall Physicians, Hospitals and otherhealthcare ormedical service providers involved withrespect to the claim; and

(c) all originalreceiptsforany costs,fees orexpensesthat have been incurredorpaid by or onbehalfofthe InsuredPerson with respect tothe claim, includingwithoutlimitationalloriginal receipts forany cashand/or credit card payments

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The InsuredPerson and/orPhysician, Hospitaland otherhealthcareandmedical serviceproviders and suppliershallhave ninety (90) daysfromthe date a claim is incurredtos ubmita complete Proof of Claim, and the Companyatitsoption may pend resolution and adjudicationof submittedclaims and/ormay denycoverage:for Proofsof Claim submittedthereafter; orfor incompleteProofs ofClaim; and/orforfailure tosubmitaPr oofof Claim;provided, however,thatthe Companyat itsoptionmay

waivetherequirementsofsubsectionB(3)(a), above, regardingsubmissionofa newClaim Formforsubsequentclaims incurred by anInsured Person relatingtoacontinuing Illness,In juryor othermedicalcondition forwhichaproperlycompleted and signed Claim Form haspreviously been submittedandreceived.

(4) APPEALING ACLAIM-In theevent theCompanydeniesallorpartofaclaim,theInsuredPerson shallhave ninety(90)days fromthe date thatthenotice ofdenial was mailed tothe InsuredPerson'slast knownresidence ormailingaddress tofile awritten appeal with the Company. Upon receipt of a writtenappeal,the Company shall have an opportunityfor further reasonable investigationand/orreviewas set forthinSectionB(22), and willrespond inwritingas soon as reasonably practicable, and in any event within ninety (90) days fromreceipt thereof.

(5) ASSIGNMENT, CHANGE OR WAIVER -Notwithstandinganylaw, statute,judicialdecision,or ruletothecontrary whichmay be or may purporttobeotherwise applicable withinthe jurisdiction,locale orforumstate ofany healthcareormedical service provider,notransfer or assignmentofany of theI nsuredPerson's rights,benefits or interestsunder this insurance shall bevalid, bindingon,orenforceableagainsttheCompany (or thePlanAdministrator) unless firstexpresslyagreedandconsented to in writingby theCompany.Anysuch purportedtransferor assignmentnotin compliancewith the foregoingTerms shall be void ab initioand withouteffect as against the Company (or the Plan Administrator), and the Company shall have no liabilityof any kind under thisinsurance to anysuch purportedtransfereeorassignee with respect thereto.The Terms of the Master Policyas evidenced by thisCertificate shall notbe waived, modifiedorchanged exceptby the express writtenagreement ofthe Company.

(6) SERVICE OF SUIT; VENUE;CHOICE OF LAW; TRIAL BY COURT-The contractofinsurancebetweentheInsuredPerson and the Companyas representedbythe MasterPolicyand evidencedbythisCertificateshall be deemedissued, finalizedand made inIndianapolis,Indiana.Soleand exclusive jurisdictionandvenue forany courtactionor administrativeproceedingrelating to this insurance shall be in Marion County, Indiana, for whichthe Insured Person expressly consents. The subjects, risksand benefitsof insurancecovered by theMaster Policyand evidenced by thisCertificate arenot intendedorconsideredbytheInsured Person orthe Company(or thePlan Administrator)tobe resident,located,or tobeperformed in anyparticularStateof theUnited States. Indiana law shall govern all rightsand claims raised under this Certificate of Insurance.

In the eventofthefailure of the Company to providebenefits or pay or reimburseanyamountclaimed to be dueunder this insurance, the Company,atthe request ofthe Insured Person and upon receipt oflawful process or summons, willsubmittothe jurisdiction of a court of competentsubjectmatter jurisdiction located in Marion County, Indiana,provided there exists an independent statutoryandconstitutional basis forin personamjurisdictionover theCompany insaid courtand by said forumState. The Companyconsentstopersonaljurisdiction and venue inthe Circuit and/orSuperior CourtsofMarion County,Indiana, and in the UnitedStates District Court for the Southern District of Indiana, Indianapolis Division (assuming that federal jurisdictionis otherwise appropriateand lawful). Alltrials regardingany disputeunder thisinsuranceshall be exclusively presented toand determinedsolely by thecourtas the trierof fact,withoutajury.The Company reserves theright,acting byand throughthe Plan Administrator,toinitiateandpursue actionsfordeclaratoryjudgment and/orotherappropriaterelief withrespect tothevalidity, bindingeffect,administration ofand/oranydispute orcontroversy arisingunder thisinsurance. Inanysuit institutedby oragainst the Company pursuant to the Terms of this Section B(6), the Company will abide by the final decision of such court or ofany appellatecourt intheevent of an appeal.

Nothing in this Section B(6) constitutes or should be deemed, considered or understood toconstitute awaiverofthe Company's rightsto:(i) oppose venue, proceduraland/orsubstantivechoice oflaw,personal jurisdiction,orsubjectmatter jurisdictioninany forumotherthanthe Circuit or Superior Courts of Marion County,Indiana, or the United States DistrictCourt for theSouthern DistrictofIndiana,Indianapolis Division (assuming that federaljurisdictionis otherwiseappropriateand lawful), (ii)commence an action inany court of competentjurisdictionin or outsideof the United States, (iii) removeanaction to aUnitedStatesDistrict Court, or (iv) seek transferofacase to anothercourtor forumas permittedby the lawsof suchforum or the lawsofthe United States or ofany Statein the UnitedStates, as applicable;allofwhich rightsare expresslyreserved and retained.

Subject toand withoutlimiting,expanding,superceding, modifyingorwaiving any ofthe foregoingTermscontained inthisSection B(6), pursuantto anystatute ofany State, territoryor districtof the United States which makes provisionthereof, the Company herebydesignates the Superintendent,Commissioner,or DirectorofInsurance (or such other officerspecified forthatpurposein the statute), orhis successoror successors in office, as itstrueand lawfulattorney, undera special powerofattorney,uponwhom may be served any lawful processissued in connection withthe initiationofany action, suitorproceeding institutedbyor onbehalf of the InsuredPerson arising out of this insurance, including specifically the Commissioner of Insurance for the Indiana Department of Insurance, 311West Washington Street, Suite 300, Indianapolis,IN 46204,and hereby designates andappoints John P.Dearie, Jr., Esq., Edwards & Angell,LLP, 750LexingtonAvenue,New York, NewYork10022,asits attorney-in-factand agent forservice ofprocesstowhom said officerorCommissioner is authorizedtomail orserveany such process oratruecopy thereof.

For Floridaresidentsonly:Ifany disputeshallariseasunderthetermsandconditionsofthis Certificate,suchdisputemaybe referred toarbitration in accordance with the procedures of the American ArbitrationAssociation. Any such arbitration shall be held within50miles ofthe Insured Person's residence, withthe Company topay costs and fees (notincludinganyattorneyfees) of the proceeding inexcess of $500.00.

(7) MISREPRESENTATION -Any misstatement,omission,concealmentorfraud,eitherintheInsuredPerson's Applicationwhich formsapartofthe MasterPolicy and this Certificate,orinrelation to anystatement, certificationorwarrantymade by theInsured Person orhis/herrepresentatives, agents orproxies, whetherin writingorotherwise,t othe Company or thePlan Administratoror their respective agents,employees or representatives, or in connection withthe makingof any claim under this insurance, shall render the Declaration and this Certificate null and void and all claims and benefits underthis insurance shall be forfeitedand waived.

(8) INSOLVENCY –The insolvency, bankruptcy,financial impairment,receivership,voluntaryplanofarrangementwithcreditorsor dissolutionoftheAssured or any Insured Personshall not impose upon the Company anyliability or obligationotherthan that specifically included in this insurance.

(9) SUBROGATIONCLAUSE –The InsuredPerson shall undertaketopursue in his/herownname and stead, and to fully cooperate withthe Companyin the pursuitand prosecutionof,any and all validclaimsthattheInsured Person may have against any third party who may be liable or responsible for any loss or damagearising out of any act, omission or occurrence which results or may resultinalosspayment, provisionof benefits,or coverage ofclaimbytheCompanyunderthisinsurance, and to fully account totheCompany forany amounts recovered or recoverable in connection therewith,on the basis thatthe Company shall bereimbursedandentitledtorecoverfirstinfullforany sums paidortobepaidby itbeforetheInsuredPerson shares inany amountso recovered.Should theInsured Person failtoso cooperate,account,orto prosecuteany validclaimsagainstany such thirdpartyor parties, and theCompany thereuponor otherwisebecomes liable or otherwiseobligated tomake payment underthe Terms of this insurance, then theCompany shall befully subrogated toall rightsand interests of theInsured Person with respect thereto and may prosecute such claims in its ownname assubrogee. The Insured Person's submission of Proof of Claim or acceptanceof coverage orbenefitsunderthisinsuranceshall be deemedtoconstitute an authorization,consentandassignment ofsuch subrogationrightsbythe Insured Person tothe Company.Any amountrecovered bythe Companyinaccordance withthe foregoingshallfirst be used topay in fullthecosts and expensesofcollection incurredbytheCompany,includingreasonable attorneys' fees, and for reimbursementtothe Company forany amountthat itmay have paid orbecome liabletopay underthis insurance. Any remainingamountsrecoveredshall be paid totheInsuredPerson or other persons lawfullyentitledthereto,as applicable.

(10) OTHER INSURANCE –The Company shall not be liable orobligatedto provideany coverage or benefits or to payor reimburse anyclaim underthis insurance if thereis anyother insurance, membershipbenefit, workers'orworkplacecompensation coverage programor other government program,reimbursement orindemnificationcoverage, rightofcontribution,recoupment or recovery, contract, oranyother third-partyobligationorliabilityforprovisionof benefits ("Other Coverage")which would, orwould butforthe existence ofthis insurance, be available or obligated toprovide such benefit ortopay orreimburse orprovideindemnity for such claim,except inrespect ofany excess beyond the amountpayable or providedunder such Other Coverage hadthis insurance notbeen effected.The Companyshall notbe liableor obligatedto provideany benefitor topay or reimburseany claim in respect toTreatment or suppliesfurnished by any programor agency funded byany governmentor governmentalauthority.

(11) CANCELLATIONBYINSURED PERSON –The InsuredPerson may requestcancellationoftheDeclaration and this Certificate,andfull return of Premium, by giving the Company written noticethereof priorto the Effective Date of Coverage, whereupon allcoveragesandbenefits underthisinsurance shall be cancelled, voidand withouteffect. Afterthe Effective Date of Coverage, the Premium is fullyearnedand is non-refundable.

(12) APPLICABLE CURRENCY –All benefitamounts,coverages, monetarylimitsandsub-limits,andotheramountsstatedinthe Master Policy, the Application,the Declaration, this Certificate, and in anyRiders, includingPremium, are in U.S. dollars.

(13) COOPERATION –The Insured Person andhis/herPhysicians, Hospitals andotherhealthcareand medicalserviceproviders and suppliersshall undertake to cooperatefully with the Companyand the Plan Administratorinreviewing, investigating, adjudicating, considering an appeal of,and/oradministeringany claim forbenefits underthis insurance, includinggrantingfullright of accesstoallrelevant or related medical documentation,medicalhistories, reports, lab or test results, x-rays,and all other available evidence relating to or affecting the review, investigation, adjudication oradministrationofthe claim. The Company at its optionmay suspend or pendadjudication ofa claim, and/ormaydeny benefits and/orcoverage foraclaim,whenthere has been: (i) a refusaltoso cooperate,(ii) an unreasonable delay insuch cooperation,and/or(iii)any other actor omissiononthepartofthe Insured Person and/orhis/herhealthcare providers which hinders, delays, impairs,orotherwiseprejudicesthe performanceofthe Company's obligations under this insurance.

