Euro Student Voyager

International Student Insurance

Premium Plan

For Sports & Hazardous Activity

Paid in full means that relevant expenses shall be paid or reimbursed within the individual Sum Insured, under conditions that such expenses are Usual, Customary and Reasonable, and relevant Treatment is Medically Necessary.

The amounts below mean limits of possible reimbursement of actual costs paid / expenses incurred under relevant items, under condition that such costs/expenses are Usual, Customary and Reasonable, and relevant Treatment is Medically Necessary.

Reimbursement of medical and transportation expenses up to the limits specified in Sections 1 and 2 below shall be provided by the Insurer in connection with the Insured Person's accidental body injuries, if resulted from the following sports and hazardous activities and if not excluded in accordance with Article 8 (General Exclusions) of this Policy:

BMX (Racing or Competitive); Bungee Jumping; Hang Gliding; Snow, and Water Skiing; Martial Arts; Parachuting; Parasailing; Snowboarding; Snowmobiling; Spelunking; Whitewater Rafting (up to and including class V rapids only); Wakeboarding.

NOTE: Any sport or hazardous activity not expressly mentioned above is excluded from this Policy, unless the sport/activity is non-contact and engaged in by the Insured Person solely for leisure, recreation, or entertainment purposes only.

Explanation of definitions used in this Schedule of Benefits is provided in the International Travel Insurance Rules.

Sum Insured (per insured person, across all sections below)	**€500.000**
Deductible	**€0**

Section 1. Medical Expenses incurred during the Covered Trip in case of Accidental Injury or Sudden Illness	
Intensive Care/Cardiac Care Unit Benefit	Paid in full, however, the following additional limits shall apply: • €30.000 for Emergency Treatment of an acute exacerbation of a Pre-Existing Medical Condition (including €15.000 for Complications of Pregnancy up to the 20th week of pregnancy)
Hospital or Day Surgery Miscellaneous Expense Benefit	
Surgeon (In or Outpatient) Benefits	
Anesthesia Benefit	
Diagnostic X-Ray and Lab Benefit	
Ambulance Benefit	
Inpatient or Outpatient Consultation Benefit	
Prescription Drugs Benefit	
Psychiatric Illness	
Emergency Dental Coverage (in case of an accident)	
Palliative Dental	

Section 2. Medical Transportation Benefits	
Emergency Medical Evacuation and Repatriation	paid in full
Repatriation or Burial locally	€25.000
Emergency Medical Reunion	€5.000
Continuation (Return to Host Country)	€5.000

Compassionate Repatriation	€5.000

Section 3. Non-Medical Benefits	
Trip Delay by 6 hours or more	€2.000 including accommodations (€150/day)
Hospitalization Daily Allowance	€50 every 24 hours (from the third day of Hospitalization)/ up to €1.000
Missed Connection	€1.000
Loss of Luggage	€2.000
Luggage Delay	€100 per day Up to €300 max
Lost or Stolen Passport	€100
Third Party Liability incl Bodily Injury and Property Damage	€500.000
Legal Expenses	€10.000
Accidental Death and Dismemberment	€25.000
Trip Cancellation / Interruption • Deductible	€5.000 €100

Excluded countries and territories	This insurance is not valid in Afghanistan, Cuba, Iran, Libya, North Korea, Rwanda, Somalia, Sudan, Syria, Ukraine, the area inside the Arctic Circle and Antarctica. Other excluded countries and/or possible restrictions can be found on dhig.net

International Travel Insurance Rules

These International Travel Insurance Terms and Conditions (hereafter referred to as the "**Rules**") specify general conditions of international travel insurance contract (hereafter referred to as the "**Contract**" or "**Insurance Contract**") concluded between the Insurer and the Policyholder.

Special conditions of insurance cover to be applicable in respect of a particular Insured Person are established in respective International Travel Insurance Certificate. Should there be a discrepancy between these Rules and the Certificate, provisions of the Certificate shall prevail.