(14) CLAIM SETTLEMENT –Eligible and covered claims forEligible Medical Expenses orotherbenefitsunderthisinsurancethat have previouslybeen paidby or on behalfof theInsured Person at thetimeofthe Company'sfavorableadjudicationthereofwillbe reimbursedby theCompanydirectly tothe Insured Person, by check, at his/herlast knownresidence ormailingaddress. While this insurance isineffect, in order to effectuate proper administrationthe InsuredPerson shall undertaketopromptly notifythe Company ofany change insuchaddresses.Eligible and covered claimsfor EligibleMedicalExpenses orotherbenefitsunderthis insurance thathave notbeen paidby or on behalfof theInsured Person at the timeofadjudicationwillbe paidby theCompany by check or wire transfer totheInsuredPerson at his/herlast knownresidence or mailing address, or, at the soleoption and discretionofthe Company (but withoutobligationtodo so),andasan accommodationtotheInsured Person, directlyto the provider(s),asapplicable. All claimset tlements, payments and reimbursements are subject to the applicable Deductible and Coinsurance, ifany, andtothebenefit limitsand sub-limitsandall otherTerms ofthis insurance.No healthcare ormedical service provider or supplier,or any other third-party,shallhave any direct or indirect claimor rightof actionagainst the Company under thisCertificate, the Declarationorthe Master Policy, whether by purportedassignment of benefits, subrogationof interestsor otherwise, unless first expressly agreed and consented toin writingby theCompany, and notwithstandingtheCompany'sexercise or failure to exercise any optionor discretionunder this Sectionregardingthemethod of claimpayment. Nosuchprovider, supplieror otherthird-partyisintended to haveorshall haveany rightsas athird-partybeneficiaryunder this Certificate, the Declaration, or the Master Policy.

(15) FRAUDULENT CLAIMS –Ifany claim or requestforbenefitsunder thisinsuranceshall beinany respect fraudulentor deceitful, or if the Insured Person or anyone acting foror onhis/her behalf underthis insurance usesany fraudulentor deceitful meansor devices, allpast, presentand futurebenefits,coverages andclaimsunder this insuranceshall beforfeitedand waived by the Insured Person and may be cancelled, voided, rescinded and terminatedbytheCompanyinitssoleandabsolute discretion,and the Companyshall haveno obligationorliability forany such benefits,coverages or claims.

(16) ARBITRATION –With theexceptionofFloridare sidents' optiontorefer to arbitration,no claim for benefits forwhich liability, eligibility,orcoverage underthis insurancehasbeen deniedinwhole or inpartb y the Companynor any other disputeor controversyarising under or related tothisinsurance shall be arbitrableor subjecttoarbitration under anycircumstances orfor any reason.

(17) TERMINATION OFMASTER POLICY –The Master Policycan be terminatedat any timeby eitherthe Company or the Assured bygiving at leastthirty (30) days writtennoticetotheother andto the Insured Person. Such terminationwillhaveno effect on thisCertificate priortothe date ofthe termination,oron eligiblecoveragesor benefits underthis insuranceaccrued prior thereto.Noadditional Certificates will be issued or furtherApplicationsaccepted for the planafter the datethe Master Policy is terminated.

(18) TERMINATION OFCOVERAGE FOR INSURED PERSONS –Coverage and benefitsforthe InsuredPerson underthis insurancewillterminateeffectiveat12:01 AM,EST,ontheearliest ofthe followingdates:

(a) the nextday followingtheendofthecoverage periodforwhich Premiumhas been fullyandtimely paid;or

(b) the datethattheInsured Person no longeris insuredundereither agroupor individualmedicalinsuranceplanformedical expenses incurred in Home Country; or

(c) the terminationdate asshownonthe Declaration for this Certificate;or

(d) the date the Master Policyis terminatedpursuantto Section B(17), above; or

(e) the datespecified bythe Companyin anynotice ofcancellation, forfeitureorrescissionissuedpursuantto oras aresultofthe circumstances set forthinSections B(7) or B(15), above, or B(20), below.

Coverage forthe Insured Person shall remain infullforce and effect unless terminatedpursuantto theprovisionsofthis Section B(18), except asotherwise providedin the Master Policy,the Declaration, or thisCertificate.

(19) PATIENT ADVOCACY –Neither the Companynor thePlan Administratorshallhave any right,obligation,orauthorityofany kindto ultimatelyselect Physicians, Hospitals, or other healthcare or healthserviceprovidersfor the Insured Person or tomake 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/orhis/herguardians,familymembers and treatingPhysicians and other healthcare providers. Subject tothe foregoing,the Companymaydeterminethat aparticularclaim, benefit, Treatment,ordiagnosis occurring under or relatingto thisinsurance may be placedunderthe Company's "Patient Advocacy"pr ogramtoe nsure that Medically NecessaryTreatment and suppliesare providedinthemostcosteffectivemanner.Intheevent theCompanydeterminesthata claim, benefit, Treatment, or diagnosis meets the Company's Patient Advocacy programguidelines, the Company willnotifythe Insured Person as soon as reasonably practicable, and a Patient Advocate willbe assigned totheInsuredPerson. Thereafter,the Company's Patient Advocate may makeevaluationsand/or recommendationsofTreatment settingsand/or procedures and/or suppliesthatmay be more costeffectivefortheCompany and/ortheInsured Person. Such recommendationswillbe madewith input fromthe InsuredPersonand/or the Insured Person's guardians, family members and treating Physiciansand other healthcareproviders, and willbe madeonly when it can ber easonably demonstratedthatthe MedicallyNe cessary Treatment and/orsupplies can be providedinamore cost effectivemanner to the Company and/ortheInsured Person. The Company will use its best efforts toevaluate and recommendTreatment settings and/orprocedures and/orsuppliesthatcan reasonably be expected toresult in the same or better care of theInsuredPerson. The Insured Person is undernoobligation toaccept orfollow any of the Company's recommendations. However, if the Insured Person accepts and follows any of the Company's recommendations, theInsured Person agrees tohold the Company and the Company's agents and representatives,includingthe Patient Advocate, harmlessfromsame, and the Companyshall notbeheldliableorother wise responsibleforany Treatment or supply provided to theInsured Person except forthepaymentofclaims and benefits eligible forcoverage underthe Terms ofthis insurance. After the Insured Person has been notified that the claim, Treatment, benefit or diagnosis meetsthe Company's Patient Advocacy programguidelines, the Company reserves the right,at its optionand in itssole discretion withoutliability,to:

(a) make paymentfor Treatmentand/orsupplies which,although notexpressly covered underthisinsurance, maybe beneficial to the InsuredPerson and cost effective to the Company; and/or

(b) deny coverage and/orbenefits forany charges, includingEligible Medical Expenses otherwise eligible forcoverage butforthe Terms ofthisSection, which exceed the amountthe Company wouldhave covered had theInsuredPerson accepted and followed the recommendationsofthePatientAdvocacy program.

(20) RIGHT OF RECOVERY –In the event ofoverpaymentby theCompany ofany claim forbenefitsunderthisinsurance, forany reason, including withoutlimitationbecause:

(a) all or part of the claimwas notincurred by orpaidb yoronbehalf of theI nsuredPerson; or

(b) the Insured Personorany memberofthe InsuredPerson's family,whetheror not the familymemberisor was an insured person under thisinsurance plan, is repaid or is entitled to be repaid forall orpart ofthe claim byOther Coverage orby orfroma source other than the Company;or

(c) all or partof the claim was noteligible for paymentorcoverage under the Terms ofthisinsurance; or

(d) all orpartoftheclaim was paidor reimbursedbased on an incorrector mistakenapplicationofbenefitsunde rthis insurance; or

(e) all orpartofthe claim has been excused,waived, abandoned,forfeited,discountedor releasedby the providerorsupplier; or

(f) the InsuredPerson is notliableorr esponsible as a matterof law for all or partof a claim;

the Company shallhavetheright to arefundof and torecover the amountof overpaymentfromthe Insured Persona nd/orthe Hospital, Physician, or other provider of services or supplies, as the case may be. For overpayment of claims under subparagraphsB(20)(c)and(d), above, theamount of the refundand recoveryshallbethedifferencebet ween: (i) the amount actually paid by the Company; and (ii) the amount,if any, thatshould havebeenpaid by the Company underthe Termsofthis insurance. For all other overpayments, the amountof the refundand recovery shall be theamountoverpaid. IftheInsuredPerson or the Hospital,Physician orother providerof services or suppliesdoes not promptlymakeany such refundto theCompany,the Companymay, in additiontoany other rightsorremedies available toit(allof whichare reserved): (i) reduce ordeduct fromthe amountofany futureclaim thatis otherwise eligiblefor coverage or paymentunderthis insurance,tothe fullextentofthe refund due tothe Company; and/or(ii) cancel this Certificate and all furthercoverage of the Insured Person under theMaster Policy by givingthirty(30) days advance writtennotice bymail tothe Insured Person at his/herlastknownresidence ormailingaddress, and offset against the amountofany pro-ratarefundof Premium due the InsuredPerson to thefullextent of the refundduetothe Company.

(21) RENEWAL/AMENDMENT-Coverage underAccess HMO Gold Internationalplan may be renewed forextendedperiodsof coverage in incrementsof12months up toamaximum totalof thirty-six(36)continuousmonths.Any onePeriod ofCoverage may notexceed twelve(12)months. If any PeriodofCoverage underthisinsurance has lapsed or terminatedforany reason, coverage underthe Access HMO Gold Internationalplancannot be renewed, butmay beseparately writtenundera newCertificate (only after all applicable eligibilityguidelines are met). A new Applicationwith premiummustbe received by the Company in order to affectnewly writtencoverage,and uponacceptance, anewCertificatewillbe issued anda newinitial Period ofCoveragewillbe established. New deductibles, scheduled benefit limitsandsub-limits, conditionsof coverage, eligibilityrequirements, andPre-existing Condition exclusions will apply to any separately written and non-continuouscoverageperiods.

(a) At the timeof any request for renewal, the Insured Person must satisfy all of thethen-current eligibilityrequirementsforthis insurance,as establishedbythe Companyat itssole discretions(see e.g.,Se ctionD); and

(b) The maximumperiodofcontinuouscoverage underthisinsurance, includingtheinitial PeriodofCoverage anda ny renewed Period(s)ofCoverage, maynotexceed atotalof thirty-six(36)continuousmonths;and

(a) Upon the Company's acceptance of a renewal Application, a new Declaration of Insurance and the then-currentformof Certificateof Insurancefor thisinsurance plan will be issuedtotheInsured PersonbytheCompany.

The Company's commitmentand the Insured Person's ability torenew is also subject to terminationuponthirty(30) days written notice totheother partypriorto theexpirationdateof the thenexistingPeriodof Coverage.The Companyreserves therightinits sole discretion to make changes, additions and/ordeletionstothe Terms of the Master Policy, this Certificate, renewals or replacements ofeither, and/ortothe Access HMO Gold International insurance plan (includingthe issuance of Riders toeffectuate same) at any time orfromtime totimeafterthe Effective Date of Coverage of thisC ertificate,uponnoless thanninety (90) days priorwrittennoticetotheAssured andtheInsured Person (Notice of Amendment).The NoticeofAmendment shall includea completedescription of the changes, additionsand/ordeletions to be made, the effective date thereof (the Change Date), and notice ofthe Insured Person'scancellation rightsas set forthbelow,andshall be sent firstclassmail, postage pre-paid,tothelast known residence or mailingaddressofthe Insured Person. Upon issuance of theNotice ofAmendment,the Assured and/orthe Insured Personshall havetheright to requestcancellation of this Certificate, above, at any time prior to the Change Date; provided,howeverthatcancellation underthis Section B(21)shallbeat the optionofthe Insured Person,and coverageunderthis insuranceshall terminate with effect from the cancellation date specified by the InsuredPerson (subject to the provisions of Sections B(18)(a)-(d)).IftheInsuredPerson does not elect to cancel this Certificate in accordance with the foregoing,the changes,additions and/ordeletions as made by the Company and specified in said Notice of Amendmentshall take effect as of the Change Date specified in the Company's Notice, andthis insurance shall thereaftercontinue in effect in accordance with its Terms, as so amended and modified.

(22) EXPLANATION OR VERIFICATION OF BENEFITS -In theevent ofanyverbal or telephoneinquiry,everyattemptwillbe made tohelptheInsuredPerson andhis/her healthcare providersand suppliersunderstandthe status, scopeandextent of available benefitsandcoverages underthisinsurance; provided,however, thatno statementmadebyanyagent,employeeor representative of the Company orthe Plan Administratorwillbe deemed orconstruedas an actionable representation, promise,or an estoppel, or will createany liabilityagainst the Company or the Plan Administratororbe deemed or construed to bindthe Company orto modify,replace, waive, extendoramend anyof theTermsofthe Master Policyor this Certificate,unless expressly set forthin writingand signed by an authorizedagentorrepresentative ofthe Company. Actual eligibilitydeterminations, benefit verifications, final coverage decisions and claim adjudications, and final payments and/orreimbursements of benefitsor claims shallbedetermined and adjudicatedonlyafter or atthe timeaproperand completeApplicationand/orProof ofClaim is submitted (asthecase may be), anopportunity for reasonable investigationand/orreview is provided,cooperationrequiredhereunder received,andall facts and supportinginformation,includingrelevant medical records when deemed necessary orappropriate by the Company,arepresented in writing.Appealed claims may be furtherinvestigated and/orreviewed. The Terms of the Master Policy govern all available coveragesand paymentsmadeor tobe made. If a definiteanswer to aspecificbenefitsor coverage questionis requiredfor any reason, the Insured Personor his/herhealthcare providers may submit a written request to the Company, including all pertinentmedical informationand astatement fromthe attending Physician (if applicable), and a written

reply will be sent by the Company and keptonfile. If the Company electstoverify generally and/orpreliminarilytoaprovider or the Insured Person that an Injury,Illness, diagnosis or proposedTreatment isor may be covered under thisinsurance, or that benefits forsame are or maybeavailable asoutlined in thisCertificate, any such verificationof benefitsdoes notguarantyeither payment ofbenefits orthe amountor eligibilityofbenefits. Final eligibilitydeterminations,coveragedecisions, claimappeals, and actual reimbursementor payment ofclaims or benefitsaresubject to allTerms ofthisinsurance, includingwithoutlimitationfilinga properand completeProof ofClaim underSectionB(3)andcooperation underSection B(13).

C. SCHEDULE OF BENEFITS/LIMITS –Subject to the Terms ofthisi nsurance, includingwithoutlimitationtheDeductibleand Coinsurance (unless otherwise expresslyset forthto thecontrary), theExclusions set forthinSection U. of theMaster Policyand this Certificate,and thevariouslimitsandsub-limitsset forthbelow,theCompany promisestoprovidetheInsured Personthe followingsummaryofbenefitsandcoveragesarising out of Injuryor Illness incurredwhile this Certificate isineffect:

Benefit/Other	Limit/Sub-limit
Maximum Limit	Age 15 days to 69 years: US$1,000,000 per Period of Coverage Age 70-75years: US$ 50,000per Periodof Coverage
Maximum Trip Duration	Asshownonthe DeclarationofInsurance
Deductible	US$250 per Insured Person per covered Illness. The Deductibleshall be waived forclaims incurred as theresult of acoveredAccident.
EmergencyRoom Deductible	An additionalDeductibleof$ 250willbe appliedforeachE mergencyRoom visit fortreatmentof an Illness which does notresult in adi rect Hospital admission.
Coinsurance	For Treatmentreceived outsidetheUS & Canada: No Coinsurance For Treatmentreceived withthe US &Canada: In thePPONetwork: The planpays90% ofEligible MedicalExpensesupto US$5000,then 100% up to Maximum Limit Outsideofthe PPONetwork: The planpays 80% ofEligible Medical Expenses up to US$5000, then100% uptoMaximum Limit
Benefit Period	30 daystoa maximumof$5000. SeeS ectionV,"Definitions; Benefit Period"forfurther Terms.
Accidental Death & Dismemberment Benefit	US$25,000(Not subjecttoDeductible and Coinsurance). See SectionLfor furtherTerms.
Common Carrier Accidental Death Benefit	US$50,000 perInsured Person, maximumof$250,000perFamilyinvolvedin thesame Accident. See Section MforfurtherTerms.
Sudden and Unexpected Recurrence of a Pre-existing Condition	Subject tothe Deductible,uptoUS$5,000 perPeriodofCoverage. SeeSection Q forfurtherTerms.
Dental Emergency	Subject to the Deductible,upto US$100 for the necessary Treatmentof Unexpected paint osound natural teeth.
Emergency Medical Evacuation	Subject to the Deductible,uptoUS$25,000forEligible Medical Expenses foran EmergencyMedical Evacuation arisingor resultingfromasuddenandUnexpectedrecurrenceofaPre-existingCondition eligibleforcoverage underSection Q.ForEligible MedicalExpenses foranEmergency Evacuation resulting fromall othercovered incidents, if under theage of66, up toMaximum Limit,if age 66 to75, up toUS$50,000. All evacuations must be approved in advance and coordinatedbytheCompany. See Sections Hand QforfurtherTerms.
EmergencyReunion	Subjecttothe Deductible,uptoa US$50,000lifetimemaximumandlimitedtoamaximum of 15days. Must be approvedinadvance andcoordinatedbytheCompany. See SectionIfor furtherTerms.
Return of MinorChildren	SubjecttoDeductible,uptoUS$50,000. Must be approved inadvanceandcoordinated by the Company.See SectionRf orfurtherTerms.
Return of Mortal Remains	SubjecttoDeductible, up to US$50,000 per InsuredPe rson. Must be approved in advancea nd coordinatedbythe Company. See SectionJforfurther Terms.

PoliticalEvacuation And Repatriation	Limited to a US$10,000 lifetimemaximum. Must beapproved in advance and coordinatedby the Company. See Section KforfurtherTerms.
LocalAmbulance Expense	SubjecttoDeductible,Usual,ReasonableandCustomary.SeeSectionG(4)(k)and(l)forfurtherTerms.
Hospital Room & Board	Subject to Deductible, the average semi-privateroom rate, includingnursingservice. See Section G(1)(a) forfurtherTerms.
Intensive Care Unit	Subject toDeductible,Usual, Reasonablea nd Customary. See Section G(1)(b) forfurtherTerms.
Eligible Medical Expenses	Subject toDeductible,Usual, Reasonablea nd Customary. See Section G for furtherTerms.
Pre-certification	50% reductionofEligible Medical Expenses ifPre-certificationprovisionsare notmet. See Section E for further Terms.
Hospital Indemnity	US$100 per day paid directlytotheInsuredPersonforeach nightofare quiredhospitalstay that is covered under all terms and conditions of this plan up to a maximum of 10 nights per Periodof Coverage. Notsubject to Deductible or Coinsurance. See Section TforfurtherTerms.
Trip Interruption	Not subjectto Deductible,up toUS$5,000 perInsured Person per Period ofCoverage. SeeSection N for further Terms.
Lost Luggage	Not subjecttoDeductible, up toUS$50 per itemof luggage, $250maximumper Insured Person per Period of Coverage. SeeSection OforfurtherTerms.
IdentityTheft	UptoUS$500 per Period of Coverage Not subjectto Deductibleor Coinsurance. See SectionS for furtherTerms.

D. ELIGIBILITY -If an Insured Person is not eligible, this Certificate is void abinitio and allpremium paid willbe refunded.In ordertobeeligible and qualifiedforcoverageunder thisinsurance,apersonmust:

(1) completeand signanApplication as theInsuredPerson (or be listed thereonby proxyas anapplicant andproposedInsured Person),and/or as the Insured Person's spouseand/or Dependent Child; and

(2) be at least 15days oldand underthe ageof76;and

(3) intendtolegally depart the Home Countryand legallyenter the HostCountry one or more timesduring the Periodof Coverage; and

(4) not be acitizen of the Host Country;and

(5) pay the requiredPremium onorbef oretheEffective Date ofCoverage; and

(6) mustbe a citizen of the United StatesofAmerica; and

(7) mustbe coveredb yanindividualor groupmedical planforexpenses incurredin Home Country, which is ineffect on the Effective Date of this plan and remains in effect duringthe duration of this plan.

E. PRE-CERTIFICATION PROVISIONS/REQUIREMENTS -Pre-certificationis a generaldetermination of Medical Necessity, only,and all such determinationsare made by the Company(acting throughits authorizedagents andrepresentatives)inreliance and based upon the completenessandaccuracy of the informationprovided by the Insured Person and/orhis/herrelatives, guardiansand/or healthcare providers at the time of Pre-certification.The Company reserves the righttochallenge, dispute and/orrevoke a priordeterminationof Medical Necessity based uponsubsequent informationobtained. Pre-certificationisnot an assurance, authorization,preauthorization,or verification of Treatment or coverage, a verification of benefits, or a guarantee of payment.The fact that Treatment orsuppliesare Pre-certifiedby the Companydoes not guarantee the paymentof benefits, the availability of coverages, or theamount of or eligibilityforbenefits. The Company's consideration and determinationof a Pre-certificationrequest, as well asany subsequent review or adjudicationof all medical claimssubmitted in connection therewith, shall remainsubjectto allofthe Termsof the Master Policya ndthisCertificate, includingexclusionsfor Pre-existingConditions and other designated exclusions, benefit limitationsandsub-limitations, and therequirement that claims be Usual, Reasonable and Customary.Also, anyconsideration ordeterminationofaPre- certificationrequestshallnotbe deemedor consideredas the Company'sapproval, authorizationor ratificationof, recommendationfor,or consent toany diagnosis orproposed course of Treatment. Neither the Company northe Plan Administrator(nor anyone acting on theirrespective behalves) has any authorityor obligationto select Physicians,Hospitals, or other healthcareproviders for the Insured Person, or to makeany diagnosisor medical Treatmentdecisions onbehalf ofthe InsuredPerson, and all such decisionsmustbe madesolely and exclusivelybythe Insured Person and/orhis/herfamily members or guardians, treating Physicians and other healthcareproviders. If the Insured Person and his/herhealthcare providerscomply with the Pre-certificationrequirements ofthe Master Policy and this Certificate, and the Treatment or supplies are Pre-certifiedas Medically Necessary,the Company will reimbursethe Insured Personfor

EligibleMedicalExpensesi ncurredinre lationthereto, subject to all Terms ofthis insurance, includingthe Deductibleand Coinsurance. Eligibilityforandpayment of benefitsare subjecttoalloftheTermsof thisinsurance.

(1) SPECIFIC REQUIREMENTS –The followingTreatmentsand/orsuppliesmustalwaysbePre-certifiedforMedicalNecessityby the Company throughthePlan Administrator:

(a) InpatientTreatmentand/or supplies ofany kind.

(b) any Surgery or Surgical procedure.

(c) anyTreatment in an Extended Care Facility.

(d) anyHome NursingCare.

(e) Durable Medical Equipment.

(f) artificial limbs.

(g) ComputerizedAxial Tomography(CAT Scan).

(h) MagneticResonance Imaging(MRI).

(2) GENERALREQUIREMENTS–To complywiththePre-certificationrequirementsofthisinsurancefortheTreatmentsand/or supplies listedinSectionE(1), above, the Insured Person or his/herPhysician or healthcareprovider must:

(a) contact the Company throughthe PlanAdministrator at the telephonenumbersprinted on the InsuredPerson'sID card, as soon aspossible before the Treatmentor supply is to be obtained, as follows:

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

(b) complywiththe instructionsoftheCompanyand submitanyi nformationordocuments requiredby theCompany;and

(c) notifyall Physicians, Hospitals and otherhealthcare providersthat thisinsurance contains Pre-certification requirementsand ask themtofully cooperate withthe Company.

(3) LOSS OF COVERAGE/BENEFITS FOR NON-COMPLIANCEWITH PRE-CERTIFICATIONREQUIREMENTS –IftheInsured Person orhis/her healthcare providersdo notcomply with the foregoingPre-certificationrequirements,allEligible Medical Expensesincurred with respect to said Treatmentsand/or supplies willfirstbe reducedbyfifty 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, andf urther benefits, if any, will beavailable only for the remaining balance of the reduced amount thereafter.

(4) EMERGENCY PRE-CERTIFICATION –In theevent ofanEmergency Hospitaladmission,Pre-certificationmustbecompleted withinforty-eight(48) hours after the admission, oras soon asis reasonably possible.

(5) CONCURRENT REVIEW –ForInpatient Treatmentofany kind,the CompanywillPre-certifyalimited numberof daysof confinementbasedupon thedisclosed medical condition.Thereafter, Pre-certificationmustagain berequestedandapproved if additionaldaysofInpatient Treatmentare necessary.