These Rules, Policyholder's and Insured Person's applications for this insurance, as well as other information and documentation provided by the Insured Person and parties to each other for the purpose of concluding the Contract, the relevant Policy (if made by the parties thereto) and Certificates (including all appendixes thereto) comprise the Insurance Contract in respect of particular Insured Person.

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

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

1 Definitions

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

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

Accumulation (Aggregate) Limit is applicable under the Insurance Contracts valid in respect of more than one Insured Person and this term means the combined limit of the Insurer's liability under the Contract if a relevant event occurs, irrespective of number of Insured Persons affected by this event, of their individual Sums Insured and of Schedules of Benefits envisaged by the Contract. If not otherwise specified in the Insurance Contract, the following Accumulation (Aggregate) limits are applicable:

Medical Benefits (Section 1, 2)	**Accumulation Limit**
Medical Expenses incurred during the Covered Trip in case of Accidental Injury or Sudden Illness	An Accumulation Limit of €/$1.000.000,00 applies for all losses arising from the same Event in any one Period of Insurance.
Medical Transportation Benefits	

*Non-Medical Benefits (Section 3)	Accumulation Limit
Third Party Liability incl Bodily Injury and Property Damage	An Accumulation Limit of €/$1.000.000,00 applies for all third party liability losses arising from the same Event in any one Period of Insurance.
Other Non-Medical Benefits	An Accumulation Limit of €/$100.000,00 applies for all losses (other than third party liability) arising from the same Event in any one Period of Insurance.

*For the complete list of benefits, please refer to the **"Schedule of Benefits"**.

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

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

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

Benefit means a Medical Treatment, good and services, as well as other payments, which the Insurer agrees to pay /compensate for (subject to terms, limitations, exclusions, other general and special conditions as set in the Contract) and that are indicated in the Schedule of Benefits as covered under the Contract. These Rules (including these Article 1 "Definitions") and other wording of the Contract may contain provisions explaining and otherwise referring to certain benefits. However, for the avoidance of any doubts, any benefit that is not expressly indicated in the Schedule of Benefits as covered by the Contract shall not be covered.

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

Bodily Injury means identifiable physical injury, which is caused by an **Accident**, and solely and independently of any other cause, except illness directly resulting from, or medical or surgical treatment rendered necessary by such injury, occasions the death or disablement of the Insured Person within twelve months from the date of the **Accident**.

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

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

Claim means a request for: reimbursement of expenses for (cost of) Medical Treatment/goods or service; reimbursement of losses or other payments due to the Insured Person or his/her beneficiary under the Contract,

submitted to the Coverholder (as the case may be) by the Insured Person or his/her beneficiary, the Policyholder or by a Provider of the said Treatment/good or service. **Claim payment** means positive settlement of the Claim, where the Claim can be eligible for payment in full or in part.

Complications of Pregnancy means the following unforeseen complications of pregnancy as certified by a medical practitioner: gestational hypertension; gestational diabetes; pre-eclampsia; ectopic pregnancy; hydatidiform mole (molar pregnancy); ante partum haemorrhage; placental abruption; placenta praevia; serious post-partum haemorrhage; retained placenta membrane; miscarriage; stillbirths; medically necessary emergency Caesarean sections/medically necessary termination and any premature births or threatened early labour more than 8 weeks (or 16 weeks in the case of a multiple pregnancy) prior to the expected delivery date. Delivery by caesarean section is considered a complication of pregnancy if the caesarean section is non-elective. A caesarean section will be considered non-elective if the foetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a caesarean section is not performed. Complications of Pregnancy do not include elective abortion, elective cesarean section, false labor, occasional spotting, morning sickness, physician prescribed rest during the period of pregnancy, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

Covered Trip (Trip) means a period of round-trip travel away from the Covered Person's Home Country; the Trip has defined departure and return dates when the Insured Person crosses his/her Home Country's border.

Coverholder means the company **dhig GmbH**, which has been duly appointed by the Insurer to implement all the Contracts for and on behalf of the Insurer, including (but not limiting to) the following: issue and signing of Policies/Certificates, Contract administration and Claims handling.