(6) APPEALPROCESS –If the InsuredPersondisagrees withaPre-certification decisionofthe Company,the InsuredPerson may inwritingask the Companyto reconsiderthe decision andmay supply additionaldocumentationtosupporttheappeal.The Company may reconsider its decision based on review of the additionaldocumentationand facts,ifany. The Company willadvise the InsuredPerson of its decision.

F. UNITEDSTATES PREFERRED PROVIDER ORGANIZATION(PPO)

PPO Information: The Company, throughthe Plan Administrator,endeavors to maintainacontractualarrangementwith one or more independentPreferred Provider Organizations (PPO) that has established and maintains a network of U.S.-based Physicians,Hospitals andother healthcare andhealth service providerswhoare contractedseparately anddirectly withthePPO and who may providere-pricings,discounts or reduced charges forTreatment or supplies providedtotheInsuredPerson.Neither the Company nor the Plan Administratorhas any authorityor controlover the operationsorbusiness ofthePPO, or overthe operationsorbusiness ofany providerwithinthe independentPPO network.Neither the PPO nor any providerwithinthe PPO network norany of their respective agents, employees or representatives has or shall have any power or authoritywhatsoever to act foror onbehalf ofthe Company or thePlan Administratorin anyrespect, including withoutlimitationnopower or authority to: (i) approve Applicationsorenrollments forinitial,renewal or reinstatedcoverage under this insurance plan orto accept Premium payments, (ii)accept risksfororon behalf ofthe Company, (iii) actfor, speak for, orbind theCompanyor the Plan Administratorin

any way, (iv) waive,alter oramend any ofthe Terms of theMaster Policy or thisCertificate orwaive, release, compromiseorsettle any of the Company's rights,remedies, orinterestsThereunder or hereunder, or (v)determine Pre-certification,eligibilityfor coverage, verification of benefits, or make any coverage, benefitorclaim adjudicationsor decisionsofany kind. It is not a requirement of this insurance that the Insured Person seek Treatment or supplies exclusively froma provider withinthe independentPPO network. However, the Insured Person's use ornon-useof thePPO networkmay affect thescope and extentof benefits available under thisinsurance, including withoutlimitationthe applicable Deductible, Coinsurance and Extra Deductible, as setforthabove. An InsuredPerson maycontacttheCompany throughthePlanAdministratorandrequest a PPO Directoryfor the area where the InsuredPerson will bereceiving Treatment (therein listingthe 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 tothe TermsofthisInsurance,includingwithoutlimitationtheDeductible,andthe various limitsand sub-limitssetforthinthe Schedule ofBenefits/Limits contained inSection C, above, and theExclusionsset forth in Section U, below,the Company willreimbursethe InsuredPerson forthe followingcosts, charges andexpenses ("Charges") incurredbythe Insured Person duringthePeriodofCoverage or any applicableBenefit Period withrespecttoan IllnessorInjury suffered or sustained by the Insured Person duringthe PeriodofCoverageand while this Certificate is in effect, solong as the Charges are Usual, Reasonable and Customaryand are incurredforTreatmentor suppliesthatare MedicallyNecessary ("Eligible Medical Expenses"):

(1) Charges incurredataHospital for:

(a) daily roomand board and nursingservices not to exceed theaverage semi-privateroom rate; and

(b) daily roomand boardand nursingservices inan Intensive Care Unit; and

(c) use of operating,Treatmentor recovery room; and

(d) services and supplieswhich areroutinely providedby the Hospital topersonsfor use while Inpatient;and

(e) EmergencyRoom Treatmentof an Injury,even if Hospitalconfinement is notrequired;and

(f) Emergency Room Treatmentofan Illness; howeveran additional$250deductiblewillbe requiredunless theInsured Personis directly admittedtothe Hospital asInpatient for furtherTreatment of that Illness;

(2) Charges incurredforSurgery at an OutpatientSurgical facility,includingservices and supplies;and

(3) Charges byaPhysician forprofessionalservices rendered, includingSurgery; provided,however,that charges by or foran assistant surgeon willbe limitedandcovered atthe rateoftwentypercent (20%) of theUsual, Reasonable and Customarycharge of the primary surgeon; and provided, further,that standby availability of a Physician or surgeon will not be deemed tobea professionalservice and is noteligibleforcoverage; and

(4) Charges incurredfor:

(a) dressings,sutures,castsorother suppliesthatare MedicallyNecessary; and

(b) diagnostic testingusing radiology,ultrasonographicor laboratoryservices (psychometric, behavioraland educational testing are notincluded);and

(c) Implantdevicesthat are Medically Necessary; however any Implantsprovidedby anon-PPOproviderare limitedtopayment of no morethan150% oftheestablished invoice priceand/orlistprice forthatitem.;and

(d) subject to theTerms ofSections T(10)(b), (c) and (d),basic functionalartificiallimbs,eye or larynxor breastprostheses,but not thereplacement orrepair thereof;and

(e) hemodialysis and the Charges by aHospitalforprocessing and administrationofbloodor bloodcomponents, butnotthecost of the actual blood or blood components; and

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

(g) anestheticsandtheir administrationbyaPhysician; and

(h) drugs whichrequire prescriptionby aPhysician forTreatmentof Illnessor Injury,but not forthe replacementof lost,stolen, damaged, expiredor otherwisecompromiseddrugs,and foramaximumsupply ofninety (90) daysofany one prescription;and

(i) care in a licensed Extended Care Facility upondirect transferfromanacute care Hospital;and

(j) Home NursingCare inbedb yaqualified licensedprofessional, providedbyaHomeHealth Care Agency upon directtransfer froman acute care Hospital; and

(k) Emergency Local Ambulance Transport necessarily incurredin connectionwithInjury;and

(l) Emergency Local Ambulance Transportnecessarily incurredin connectionwithanI llness resultingin Hospitalization;and

(m) Accident-relatedDental Treatment and DentalSurgery,as necessary to restore or replace sound natural teeth lost or damaged in anAccident leading to an Injury that is covered under thisinsurance; and

(n) physical therapyprescribedby aPhysician and performedbyaprofessional physical therapist,and necessarily incurred to continue recovery from acoveredInjury or covered Illness; and

(o) MedicallyNecessary rentalof Durable Medical Equipment,uptothe purchaseprice.

(5) Subject tothe Terms ofSection U, Exclusions, subsection 1(e) "War; MilitaryAction"and Section T, subsection2."Terrorism", below,andsubjectalso tothe Deductible,Coinsurance and limitsandsublimits set forthin Section C ofthe Certificate"Schedule of Benefits/Limits,"theCompanywillpay and/orreimbursetheInsured Personupto$50,000fortheEligible Medical Expenses described inSections G.1-4, a-oofthe Certificatearising outof InjuryorIllnessincurred by the InsuredPerson asaresult oforin connection withan act ofTerrorism while this insurance is in effect.

H. EMERGENCY MEDICALEVACUATION BENEFIT -Subject to the applicableMaximumLimitsetforthin theSchedule of Benefits/Limitsset forthin Section C, above, and theother Terms of thisinsurance, includingthe Exclusions set forthinSection T and the Conditions and Restrictions setfor thbelow, the Company will reimburse the Insured Personforthe following transportationcosts, when the Company or PlanAdministrator arrangessuch transportation,andexpenses incurred by the Insured Person arisingout ofor inconnection withan EmergencyMedical Evacuation occurringwhilethisCertificateis in effect and during the Period of Coverage:

(1) Emergencyair transportationtoasuitable airportnearest to theHospital wherethe InsuredPerson willreceive Treatmentorto theirHome Country;and

(2) Emergency groundtransportationnecessarily preceding Emergency air transportationand fromthe destination airporttothe Hospital where theInsuredPerson will receive Treatment or to theirHome Country;and

(3) Return groundand air transportation,uponmedicalrelease by theattendingPhysician, to the country where the evacuation initiallyoccurred or tothe Insured Person's Home Country,at the Insured Person's option.

Conditions and Restrictions - To be eligibleforcoverage forEmergency Medical Evacuation benefitstheInsuredPerson must be in compliancewithallTermsofthis insurance. The CompanywillprovideEmergency Medical Evacuation benefits onlywhen the condition,Illness, Injury or occurrence givingrise to the Emergency Medical Evacuation is covered under the Terms ofthis insurance, subjecttotheprovisionsof subparagraph(f)(ii),below. The Company will provide Emergency Medical Evacuation benefits only when allof the followingconditions and restrictions are met:

(a) MedicallyNecessary Treatmentcannotbe providedlocally;and

(b) transportationby any other means or methods would resultinloss of the InsuredPerson'slifeorlimb based upon a reasonable medicalcertainty;and

(c) Emergency Medical Evacuation is recommendedby the attendingPhysician whocertifies tothe mattersinsubparagraphs(a) and (b),above; and

(d) Emergency MedicalEvacuationisagreed toby the InsuredPerson or aRelativeofthe InsuredPerson; and

(e) Emergency Medical Evacuationisapproved in advance and all arrangementsare coordinatedby the Company;and

(f) the condition,Illness,In jury or occurrence giving rise to the need forthe Emergency Medical Evacuation:

(i) occurred suddenly,Unexpectedly,andspontaneously,and without:(1) advance warning, (2) advance Treatment, diagnosis orrecommendationforTreatment byaPhysician, and (3) priormanifestationofsymptomsorconditionswhich wouldhavecaused areasonablyprudentpersontoseek medicalattentionpriorto theonset of the Emergency, and

(ii) was notaPre-existing Condition;provided,however that ifsuch condition,Illness orInjury is aPre- existingCondition that iseligible for coverage undertheTerms of SectionQ,below,Emergency Medical Evacuation benefits willbe providedupto US $25,000so long aseach and allof otherTerms,Conditionsand Restrictions set forthinthisSection H havebeen satisfied;and

(g) The Company will cover reimbursementfor the above-describedcostsandexpenses and will arrange Emergency Medical Evacuation only to thenearestHospital that is qualifiedto provide the MedicallyNecessary Treatment toprevent the Insured Person'sloss oflifeor limb. The Insured Person may select adifferent Hospital in his/herHome Country at his/heroption,butin suchevent shall retainfortheInsured Person'sown accountand responsibilityallcosts andexpensesin excess oftheamounts that wouldhave been incurredto the nearest qualifiedHospital. If a Hospital otherthanthenearest qualifiedHospital is selected by the InsuredPerson, the attendingphysician,Insured Person,or arelativeof theInsuredPerson shall certifytotheCompanythe Insured Person's understandingandacknowledgementofsuch responsibilityforexcess costs and expenses inaddition tothe matterssetforth in subsections (a) and (b) of the Conditionsand Restrictions, above. In all cases the Company will makethe necessary arrangements fortheEmergency Medical Evacuation, and will use its best efforts toarrange withindependent,third-

party contractorsany Emergency Medical Evacuation withintheleast amountof timereasonably possible.By acceptance of this Certificate and requestfor Emergency Medical Evacuation benefits hereunder, the Insured Person understands, acknowledges and agrees thatthe timeliness,duration,occurrences during,and outcomeofanEmergencyMedical Evacuation can be directly and indirectly affected by events and/orcircumstances which are not withinthe supervision or control ofthe Company, including but not limitedto:the availability,limitations, physical condition,reliability, maintenance andtraining schedules and procedures, and performance or non-performanceof competent transportation equipment,supplies and/orstaffof such third-partycontractors; delaysor restrictionsonflightsor othermodes ormeansoftransportation caused by mechanical problems,governmentofficials, telecommunications problems,non-availabilityof routes, and/orothertravel, geographical orweatherconditions; and otheracts of God and unforeseeable and/oruncontrollableoccurrences. The Insured Person agrees to release and toholdthe Company,the Plan Administratorand theiragents and representatives harmless from,andagreesthat theCompany,thePlanAdministratorand their agents and representatives shall not be held liable or responsible for, any delays, losses, damages, further injuries or illnesses,orany otherclaims thatarise fromor are caused in wholeor inpart bythe acts oromissionsofsuch independentthird-party contractorsortheir agents, employees or representatives, or thatarise fromor are caused in whole or in part by any acts, omissions, events or circumstances that are notwithin the directand immediatesupervision andcontrolofthe Company,the Plan Administratorand/ortheir authorizedagentsandrepresentatives, includingwithoutlimitationtheevents and circumstancesset forthabove. The Insured Person furtheragrees thatuponseeking anEmergency Medical Evacuation, he or she will cooperate fullyas requiredbySection (B)(13). Failureto socooperateand/orfailuretouse oraccept Emergency Medical Evacuationonce it has been arranged by the Company or Plan Administratorwill require the Insured Person to reimburse the Company for costs incurredforany Emergency Medical Evacuation thatwas arranged,butnotused, bytheInsuredPerson. Furthermore,theInsured Person may be requiredtoarrange for paymentofany subsequentEmergency Medical Evacuation andseek reimbursement thereafter for eligible costs associated withthatsubsequent Emergency Medical Evacuation.