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

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

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

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

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

Doctor (Physician, Therapist) means a person, who graduated from a medical school, passed state attestation and who is licensed to practice medicine in the country where the Treatment is received. Insured Persons are allowed to select any Doctor qualifying these requirements, unless otherwise indicated in the Policy/Certificate. For the avoidance of any doubts, the parties to the Contract may specifically agree that certain or all Medical Treatment/goods/service (including but not limited to Hospitalization and Out-patient Care) are eligible (i.e., covered by this insurance) only if they are executed/provided at/by the specific Doctors/Specialists/medical facilities as expressly indicated in the Policy/Certificate — such an agreement shall be set in the Policy and/or the Certificate.

Emergency Treatment of an acute exacerbation of a Pre-Existing Medical Condition means medical manipulations aimed at waiving strong pain or at eliminating immediate threat to the Insured Persons's life caused by the said exacerbation.

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

Home Country means the country where an Insured has his or her true, fixed and permanent home and principal establishment.

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

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

Host Country means any country other than the country where an Insured has his or her true, fixed and permanent home and principal establishment holds a current and valid passport.

Injury means Bodily Injury caused by an Accident.

Insurance Expiry Date means the day when the insurance cover under the Contract ends. Insurance Expiry Date shall be indicated in the Certificate. Should at any time during the Insurance Period an Insured Person be excluded from the coverage under the Contract, then the insurance cover in respect of such excluded Insured Person will end on the date as agreed between the Insured Person and the Insurer.

Insurance Period is a period of time between the Insurance Start Date and Insurance Expiry Date as set in the Certificate, when the insurance cover is in force, unless it is cancelled by the Policyholder or by the Insurer prior to the Insurance Expiry Date. Benefits occurred/received out of the Insurance Period are not covered by the insurance under the Contract.

Insurance Premium means a payment for insurance under the Contract due to be made by the Policyholder in the manner and within the time period as set in the Contract. The Insured Person is allowed to pay the Insurance Premium in respect of his/her own insurance cover under the Contract. Should the Insured Person pay the Insurance Premium for his/her insurance cover, the Policyholder will be released from its obligation to pay respective Insurance Premium to the Insurer. Under group insurance Contracts, Insurance Premium rates may be established.

Insurance Start Date means the day as specified in the Certificate, when the insurance cover under the Contract goes into effect (subject to general and special conditions as set herein and elsewhere in the Contract). Should at any time Insurance Period a new Insured Person(s) be included into the coverage under the Contract, then the insurance cover in respect of such newly included Insured Person will start from the date as indicated in respective individual Certificate of this Insured Person and will end at the Insurance Expiry Date as set therein.

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

Insurer means the duly licensed insurance organization as indicated in the Policy/Certificate, who ultimately carries the insurance risk under the Contract.

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

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

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

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

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

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

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

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

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

Out-patient Care also includes visiting a patient at home by the Doctor, provided that this visit is arranged by the Assistance Service or approved by it in accordance with the Contract, if the reason for Doctor's visit is the health condition of the patient insured under the Contract who is not able to get to the Hospital by him/herself without

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

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

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

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

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

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

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

Prescription Drugs (Drugs) means medicines necessary to treat a confirmed medical diagnosis or medical condition as prescribed by a Doctor, except for "over-the-counter" medicines like Aspirin, cold remedies (for nose relief, cold and flu), homeopathic drugs and herbs, lifestyle products, vitamins, food additives, dietary products, and any experimental drugs, even if prescribed by a Doctor.