I.EMERGENCY REUNION - SubjecttotheTermsof thisinsurance, includingwithoutlimitationtheConditionsandRestrictions set forthbelow,EmergencyReunionexpensesupto$50,000perPeriod of Coverage (and also notto exceed$50,000lifetime maximum)willbe reimbursedto an Insured Person as outlinedin theSchedule ofBenefits/Limitssetforth in Section C, above, in cases where there has beenanEmergency MedicalEvacuationcovered underthe Termsof this insurance.Subject tothe applicable Deductibleand Coinsurance andother limitsandsub-limits as specified inthe Scheduleof Benefits/Limits,andsubject to the Conditionsand Restrictionsset forthbelow,the followingcostsand expenses incurredinrespectoftravel byaRelativeor friend of the InsuredPerson will be reimbursable totheInsured Person upon the recommendationand prior approval of the Company:

(1) the costofaround-trip economyairticketforoneRelative orfriendfrom the airportnearestto the locationoftheRelativeor friend at thetime of the Emergency to the airportservingtheareawhere theInsuredPerson is Hospitalizedas a result of the Emergency oristobe Hospitalizedas aresult of theEmergency Medical Evacuation (tobe determinedpursuanttothe Terms of subsection (c) oftheConditions and Restrictions,below), and returnfromwhichever of such locationsisactually selected tothe point of the original departure; and

(2) reasonable and necessary travel costs,meals (maximum of $25 per day), transportationand accommodationexpenses incurredin relationtothe EmergencyReunion(butexcluding entertainment).

Conditions and Restrictions:

(a) The allowableperiodofcoverage fortheEmergencyReunion shallnotexceed fifteen(15) days, includingtraveldays, and all costsandexpenses incurredbeyondsuch periodofcoverage shall beretained for the sole account and responsibilityofthe Insured Person, Relative, or friend;and

(b) the Emergency Reunion mustbe duet oan Emergency Medical Evacuation coveredunderthe Termsof thisinsurance;and

(c) the InsuredPerson mustbe so seriouslyill thatthe attendingPhysician deemsitnecessary and recommendsthepresence of aRelative or friendat eitherthe location where the Insured Person is being evacuated fromor thedestination ofthe evacuation, whicheveris consideredbytheattendingPhysician and the Companytobethe morereasonable;and

(d) all EmergencyReunion travel,transportation and accommodationarrangements and benefitsmust be coordinated and approvedin advanceb ytheCompanyinorder tobe eligiblefor coverage underthis insurance;and

(e) The InsuredPerson, Relativeand/orf riendmustsubmittothe Company upon completionofthe EmergencyR eunion travel legible and verifiable copies of all paidreceiptsforthetravel and transportationcosts and expenses so incurred for which reimbursementissought.

J.RETURN OF MORTAL REMAINS - IntheeventofthedeathoftheInsuredPersonduringthePeriodofCoverageas aresult of an Illnessor Injurycovered underthisinsurance while theInsured Person is outsideof his/herHomeCountry,theCompany will reimbursetheestateofthe InsuredPerson uptoUS $50,000forthecostsandexpensesincurred to returntheInsuredPerson's Mortal Remains to his/herHome Countryand thereaftertotheplace ofburial orother finaldisposition(butnot includinganycosts of burialor otherdisposition); provided,however, that the Company must coordinate and approveall costs and expenses related to the returnofthe InsuredPerson's MortalRemains in advance asacondition totheavailabilityofthis benefit.

K. POLITICAL EVACUATION AND REPATRIATION -Ifthe UnitedStates DepartmentofState,Bureau ofConsularAffairsor similargovernment organizationof the Insured Person's Home Country orders theevacuation ofall non-emergencygovernment personnelfrom the HostCountry, due topoliticalunrest,that becomeseffective on or after theInsured Person's date ofarrival in

the HostCountry, the Companywillpay uptoUS$10,000 lifetimemaximumfortransportationtothe nearest place of safety orfor repatriationto the Insured Person's home country or countryof residenceprovided that:

(1) theInsured Personcontacts theCompany within10days oftheUnited StatesDepartment ofState, Bureau ofConsularaffairs or similar government organizationof the Insured Person's Home Country issuing the evacuation order; and

(2) the evacuation orderpertainstopersonsfromthe same HomeCountryastheI nsuredPerson; and

(3) PoliticalEvacuationand Repatriationisapproved and coordinatedby the Company;

In noeventwill the Companypay foraPolitical Evacuation if thereisaTravel Warning in effectonorwithin six(6) monthspriorto the Insured Person's date ofarrival inthe Host Country. This coverage willprovidethemostappropriateandeconomical means of travel consistent under the circumstances with the Insured Person's health and safety.

L. ACCIDENTALDEATH AND DISMEMBERMENT BENEFIT

(1) Accidental Death –Subject tothe Terms ofthisinsurance, includingall ofthe Exclusions containedinSection U, intheevent of the Unexpected death ofan Insured Personduring thePeriod of Coverage as aresultof covered Injurythat was suffereddue to an Accidentthat occurredduringthePeriod of Coverage, regardlessofwhether ornotaclaimfor medical expenses is submitted, theCompany willpay totheInsured Person's estate ortotheInsured Person's designatedbeneficiaryan AccidentalDeath benefit in theamount of $25,000.

(2) Dismemberment–Subject to theTerms ofthisinsurance, includingall oftheExclusions containedinSection U ,intheevent of an Unexpected dismemberment/losssufferedbyan InsuredPerson, asdetailed below,duringthe Periodof Coverage as a result of acoveredInjuryor Illness thatwas sufferedddueto anAccident that occurredduringthePeriod ofCoverage,theCompany will pay to theInsuredPerson the applicable loss/dismembermentbenefitas specified below.

Loss	Benefit
Sightofone Eye	$12,500
One handor one foot	$12,500
One handandthe loss of sightof one eye	$25,000
One foot and the loss of sight of one eye	$25,000
One handand one foot	$25,000
Both handsor bothfeet	$25,000
Sight ofboth eyes	$25,000

The maximumbenefitpayable forall dismembermentorlosses resultingfromany one Accidentor Injuryshall notexceed $25,000. The lossofahand or footmeans the completeseverance at orabove the wristor ankle joint. The loss of sightmeans the entire and irrecoverable loss of sight.

The Accidental Death and Dismembermentbenefits will be paid to the Insured Person ortotheInsured Person's estate or designated beneficiary, asthe case may be, uponproperapplicationtherefor.

M. COMMON CARRIER ACCIDENTALDEATHBENEFIT –Subject to theTermsof thisinsurance,includingthePre-Existing Conditionsexclusion as defined herein, inthe event of theUnexpected death ofan Insured Person duringthe Periodof Coverage as aresultof an Injurythatwas sufferedddue toa nAccidentthatoccurredduringthe Period of Coverage and whilethe Insured Person was travelingon a Common Carrier, the Company will payt otheInsuredPerson'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 maximumof $250,000per Familyinvolved in thesame Accident.

N. TRIP INTERRUPTION –Subject tothe limitsset forthinthe Schedule of Benefits/Limits,inthe event oftheUnexpecteddeath of aRelativeof theInsured Person, orinthe event the Insured Person's triportravelplans mustbe cancelled orinterruptedas a resultofabreak-in or substantialdestructiondue to a fire or Natural Disaster of an Insured Person's principal residence inhis/her Home Country,the Companywill reimbursethe InsuredPerson'sactual expense upto US $5,000forthe costs ofaone-wayairor groundtransportationticketofthe same class asthe unusedtravel ticket toreturnan InsuredPersonfrom the Internationalairport nearest towhere the Insured Person was locatedatthetimeoflearningofsuch death or destructionto the Internationalairport nearest to:(i) thelocation of the funeralor place of burialin the case of the Unexpecteddeath ofaRelative, or (ii) the Insured Person's principal residence in the caseofsubstantial destructionthereof; subject to the followingconditionsand limitations:

(1) The Insured Person must be outside of his/herHome Country at the time oftheUnexpected death of the Relativeorthe substantialdestructionoftheprincipal residence; and

(2) The Unexpected death ofthe Relative or the substantialdestructionofthe residence musthave occurred duringthe Periodof Coverage; and

(3) The Company will deduct fromtheTrip Interruptionbenefitspayable hereunder the value, if any, of the unused return ticket held bythe Insured Person at the timeof thedeath ordestruction,whichvalue the Insured Person mustat temptto receive credit for or apply towards the costs of the return trip.

The Companywill notprovide any benefits, reimbursementsor coverage forany ofthe costs orexpenses incurredby the Insured Person for are-returntrip,if any, to the originallocation ofthe Insured Person at the timeoflearning ofsuch death or destruction.

O. LOST LUGGAGE -Subject tothe limitsset forthin the Schedule ofBenefits/Limits,theCompany willreimbursethe Insured Person for the cost of lost checked luggage when such luggage was permanently lost in transitby a Common Carrier during the Period of Coverage, subject to the followingconditions:

(1) The Insured Person must submitto the Companyacop yoftheCommon Carrier's claimform andsuch otherdocumentation as the Company may reasonably require to prove thatthe Insured Person's luggage was permanentlylost;and

(2) The CommonCarrier musthavefirstrei mbursed theInsured Person the fullamountthat it islegally required to pay for lost checked luggage, andproofofsuch reimbursementshallbe providedto the Company by the Insured Person. Lost Luggage benefitsunder thisinsurance will be providedonlyif andto theextenttheamountofthe InsuredPerson'sloss sufferedas aresult of lost checked baggage exceeds any such reimbursement by the Common Carrier (and subject to the limits setfor th inthe Schedule of Benefits/Limits).

P. DENTALEMERGENCY-Subjectto thelimitssetforthintheSchedule ofBenefits/Limits,theCompanywillpayuptoUS$100 for the Treatment andrelief of Unexpected pain to sound natural teeth.

Q.SUDDEN AND UNEXPECTED RECURRENCE OF A PRE-EXISTING CONDITION. SubjecttotheTermsofthisinsurance, includingwithoutlimitationtheExclusions set forthin SectionU, the Conditionsand Restrictionsset forthbelowand theapplicable Deductible and Coinsurance and other limitsand sub-limitsas specified in theSchedule ofBenefits/Limits set forthin Section C, above, intheeventtheInsuredPerson suffersor experiencesan UnexpectedrecurrenceofaPre- existingConditionduringthe Period of Coverage forwhichimmediateTreatmentis essential and necessary tostabilize thePre-existingCondition,the Insured Person will be reimburseduptо US$5,000 forEligible Medical Expenses incurredduring the Period ofCoverage withrespect to the Unexpectedrecurrence of the Pre-existingCondition.

ConditionsandRestrictions -Tobeeligible fortheforegoing limitedcoverage andbenefits foran UnexpectedrecurrenceofaPre-existingCondition,the Insured Person must be incompliance with allTerms of thisinsurance. The Company will providesuch coverageand benefitsonly when all of the followingconditions and restrictions have been met. At the time of the Unexpected recurrence of the Pre-existingCondition:

(1) The Insured Person must notbetravelingagainst orin disregardof the recommendations,establishedTreatmentprograms,or medicaladvice ofaPhysician or otherhealthcare provider;and

(2) The Insured Person must notbetraveling with the intent orpurpose toseekor obtain Treatmentfor thePre-existingCondition; and

(3) The Insured Person must notbetraveling during aperiodoftimewhen the Insured Person is preparingor waitingfor,involved in, or undertakinganew,changed or modifiedTreatment programwith respect to the Pre-existingCondition, and is nottraveling subsequenttoany suchnew,changed or modifiedTreatmentprogramhavingbeen advisedorr ecommended;and

(4) The Pre-existingConditionmust have been stabilized forat least thirty(30) daysprior to the Effective Date withoutchange in Treatment;and

(5) The InsuredPerson mustbetraveling outsidetheir Home Country.

R. RETURN OF MINOR DEPENDENT CHILDREN -Subject totheTermsofthisinsurance,intheevent theInsuredPersonis hospitalizedas anInpatient duringthe Period ofCoverageduet oan Injury orIllnesssuffered duringthe Period of Coverage and eligible forcoverage underthe Terms of the plan, and at thetime ofsuch hospitalizationtheInsured Person is travelingalonewith aDependentChildorChildren, theCompanywillreimbursetheInsured Person'sactual expense uptoU.S. $50,000forthecosts ofone-wayeconomy airfare toreturnthe DependentChild orChildren totheirHome Country,includingsuch costs forachaperone if necessary forthe safety of the Dependent ChildorChildren,subject to the followingconditionsandlimitations:

(1) The InsuredPerson must be outside the Home Country at thetimeof the hospitalizationas an Inpatient; and

(2) The return ofthe Dependent Child or Children must occur duringthe hospitalization;and

(3) Reimbursable costs are only for one-wayeconomy airfares fromthe Internationalairportnearest towherethe Dependent Child or Children were located at the time of theInsured Person's hospitalization,to the Internationalairport nearest to the Dependent Child'sor Children'sprincipalresidence inthe 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 inalocation, post, area, territoryor countryfor which the United States Departmentof State, Bureau of ConsularAffairsissuesaTravel Warning thatbecomes effectiveorisineffect onor afterthe InsuredPerson's date of arrival in said location, post,area,territory or country,and theInsuredPerson unreasonably failsor refuses to heed such warningand thereafterremainsinsaid location,post, area,t erritoryor country.

(3) Pre-existing Conditions -Charges arisingorresultingdirectlyor indirectlyfromorrelatingtoany Pre-existingCondition,as herein defined, except forasprovided forin Section Q,above; and

(4) Maternity and NewbornCare -Chargesfor pre-natalcare, delivery,post-natalcare, and care of Newborns,including complicationsofPregnancy, miscarriage, complicationsof delivery and/orcomplicationsof Newborns; and

(5) Charges forTreatmentof Mental or Nervous Disorders;and

(6) Charges for any Treatmentor suppliesthat are:

(a) not incurred,obtainedor received by an InsuredPerson duringthe Period of Coverage;and/or

(b) not presented to the Company for payment by way of acompleteProofofClaim withinninety (90) days ofthe date such Charges are incurred;and/or

(c) not administeredor orderedbyaPhysician; and/or

(d) notMedicallyNecessary;and/or

(e) providedat no cost totheInsured Person orforwhichthe Insured Person is nototherwiseliable; and/or

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

(g) incurred byan Insured Person who was HIV +on orbefore the Effective Date of this insurancerelating toorarisingorresulting directly orindirectlyfromHIV, AIDS virus, AIDS relatedIllness, ARC Syndrome, AIDS and/orany otherIllness arisingor resulting fromanycomplicationsor consequences ofanyof the foregoingconditions;whether ornot theInsured Person had knowledgeof his/herHIV statusprior totheEffective Date, and whetherornotthe Charges are incurredin relationto or asaresult of said status; and/or

(h) provided by or at the directionor recommendationof achiropractor, unlessordered in advance by aPhysician; and/or

(i) performedorprovided by a Relative ofthe Insured Person; and/or

(j) not expressly includedas Eligible MedicalExpenses as defined in Section F, above; and/or

(k) providedby aperson who resides or has resided withtheInsured Person or intheInsured Person'shome; and/or

(l) requiredorrecommendedas a resultofcomplicationsorconsequences arisingfromorrelated toany Treatment,Illness,Injury, or supplyexcludedfrom coverage or which isotherwise not covered under this insurance; and

(m) for Congenital Disorders and conditionsarising out of or resultingthere from;and

(7) Charges incurredfortelephoneconsultationsexcept Telemedicine consultationsthroughanestablished Telemedicine protocolsystem will beconsidered individuallybased on medicalnecessity and appropriatenessas determinedbythe Companyunder the plan;and

(8) Chargesincurredduetoaf ailuretokeepas cheduledappointment;and

(9) Charges incurredforSurgeriesor Treatmentor supplieswhich are:

(a) Investigational,Experimental, or forresearch purposes, and/or

(b) related togeneticmedicine, genetic testing,surveillancetesting and/orwellnesssc reening procedures for genetically predisposed conditionsindicated by genetic medicineorgenetictesting, including,but notlimited to amniocentesis, genetic screening, riskassessment, preventive andprophylacticsurgeries recommendedby genetic testing,and/oranyproceduresused to determine pre-disposition,provide genetic counseling, or administrationof genetherapy; and

(10) Charges incurred while confinedprimarilyto receive Custodial Care, EducationalorRehabilitative Care; and

(11) Charges incurredforany surgery,Treatmentor supplies relatingto, arisingfromorin connectionwith,for,oras aresultof:

(a) weight modificationorany Inpatient, Outpatient, Surgical orotherTreatment of obesity (including withoutlimitationmorbid obesity), includingwithoutlimitationwiringoftheteeth and all formsorprocedures ofbariatricSurgeryby whatevername called, or reversal thereof,including withoutlimitationintestinal bypass, gastric bypass, gastricbanding, verticalbanded gastroplasty, biliopancreaticdiversion, duodenal switch, or stomach reduction or stapling; and/or

(b) modificationof the physical body in order tochange or improveorattempttoc hange or improvethe physical appearance or psychological, mental or emotionalwell-beingof the Insured Person (such as but not limitedtosex-changeSurgery or Surgery relating to sexual performance or enhancement thereof); and/or

(c) electiveSurgery or Treatmentof anykind; and/or

(d) cosmeticor aesthetic reasons, exceptforreconstructiveSurgerywhen suchSurgeryisMedicallyNecessary and isdirectly relatedtoandfollowsaSurgery whichwas covered underthisinsurance;and/or

(e) any IllnessorInjury sustained while taking part in: Amateur Athletics, Professional Athleticsandadventure sports and activities, including, withoutlimitation the following (including any combination or derivative ofthe following): abseiling; mountaineeringactivities wherespecialisedclimbing equipment,ropesor guidesare normallyor reasonably shouldhave been used;athletic or sportingactivities (except foractivitiesthatare non-contact,non-professional,and engaged in by You solely for recreational, entertainmentorfitnesspurposes); aviation(except whentravellingsolelyasapassenger in a commercialaircraft); motocross(MOTO-X); BMX;BASEjumping;bobsledding; bungeejumping; canyoning;,caving; hanggliding; heli-skiing;high diving; hot air ballooning;inlinesk ating; jet skiing; jungle zip lining; kiteboarding; kayaking; luge; mountainbiking; parachuting; paragliding; parascending; rappelling;racing ofany kind including by horse, motor vehicle (of any type) or motorcycle;rock climbing;any rodeoactivity;ski jumping;skydiving; snowskiingexcept forrecreationaldownhill and/orcross countrysnowskiing (no cover provided whilst skiinginviolation of applicable laws, rules or regulations; away from prepared and marked in-bound territories;and/or against the advice of thelocal ski school orlocal authoritative body;snowboarding; snowmobiling;spelunking; surfing; trekking;whitewater rafting;windsurfing; wildlifesafaris; and subaqua pursuitsinvolving underwater breathing apparatus below adepthof 10 meters. Practice or traininginpreparation forany excluded activitywhich resultsinInjurywillbe considered as activity while taking part in suchactivity and/or

(f) any Illness or Injurysustained while participatingin any sporting,recreational or adventureactivity where such activityis 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 governingbody for the sport or activity; and/or

(g) any IllnessorInjury sustainedwhile participatinginanyactivity where such activityisundertakenin disregardoforagainstthe recommendations,Treatmentprograms,or medicaladvice ofaPhysicianorother healthcare provider;and/or

(h) any Injury or Illnesssustainedasaresult of being under the influenceof or due whollyor partlyto the effects of intoxicating liquor or drugs other thandrugs taken in accordance with Treatment prescribed and directedb y a Physician butnot for the Treatment of SubstanceAbuse; and/or

(i) any Injury or Illnesssustained while operatingamoving vehicle after consumptionofintoxicating liquoror drugs other than drugs takeninaccordance withTreatmentprescribed anddirectedby a Physician.Forpurposes ofthisexclusion,"vehicle"shall includemotorized devices regardless of whether or notadriveroroperator license is required(includingwatercraftand aircraft) and non-motorizedbicyclesandscooters for which nopermitorlicense is required; and/or

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

(k) anyvenerealdisease; and/or

(l) any testing forthef ollowing:HIV, seropositivitytothe AIDS virus,AIDS relatedIllnesses, ARC Syndrome, AIDS; and/or

(m) any Illness orInjury resultingfromoroccurringduringthe commissionofaviolationoflawby theInsured Person, including, withoutlimitation,theengaginginanillegal occupationoract, but excludingminortraffic 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 eyetr aining; and/or

(q) any Illnessor Treatment of thefeet, including withoutlimitation:orthopedicshoes; orthopedic prescriptiondevices tobe attached toorplaced in shoes; Treatment ofweak, strained, flat, unstable orunbalanced feet;metatarsalgia, bonespurs, hammer toes or bunions; and anyTreatment or supplies forcorns, calluses or toenails; provided,however, that claimsfor Treatment or suppliesforthefeet may be eligible for coverage under thisi nsurance at the sole optionof the Company and subjecttoall other Terms of thisinsurance when related to:

(i) an Injury tothe footarising fromanAccident covered hereunder; or

(ii) an Illness for whichfootSurgery is Medically Necessary and determinedto be theonly appropriatemethodof Treatment;and/or

(r) hair loss, including withoutlimitationwigs, hair transplantsor any drug that promisestopromote hairgrowth, whether or not prescribed by a Physician;and/or
(s) any sleep disorder,including withoutlimitationsleep apnea; and/or

(t) any exercise program,whetherornot prescribed or recommendedby aPhysician; and/or

(u) any exposure to any non-medicalnuclear or atomic radiation, and/orradioactivematerial(s); and/or

(v) any organ or tissue orother transplantor related services, Treatment or supplies;and/or

(w) any artificial or mechanical devices designed to replacehuman organs temporarilyor permanently;and/or

(x) any effortstokeep adonoraliveforatr ansplantprocedure;and/or

(12) Charges incurredforany Treatment orsupply that either promotesor prevents or attempts topromote orprevent conception or birth;including butnot limitedto: artificial insemination; oral contraceptives, Treatment for infertility or impotency; vasectomy or reversal of vasectomy; sterilizationor reversal of sterilization;surrogacy;orabortion; and

(13) Charges incurredforany Treatmentorsupplythateither promotes,enhances orcorrectsorattempts topromote,enhance or correct impotency or sexual dysfunction; and

(14) Charges incurred forDental Treatment,except forAccident-relatedDental TreatmentandDental Surgerynecessaryto repair or replace sound naturalteeth lostor damagedin an Accident leading toan Injurycovered hereunder,or as necessary treatment of sudden, unexpected pain to sound naturalteeth, and subject tothe limitsset forthinthe Schedule of Benefits/Limits;and

(15) Charges incurredforeyeglasses, contact lenses, hearing aids, hearingimplantsand Charges foranyTreatment, supply, examinationorfittingrelated tothese devices, or foreyeref raction forany reason; and

(16) ChargesincurredforeyeSur gery,such asbutnot limitedtoradialkeratotomy,when theprimary purpose is to correct or attempt to correct nearsightedness, farsightedness, or astigmatism; and

(17) Charges incurredforTreatment of the temporomandibularjoint;and

(18) Charges incurredforanyimmunizations and/orRoutine Physical Exams; and

(19) Charges incurred for anytravel, meals, transportationand/oraccommodations, exceptas otherwiseexpresslyprovidedforin this insurance; and

(20) Any taxes, involuntaryor forcedcontributions,assessments, charges, feesor surcharges imposed by any governmental agency or authority:

(a) arisingoutoforas aresultof any Treatmentorsuppliesreceived by theInsuredPerson,or

(b) basedupon the Company's electionhereunder,if any,topay benefits directlytoprovidersasanaccommodation to the Insured Person, or

(c) for any other reason; and

(21) Charges or expenses incurred for nonprescription drugs, medicines, vitamins, foodextracts, or nutritionalsupplements; IV vitaminor herbal therapy;drugsor medicines not approved by the U.S. Foodand DrugAdministrationor which are considered "off-label"druguse;andfordrugs or medicinesnot prescribedbyaPhysician.