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

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

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

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

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

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

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

a. the original Accident or Illness/Injury must occur after the Insurance Start Date (and in case when the insurance cover of an Insured Person enters into effect after the Insurance Start Date, then the original Accident/Illness/Injury of such Insured Person must occur after such date of entry into force of the cover of this Insured Person) and be covered by this insurance, and
b. the Reconstructive Surgery itself must take place within 24 months since the original Accident or Illness/Injury, and the date of Reconstructive Surgery must be within the Insurance Period

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

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

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

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

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

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

Sudden Illness (sickness, disease) means such disorder of the normal well-being of an organism due to functional and/or morphological changes diagnosed, that meets all of the following conditions:

a) its symptoms first appeared between the Insurance Start Date and the Insurance End Date while the Insured Person is in the Covered Trip outside of his/her Home Country;
b) the Insured Person's medical conditions require Hospitalization or urgent consultation by a Doctor followed by Outpatient Care prescribed by the Doctor.

Sudden Illness shall include an acute exacerbation of a Pre-Existing Medical Condition, if such acute exacerbation requires urgent admission to Hospital or **Out-patient Care**.

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

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

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

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

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

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

2 Entering into the insurance contract

2.1 This insurance is designed for all natural persons of the Insured Group, meeting the following conditions:

a. Natural persons who are students, visiting faculty, scholars, au-pairs, interns, attending language schools, or participating in linguistic stays, homestays or other similar programs, age 6 or older who are temporarily residing outside their Home Country are eligible for coverage under this Policy/Certificate;
b. Dependents are not eligible for coverage;
c. A list of Insured Persons and their respective Sums Insured shall be provided by the Insured Group before the Insurance Effective Date in a template offered by the Coverholder. Subsequent changes to the List shall be provided by the Insured Group from time to time, however, no backward changes ("back-dating") are accepted without the Coverholder's express consent in writing;
d. The original Insured Person's census and requests for changes shall be made via the GDPR-compliant data exchange portal https://send.dhig.net/.

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

2.3 Policies or Certificates to be issued in accordance with these Rules shall indicate:

a. Names of the Insurer, the Policyholder and the Coverholder;
b. Reference to these Rules;
c. Host Country, if requested
d. The Schedule of Benefits;
e. the Insured Persons;
f. Assistance Service and/or reference to the network of Providers (if applicable);
g. contact details (website, e-mails, etc.) for presenting the Claims and complaints (if presented directly to the Insurer);
h. the Insurance Premium, its payment currency and other payment related conditions;
i. the Insurance Start Date and the Insurance Expiry Date;
j. Applicable law and jurisdiction for handling disputes;
k. other conditions as agreed between the parties thereto

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

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

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

2.7 This insurance is available for people under 85 years old. This insurance shall automatically terminate when the Insured Person turns 85.

2.8 Unless otherwise expressly confirmed by the Coverholder, this insurance is not valid for a business trip or a corporate event (organized or inspired by the Policyholder or by the Insured Persons' employer) concerning more than 10 Insured Persons simultaneously. The Coverholder should be requested well in advance to have time for underwriting and possible quotation of an additional insurance premium reflecting the expected cumulation of risk.

3 Insurance premium

3.1 The Coverholder shall determine the size of the Insurance Premium due, taking into account the following: selected Area of cover and Schedule of Benefits, Sums Insured, Individual and Aggregate Limits per event, Deductibles, Co-payments, exclusions, and other special insurance conditions, as well as expected level of the insurance risk (risk of utilization of the Benefits).

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

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

3.4 Insurance Premium can be paid single time. The specific amount, and currency of the Insurance Premium shall be established in the Certificate. Insurance Premium shall be paid via wire transfers or by credit/debit card (Visa/MasterCard/American Express).

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

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

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

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

4 Sums insured and limits of benefits

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

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

5 Insured persons' rights & duties

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

5.2 Save for specific cases regulated otherwise herein, if the Insured Person wants to apply for reimbursement of incurred expenses or for other payment due under the Contract, he/she must do so within a period of 90 days immediately after incurring such expenses / the rise for the grounds for such payment, or as soon as practicably possible in given circumstances, by submitting a Claim form provided by the Coverholder with

supporting medical and other documentation, original invoices and receipts attached. In case when the payment under the Contract is due to the beneficiary of the Insured Person (e.g., in case of death of the Insured Person), then this beneficiary has all liabilities and rights of the Insured Person related thereto. Articles 6 and 7 specifye various terms and conditions for submitting Claims for benefits described therein.

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

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

a. Emergency Medical Evacuation;
b. Hospitalization or Day-Care Treatment, or the undergoing of Day-Surgery;
c. any medical procedure, involving general anesthesia;
d. Home visit by a Doctor;
e. Out-patient Treatment, if its cost will likely exceed the equivalent of 5 hundred EUR;
f. any medical condition for which Treatment cost will likely exceed the equivalent of 5 thousand EUR;
g. Repatriation or Burial;
h. other specific cases as set in the Certificate or elsewhere in the Contract.

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

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

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

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

5.8 If the Insured Person or his/her authorized representative would like to invite a Doctor to visit the Insured Person at home, then pre-authorization of the Assistance Service must be received by the phone (to be also confirmed by SMS from the Assistance Service), prior to the Doctor's invitation being made. The pre-authorization can be obtained if the reason for Doctor's visit is the health condition of the Insured Person, who is not able go to the Doctor's place by him/herself without putting his/her life at risk (due to specific manifestations of the disease) or without the risk of further deterioration of health (progression of the disease or its complications). The Assistance Service reserves the right to request that the Doctor's visit is made by

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

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

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

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

5.12 In circumstances not requiring pre-authorization, the Insured Person shall contact a Provider for an appointment directly. In case when the Policy/Certificate foresees a specific network or list of Doctors, Hospitals, or other Providers eligible under the Contract, then the Insured Person shall contact such eligible Doctors/Hospitals/other Providers.

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

5.14 The Insured Person is also obliged:

a. to strictly follow the advice given by the ambulance team, procedures of In-patient or Day-patient Medical Treatment/Day-Surgery and to follow internal rules established by a relevant medical facility;
b. not to hand out his/her insurance card or individual Certificate to other people who are not insured under the relevant Contract;
c. to cancel immediately (or as soon as possible in given circumstances) a Doctor's appointment or ambulance call if the Insured Person recognizes that it is no longer possible or necessary or

desirable for him/her to use medical services from this relevant Doctor, Provider, or ambulance team;

d. to follow the Doctor's recommendations given during any kind of Out-patient Medical Treatment, health examination, or consultation;
e. to timely pay amounts corresponding to the Deductibles and Co-payment, if any is envisaged by the Contract;
f. to timely advise the Policyholder and the Coverholder about a change of surname or address details;
g. duly execute other obligations as established elsewhere in the Contract.

6 Reimbursements to Insured Persons and directs settlements to Providers

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

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

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

6.4 For the Coverholder to make a decision on reimbursement of expenses / on payment of other benefit to the Insured Person/Provider, the Insured Person shall submit the following documents to the Coverholder (and shall do so within 90 calendar days since receipt of the Medical Treatment or since becoming physically able to submit the Claim):

a. completed Claim form provided by the Coverholder, including the consent to disclose the health-related Personal data of the Insured Person to the Coverholder, Assistance Service, Medical Consultant, Insurer, Reinsurer(s), and third parties appointed by the Coverholder to adjudicate and settle the Claim, for the purposes (and to the extent it is necessary for these purposes) related to the handling and settlement of the Claim, and to provide necessary assistance to the Insured Person as foreseen under the Contract. Failure to provide such consent shall prevent the Coverholder and parties mentioned in the previous sentence from being able to process health-related Personal data of the Insured Person; which, consequently, will preclude them from being able to provide necessary assistance and duly handle and settle the Claim. Therefore, should the Insured Person refuse to provide the herein discussed consent or should such consent be revoked, the Insurer will be entitled to reject the Claim;
b. the Doctor's prescription for Medical Treatment as well as all pieces documenting the delivery of services to the Insured Person (an extract from the medical history, discharge summary, medical prescription, and other related documentation);
c. originals of paid invoices clearly indicating the Provider's name and address, the detailed list of services/goods provided, and their costs. In some jurisdictions, documents proving the legal ground for organization of relevant services for the Insured Person (e. g. service contracts) are required as well;
d. when a Benefit is associated with reimbursement of expenses incurred by the Insured Person for purchase of Prescribed Drugs and/or medical products that are covered under the Contract: a