(22) Charges incurredforTreatmentinthe Insured Person's Home Countryexcept as expresslyprovidedforinthis insurance.

(23) Charges incurredforIllnessor Injury where thetrip to the Host Countryis undertakenforthepurpose of securing medical treatmentof advice for such IllnessorInjury.

(24) Charges first incurred forIllnessor Injury beyond the MaximumTripDuration.

V. DEFINITIONS -Certain wordsand phrases used inthis Certificateare definedbelow. Other wordsand phrases maybe defined elsewhere in thisCertificate, includingwhere they arefirst used.

Accident:AnUnexpected occurrencecaused by external,visible means and resultingin physicalI njuryto the Insured Person.

AIDS.: Acquired ImmuneDeficiency Syndrome, asthat termis defined by the United States Centers for Disease Control.

Amateur Athletics: An amateuror othernon-professionalsporting,recreational,orathleticactivity thatis organized,sponsored and/orsanctioned, and/orinvolves regular or scheduled practices, games and/orcompetitions (collectively,"or ganized athletic activities"). Thisdefinition doesnot include non-organizedathleticactivitiesthat are non-contactand engaged in by the Insured Person solely for recreational, entertainmentor fitness purposes.

Application: The fullyanswered and signedindividual or Family Application/enrollmentformsubmittedbyor onbehalfofthe Insured Person for acceptanceintothis insurance plan, which Applicationshallbeincorporatedinandbecome part of this Certificate. Any insurance agent/brokeror other person or entityassigned to, soliciting, or assisting with the Applicationis the agent and representativeofthe applicant/InsuredPerson and is not andshall notbedeemed or consideredas an agent or representativefororonbehalf of the Company or the Plan Administrator.

ARC: AIDSrelated complex,asthat termis defined by the United States Centers for Disease Control.

Assured: The GlobalMedicalServices GroupInsuranceTrust, c/oMutualWealthManagementGroup, Carmel, IN.

Benefit Period:Ifa covered Injury or Illness requires continuingTreatmentafter the expirationof thePeriod ofCoverage, a supplemental BenefitPeriod may provide continuingcoverage forthe covered InjuryorIllness foruptothirty(30)continuousdays, not to exceed $5,000, subject to the following:when thePeriod of Coverageexpires while a covered Injury or Illness requires continuingTreatment, the Company will review anddetermine the date of initialTreatment forthe covered Injury orIllness, and if suchdate is lessthan thirty(30)dayspriortothe expirationofthe Periodof Coverage, benefitsforthe covered InjuryorIllness will continue untilthere has beenat least thirty(30) days ofcontinuous coverage forthe covered InjuryorIllness, subjectto the limits and sub-limitssetforthin the Schedule of Benefits/Limits,and subject toallother Terms oftheplan.

Certificate:Thisdocument, includingany Riders, asissued tothe InsuredPerson, whichdescribes andprovidesan outlineand evidence ofeligibleinsurancecoveragesand benefitspayable to orforthebenefit ofthe InsuredPersonunder the MasterPolicy. The Applicationand the Declaration are incorporatedherein by this referenceandmade apartthereof.

Coinsurance: The paymentby orobligationsoftheInsured Personf orpayment ofEligible Medical Expenses at the percentage specified intheSchedule of Benefits/Limitscontained herein, and exclusiveof the applicable Deductible.

Common Carrier: A company or organizationthatholds itself out to the public as engaging in the business of transporting persons fromplace toplace by air, rail, busand/or sea for compensation,offeringits scheduled services to the publicgenerally, and is licensed by a recognized and approved government authority to transportfare-paying passengers.The term Common Carrier does not includetaxi, motorcar, motorcycle, or limousine services, or transportationby animalorhuman means (for example, by horse, camel,elephant orrickshaw).

Company: The "Company," as referredtoin the Master Policy and this Certificate,is Sirius InternationalInsurance Corporation (publ), headquarteredin Stockholm,Sweden. This insuranceand its risks are underwrittenbytheCompanyas the insurerand carrier,andthe Companyis solely obligatedand liable forthe coverages and benefitsprovided by thisinsurance.

Congenital Disorder: Physical abnormalitythatis presentatbirth.

Custodial Care: Those types ofTreatment,care orservices, wherever furnishedand bywhatevername called, thatare designed primarily to assist an individual in activities of daily life.

Declaration: The DeclarationofInsurance issuedbythePlanAdministratorforandonbehalf of the CompanytotheInsured Person contemporaneouslywiththis Certificate evidencingtheInsured Person's insurance coverage under theMaster Policy as evidenced bythisCertificate, which Declarationshall beincorporated inandbecome apartof thisCertificate.

Deductible: The dollaramountofEligible Medical Expenses, as selected on theApplicationand specified intheDeclaration,that the Insured Person mustpay per Period ofCoverage priortoreceivingbenefitsor coverages underthisinsurance,ande xclusive of Coinsurance.

Dental Treatment: Treatmentor supplies relatingto thecare, maintenance orrepairofteeth,gums orbones supportingtheteeth, including dentures and preparation for dentures.

Dependent Child:Anaturaloradopted child of the namedInsured Person orthenamed Insured Person's spouse, who is unmarried and livingwith the named Insured Person and/orsuch Spouse, who is under the age of 18 years old butolder than14 daysandotherwise eligibleforthis insurancepursuant to Section D, and who hasbeenproperly listedandidentified onthe Applicationand forwhomtheproperPremium hasbeen timelypaid.

Disabled:Aperson whohas acongenital oracquired mentalor physicaldefectthat interfereswithnormalfunctioningofthebody system or the ability to beself-sufficient.

Durable Medical Equipment (DME):Durable Medical Equipmentshall mean exclusivelythefollowingitems:astandardbasic hospitalbed;and/orastandardbasic wheel chair.

Educational orRehabilitative Care: Care forrestoration(byeducation ortraining)of aperson's abilityto functionina normalor near normal manner followingan Illness orInjury. This type of care includes, but is not limitedto, vocational or occupational therapy, and speech therapy.

Effective Date; Effective Date of Coverage: The date coverage fortheInsured Personbegins undertheTermsoftheMaster Policyasevidenced by thisCertificate, as indicatedon the Declaration.

Eligible Medical Expenses: AsdefinedinSection F, above.

Emergency:Amedicalcondition manifestingitselfby acute signsor symptomswhich could reasonably result in placingthe Insured Person's lifeor limbindangerif medicalattentionis notprovidedwithintwenty-four(24) hours,based uponareasonable medicalcertainty.

Emergency Medical Evacuation: Emergency transportationfromthe Hospital or medical facilitywhere the Insured Person is located toanon-localHospitalor medical facility,recommended bythe attendingPhysician who certifiestoareasonable medical certaintythatthe Insured Person hasexperienced

- amedical conditionmanifestingitself byacute signs or symptomswhich could reasonably result inplacing theInsured Person'slife or limbindanger ifmedical attention is not providedwithintwenty-four(24) hours; and
- where MedicallyNecessaryTreatment cannotbeprovided locally,either in the facilityof the attendingPhysicianor anotherlocalfacility.

EST: UnitedStates Eastern Standard Time.

Experimental:Any Treatmentthatincludescompletelynew,untested drugs, procedures,or services, ortheuse ofwhich isfora purpose other than the use forwhich they have previouslybeen approved;new drugprocedure or service combinations;and/or and/or alternativetherapies which are not generallyacceptedst andards of current medical practice.

Extended Care Facility:Aninstitution, oradistinctpartofan institution,whichislicensedas a Hospital,ExtendedCare Facilityor rehabilitationfacilityby the stateorcountry inwhich itoperates; and is regularlyengaged in providing24-hourskillednursingcare underthe regularsupervisionofa Physician and the directsupervisionofaRegistered Nurse; andmaintainsadaily recordon each patient;and provideseach patientwith aplannedprogramofobservationprescribed byaPhysician; and provideseach patientwithactive Treatmentofan Illness orInjury.Extended Care Facility doesnot includeaf acilityprimarilyforrest, the aged, SubstanceAbuse, Custodial Care, nursingcare, or forcare of Mental or Nervous Disordersorthementally incompetent.

Family:AnInsured Person andhis/herspouse whois covered asan insuredpersonunderthisinsuranceplanandhis/hernatural Child or Childrenwho are under the age ofeighteen (18) andcovered asinsuredpersons under thisinsurance plan.

HIV: HumanImmunodeficiency Virus, asthat termis 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:ForU.S. citizens,theHomeCountryis theUnitedStates. For non-U.S.citizens,theHomeCountryis thecountry of which the InsuredPerson is acitizen ornational; includingany countrywhere the InsuredPersonmaintains his/herprimary residence or usual place ofabode and any countryofwhich the Insured Person isthepossessor ofavalidlyissued passport. In the event there ismorethanonehome countryunder the above-listedcriteria,theHome Countryis thecountry meetingthe above-listedcriteriaand listedbytheInsuredash isor her Home Countryon the Application.

Home Health Care Agency:Apublic orprivateagency orone ofitssubdivisions,whichoperatespursuanttolaw;andis regularly engaged in providingHome Nursing Care under the supervisionofaRegistered Nurse; and maintainsadailyrecordon each patient; and provideseach patientwithaplannedprogramofobser vation and Treatmentprescribed by a Physician.

Home NursingCare: Servicesand/or Treatmentprovidedby a Home Health Care Agency and supervised by a Registered Nurse, whichare directedtowardthe personalcare of apatient,providedalways that such care is Medically Necessary and inlieu of MedicallyNecessary Inpatient care, and not primarilyfor Custodial Care or rehabilitativepurposes.

Hospice: Aninstitutionwhichoperates asahospice;andislicensed by the state or countryin whichit operates;andoperates primarilyforthe reception,careandpalliative controlofpain forterminallyillpersonswho have, as certifiedby a Physician,alife expectancy of not more than six (6) months.

Hospital: Aninstitutionwhichoperatesas a hospitalpursuantto law; and is licensedb ythe state or countryin whichitoperates; and operates primarilyfor the reception, care, and Treatment of sickorin juredpersons asIn patients;and provides 24-hour nursingserviceby RegisteredNurses ondutyor call;andhas astaf fof one ormore Physiciansavailable atall times;andprovides organizedfacilities and equipment for diagnosis and Treatment of acute medical, surgical or mental/nervousconditionsonits premises; andisnot primarilyalong-term care facility,Extended Care Facility,nursing, rest, Custodial Care, or convalescent home,aplace forthe aged, drug addicts or abusers, alcoholics or runaways; or similarestablishment.

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

Host Country: The countryor countriesother thanthe Home CountrythattheInsuredPe rson is travelingto/in.

Illness:Asickness, disorder,illness,pathology,abnormality,malady,morbidity,affliction,disability,defect, handicap,deformity, birthdefect, congenital defect, symptomatology,syndrome, malaise, infection,infirmity,ailment, disease ofany kind,orany other medical, physical or health condition. Provided, however, that Illness does not include learningdisabilities, or attitudinal or disciplinaryproblems. AllIllnessesthat exist simultaneouslyor which arise subsequenttoa priorIllness and which directlyor

indirectlyrelate toorresult or arisef rom the same orr elated causes or asaconsequence thereofor fromone anotherare considered tobeoneIllness. Further,ifa subsequentIllness results orarises fromcauses orconsequences thatare thesame as or relatedtothecauses orconsequences ofaprior Illness, thesubsequentIllness willbe deemed tobea continuationoftheprior Illness and notaseparateIllness.