Doctor's prescription, as well as the original receipts of payment for these Prescribed Drugs and/or medical products.

e. when a Benefit is associated with reimbursement of expenses incurred by the Insured Person for Preventive Care: the documents confirming those examination being prescribed by the Family Doctor and/or Specialist's prescription.
f. in the case that the Insured Person's Medical Treatment is related to an Accidental body Injury, the Insured Person shall provide detailed description of all the relevant circumstances of the Accident (including but not limiting to the date, place, persons involved, witnesses, persons possibly liable, etc.), and if registered by the police or other competent authorities, a copy of their report.
g. Articles 9-10 foresee additional specific provisions for placing supportive documentation with regards to specific benefits described therein.

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

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

6.7 The Coverholder may decide to settle the Claim without full delivery of the documents/information referred to in paragraphs 6.4 and 6.5 and in Article7 of these Rules, or to accept the copies of certain documents, if submitted (copies of) documents are clear and sufficient to understand the circumstances of the Claim and to eliminate any doubts regarding the Claim being eligible for reimbursement under the Contract.

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

6.9 Within 10 business days from the date of receipt of all the documents and information as discussed in paragraphs 6.4 – 6.7, Articles 9-10 of these Rules, the Coverholder shall pay the Claim (in part or in full, as the case may be) or send (in writing or per e-mail) a letter of rejection containing explanation/reasons for refusal. When an audit of invoices is carried out by the Insurer or by competent authorities to confirm their relevance to the Claim, the term of payment thereof may be increased to 90 calendar days, and the Coverholder shall notify the Insured Person about the invoice audit and a new term of settlement.

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

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

6.12 The Coverholder shall keep records of Claims paid in both the nominal currency of each claimed amount and of its equivalent in the currency of the Schedule of Benefits. Depending on the applicable law or customary business practice in the jurisdictions of the Providers and the Assistance Services, engaged in Claims'

settlement, the applicable exchange rates are those valid on the dates of Claims processing, and include those available at www.oanda.com and/or those established by competent/regulatory authorities (e.g., Central Banks) and/or by the banks effecting payments.

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

a. wire transfer fees associated with the remittances, if taken by the bank;
b. exchange rate costs, associated with conversion of the equivalent of Benefit amount from the currency as set in the Schedule of Benefits into the currency of the bank account where the Benefit amount shall be paid in accordance with the claimant's instruction;
c. local intermediary fees and charges if, due to the peculiarities of local regulations, settlement of the Claim is only possible via engagement of a local intermediary.

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

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

a. the claimed Medical Treatment is subsequently proven to be not Medically Necessary; or
b. services rendered /goods provided to the Insured Person / claimed benefits are not covered by this Contract; or
c. the aggregate (during the whole Insurance Period) amount of expenses paid under the Contract has reached the Sum Insured or the applicable limit specified in the Contract; or
d. the Insured Person applied for a Medical Treatment other goods/services / benefits covered by the Contract after expiration of the Insurance Period or before the Insurance Period commencement date; or
e. the Policyholder's obligation to pay Insurance Premium (or any installment thereof) remains unfulfilled by the end of the Grace Period; or
f. in the occurrence of any kind of fraud on the side of the Insured Person/Policyholder/their representatives; or
g. in other specific cases as set elsewhere in the Contract.

7 Description of Benefits

7.1 Urgent Medical Expenses in case of Injury or Illness

This insurance will reimburse medical and the related expenses for medically necessary treatment of the Insured Person in case of an accident or an acute sickness. The insured benefits are subject to the Deductibles, Co-Payment, Coinsurance Factors, Benefit Periods, Benefit Maximums and other terms or limits shown below and in the Schedule of Benefits.