Injury:Bodily injuryresultingorarising directlyfromanAccident. All Injuriesresultingorarising fromthe sameAccidentshall be deemedtobeoneInjury.

Inpatient: A personwho is an overnightresident patientofaHospital, using and being charged forroom and board.

Insured Person: The personnamed asthe InsuredPerson on theDeclaration.

Intensive Care Unit: A cardiac careunitorother unitor area of aHospitalthatmeetsthe requiredstandardsof theJoi nt Commissionon AccreditationofHealthcare OrganizationsforSpecial Care Units.

Investigational: Treatment thatincludes drugs not yet released for distributionby the US Food and Drug Administrationand/or proceduresor services whicharestill inthe clinical stages of evaluation.

Local Ambulance Transport; Local AmbulanceExpense: Transportationandaccompanyingcare providedby designated professional emergencypersonnel fromthelocation ofan accident or acute illness toaHospitalorother appropriatehealthcare facility. Local ambulance transport doesnotinclude subsequent inter-facilitytransfers of admittedpatients.

Master Policy: The applicable MasterPolicy forAccess HMO Gold Internationalmedicalinsurance forcitizenstravelingoutsideof theirHome Country,asissued on an annual basis by the Companytothe Assured, and under which insurance coverage and benefits are providedby the Company to theInsured Person, subject tothe Terms thereof,and as outlinedand evidencedbythis Certificate and subjectto the Terms hereof.The Company,asinsurancecarrier and underwriterof the Master Policy, issolely liable and responsible for the coverages and benefitsprovidedthereunder.

Maximum Limit: The cumulativetotal dollaramountof benefitpaymentsand/orreimbursementsavailable to an Insured Person under this insurance duringthe Insured Person's PeriodofCoverage. When the MaximumLimitis reached, no furtherbenefits, reimbursementsor payments will be availableunder this insuranceduring the Insured Person's Period of Coverage.

MedicallyNecessary; MedicalNecessity:ATreatment, service,medicineorsupplywhichisnecessaryand appropriatefor the diagnosis orTreatmentofan Illness orInjurybased on generally accepted standards ofcurrentmedical practice as determinedby the Company.By way of examplebut not limitation,a service,Treatment, medicine or supply will not beconsidered Medically Necessary or aMedicalNecessityifit isprovided or obtainedonlyas aconvenienceto theInsuredPerson or his/herprovider; and/orif it isnotnecessary or appropriateforthe Insured Person's Treatment, diagnosis or symptoms;and/orif it exceeds (in scope, durationorintensity) thatlevel ofcare whichis needed toprovide safe, adequate, and appropriatediagnosisorTreatment.

Mental or Nervous Disorders: Any mental, nervous, or emotionalIllness 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 bysocially deviant behavior. Mental or Nervous Disorders include withoutlimitation:psychosis; depression; schizophrenia; bipolar affective disorder; learning disabilities and attitudinalordisciplinary problems;any disease or condition,regardless of whether thecause is organic,thatisclassified as a Mental Disorder in thecurrent editionofthe International Classification of Diseases aspublished by theU.S. DepartmentofHealth and Human Services; and thosepsychiatric and othermentalIllnesseslisted in thecurrent editionofthe Diagnosticand Statistical Manual forMental Disorders publishedby the American Psychiatric Association. For purposes of this insurance, Mental orNervous Disorderdoesnoti nclude Substance Abuse.

Mortal Remains: The bodilyremainsor ashesofanInsured Person.

Natural Disaster: Widespreaddisruptionof human lives by disasters such as flood, drought, tidal wave, fire, hurricane, earthquake,windstorm, or otherstorm,landslide, or other naturalcatastrophe orevent resultingin migrationof thepopulationfor its safety.

Newborn: Aninfantfromthemoment of birththroughthefirst thirty-one(31)daysoflife.

Other Coverage: AsdefinedinSection B(10), above.

Outpatient:Aperson who receives MedicallyNecessaryTreatment byaPhysicianorother healthcareproviderthatdoes not requireanovernight stay in aHospital.

Period of Coverage:The periodbeginningontheEffective Date ofCoverage ofthis Certificateand endingonthe earliestofthe followingdates:(a) theterminationdate specified inthe Declaration,or (b)the terminationdate as determinedin accordance with Section B(18), above. The Period ofCoverage canbe no morethantwelve(12)consecutive months.

Physician:Aduly licensed practitionerof the medical arts. A Physicianmust be currentlylicensed by the state or countryin which the services are provided,and the services mustbe withinthe scope ofthatlicense.

Plan Administrator: The Plan Administratorforthisinsurance is Access Health Maintenance Organization,inc. 2885Sanford Avenue SW Grandville, MI 49418Telephone Number+1.616-855-7670, or +420.777 322 522, Website:https://www.accesshmo.com, Email: claims@accesshmo.comAsthe Plan Administrator,International Medical Group, Inc., acts solely as the disclosedand authorizedagent andrepresentative for and on behalf of the Company,and doesnot have, and shallnot be deemed, consideredor alleged to haveany, direct, indirect,joint, several, separate, individual,or independent liability,responsibilityor obligationof any kindunder the Master Policy, the Declaration, or this Certificatetothe Insured Person or toanyother person orentity,includingwithoutlimitationtoanyPhysician, Hospital,ExtendedCare Facility, Home Health Care Agency, or any other health care or medical service provider or supplier.

Pre-certification; Pre-certify: A general determinationofMedicalNecessity,only, made bythe Companyin relianceand based uponthe completeness and accuracy ofthe informationprovidedbythe InsuredPerson and/ortheInsuredPerson's healthcare or medicalservice providers, guardians, Relatives and/or proxies at the time thereof. Pre-certification is notanassurance, authorization,pre-authorizationorverificationofcoverage, averificationofbenefits,or aguarantee of payment. See Section E, above, for further details.

Pre-existing Condition:Any Injury,Illness,sickness, disease, orotherphysical, medical,Mental or Nervous Disorder,condition or ailmentthat, with reasonable medical certainty, existed at the timeof Applicationor at any time duringthethree yearsprior to the Effective Date of this insurance, whether or not previouslymanifested, symptomatic or known, diagnosed, Treated, or disclosed to the Companypriortothe Effective Date, andincludinganyand all subsequent,chronic orrecurringcomplicationsor consequences related theretoorresulting or arisingtherefrom.

Premium:The premiumpayments requiredto effectuate and maintain the InsuredPerson's insurance coverage and benefits underthisinsurance,in theamountsandat thetimes ("Due Dates") established by the Companyin itssole discretionfromtimeto time.

Pregnancy; Pregnant: The process ofgrowthand developmentwithinawoman'sreproductiveorgansofanew individualfrom the timeof conceptionthroughthe phases where the embryogrowsandfetusdevelopsto birth.

Professional Athletics:Asport activity,including practice, preparation,and actual sporting events, for any individual or organizedteam that is amemberofa recognizedprofessionalsportsorganization,isdirectly supportedor sponsoredbya professional team or professional sportsorganization,is a memberofaplayingleague thatis directlysupported orsponsored bya professionalteamor professionalsportsorganization; or has any athlete receiving forhisor her participationany kindofpayment or compensation,directly or indirectly,fromaprofessional team orprofessional sports organization.

Registered Nurse:Agraduatenurse whohas been registeredorlicensedtopracticebyaState Board of Nurse Examinersor otherstateauthority,andwho is legallyentitledtoplace theletters"R.N."after hisorhername.

Relative: A parent,legal guardian,spouse, son, daughter,orimmediate familymemberof the InsuredPerson.

Rider:Any exhibit,schedule, attachment,amendment,endorsement, Rider orotherdocumentattached to,issued inconnection with, orotherwise expresslymade apartofor applicableto, theMaster Policy, this Certificate, the Declaration, or theApplication, as thecase maybe.

RoutinePhysical Exam: Examinationof thephysicalbodyby aPhysician forpreventativeorinformativepurposesonly,andnot fortheTreatment of any previouslymanifested,symptomatic,diagnosedorknownIllness orInjury.

ScheduleofBenefits/Limits:The summarizedscheduleof benefits,coverages, limitsandsub-limitsassetforth forease of referencein Section C ofthisCertificate,allofwhichare subjecttothefullTermsofthis insurance.

Self-inflicted: Action or inactionbythe Insured Person thattheInsured Person consciously understandswill or may cause or contribute,directly orindirectly,tohis or her personal Injury or Illness. Self-inflictedspecifically includesf ailureofan Insured Person to followhis or her doctor'sorders, completeprescriptions as directed, or followany healthcare protocolorprocedures designedtoreturn or maintainhis or her health.

Substance Abuse: Alcohol,drugor chemicalabuse, misuse,illegaluse, overuse ordependency.

Surgery or Surgical Procedure:An invasivediagnosticorsurgicalprocedure;ortheTreatmentofIllnessorInjurybymanualor instrumentaloperationsperformedby aPhysician while thepatient is under general or local anesthesia.

Telemedicine: Telemedicineis the use ofmedical information(beyondaverbalhistory)exchangedfromone healthcare provider site to another via electroniccommunicationstoimprove patients' health status. Videoconferencing,transmission ofstill images, and remotemonitoringofvital signsare all considered part ofTelemedicine. Telemedicine services thatwouldbe considered for Medical Necessity andappropriatenessbytheCompanyunder the plan would include withoutlimit:

- Specialist referralservices whichtypically involves of aspecialistassistingageneralpractitioner inrenderingadiagnosis to guide Treatment.
- Patient consultationsusingtelecommunications to provide medical data, whichmayinclude audio, stillor liveimages, between a patientand a Physician orother healthcare providerforuse inrenderingadiagnosisand Treatmentplan.This mightoriginatefromaremoteclinictoaPhysician's office usingadirecttransmissionlinkormay includecommunicating over the internet..

- Remote patientmonitoringuses devices toremotely collect and send data fromamedicalfacilitytoamonitoring station forinterpretation.Such applicationsmightincludeaspecific vital sign, such asblood glucoseorheart ECG.

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

Terrorism:Criminalacts, includingagainst civilians, committedwiththeintenttocause deathor serious bodilyinjury,ortakingof hostages, with the purpose to provide ast ate ofterror in thegeneral publicor in a groupofpersonsor particularpersons, intimidateapopulation,orcompel agovernmentof internationalorganizationtodoortoabstainfromdoing an act.

Travel Warning: Publishedstatementorweb-sitedocumentissued bythe United States DepartmentofState,Bureau ofConsular Affairs or similargovernment agency ofthe Insured Person's Home Country, warning thattravel to specific identified countries is hazardousandisnotadvised.

Treated; Treatment: Any and all undertakings, services and/or procedures rendered or employed with respect to the management and/orcare ofanInsured Person for the purpose of identifying,testingfor, analyzing, diagnosing, treating, curing, resolving, preventing, monitoring,attending to, caring for, controlling and/orcombating any Illnessor Injury or the symptoms or manifestations thereof, includingwithoutlimitation:verbal orwritten advice, consultation, examination,discussion, diagnostic or laboratorytestingorevaluationofany kind,pharmacotherapyor othermedication,and/orSurgery.

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

Usual, Reasonable andCustomary: Atypicaland reasonableamountof reimbursementforsimilarservices,medicines, or supplies withinthe area in whichthe charge is incurred. In determiningthetypical and reasonable amount ofreimbursement,the Company may, in its reasonable discretion, consider one or moreof the followingfactors, withoutlimitation:the amount charged by the provider;theamount charged by similarprovidersorproviders in the same or similar locality;the amountreimbursedby otherpayorsforthe sameor comparable services, medicines orsupplies inthesame orsimilarlocality;theamountreimbursedby otherpayorsfor the same or comparableservices, medicinesor suppliesinotherparts of thecountry;thecost totheprovider of providingthe service, medicine orsupply; thelevel ofskill, extentoftraining,and experience required toperformtheprocedure or service; the lengthof timerequired to performthe procedure or serviceas compared tothe lengthoftimerequired toperformother similarservices;thelength of timerequiredtoperf orm the procedure or service as compared to national standards and/or benchmarks;theseverity ornature ofthelllness orInjury beingtreated;andsuch otherfactorsas the Company,in the reasonable exercise of its discretion,determinesareappropriate.