The insured benefits are only payable:

a. for Usual, Reasonable and Customary Charges incurred after the Deductible has been met;
b. for those Medically Necessary Eligible Expenses incurred by or on behalf of the Insured Person;

No benefits will be paid for any expenses incurred that are in excess of Usual, Reasonable and Customary Charges.

Eligible Medical Expenses include:

a. Hospital Admission Expenses: Charges for each hospital admission.
b. Dressings, drugs, and medicines that can only be obtained upon a written prescription of a Doctor or Surgeon.

7.1.1 Hospital Room and Board Benefit

This insurance will pay charges for the Average Semiprivate Charge for each day of the Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule. In computing the number of day's payable under this benefit, the date of admission will be counted, but not the date of discharge. Hospital Room and Board expenses will include floor nursing while confined in a ward or semi-private room of a Hospital and other Hospital services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation.

7.1.2 Intensive Care/Cardiac Care Unit Benefit

This insurance will pay charges for each day of Intensive Care/Cardiac Care Unit confinement, up to the Daily Maximum Benefit shown in the schedule per day. This payment is in lieu of payment for the Hospital Room and Board charges for those days and includes nursing services.

7.1.3 Hospital or day-surgery miscellaneous expense benefit

This insurance will pay for services, supplies, and charges during a Hospital Stay, up to the Maximum Daily Benefit Amount shown in the schedule per day. Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies; and blood and blood transfusions. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

7.1.4 Surgeon (In or Outpatient) Benefits

This insurance will pay charges for a Doctor (and for his/her assistants if necessary), for primary performance of a surgical procedure other than dental, up to the Maximum Benefit Amount shown in the Schedule of Benefits per procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, this insurance will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, this insurance will pay for the most expensive procedure and 50% of Eligible Expenses for the additional surgeries.

7.1.5 Anesthesia Benefit

This insurance will pay benefits for anesthesia (other than dental) for pre-operative screening and administration of anesthesia during a surgical procedure whether on an inpatient or outpatient basis.

7.1.6 Diagnostic X-Ray and Laboratory Benefit

This insurance will pay the benefit if the Insured Person requires diagnostic x -ray and/or laboratory examinations and services due to a Covered Loss, up to the Maximum Benefit per Covered Accident or Sickness indicated in the Schedule of Benefits. Outpatient x-ray services and laboratory tests are limited to the amount shown in the Schedule of Benefits.

7.1.7 Ambulance Benefit

When, by reason of Injury or Sickness, an Insured Person requires the use of a community or Hospital Ambulance in a Medical Emergency, this insurance will pay a Benefit Amount up to a Maximum shown in the schedule, within the metropolitan area in which the Insured Person is located at that time the service is used. Ambulance Service is transportation by a vehicle designed, equipped, and used only to transport the sick and injured from home, the scene of the Accident or Medical Emergency to a Hospital or between Hospitals. Surface trips must be to the closest

local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area

Air transportation is covered when Medically Necessary because of a life-threatening Injury or Sickness or if the Insured Person is in a rural area, then air ambulance transportation to the nearest metropolitan area will be considered an Eligible Expense. Air Ambulance is air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to and from a Hospital for inpatient care.

7.1.8 **Inpatient or Outpatient Consultation Benefit**

This insurance will pay charges by a Doctor for inpatient and outpatient visits, up to the Maximum Benefit Amount shown in the Schedule of Benefits for Doctor's Visit.

7.1.9 **Emergency Room Benefit**

This insurance will pay this benefit if the Insured Person requires Emergency Room treatment due to a Covered Loss resulting directly and independently of all other causes from a Covered Accident or Sickness.

Emergency Room means a trauma center or special area in a Hospital that is equipped and staffed to give people emergency treatment on an outpatient basis. An Emergency Room is not a clinic or Doctor's office.

Services including Doctor charges and related x-ray/laboratory interpretations will be paid under this benefit.

7.1.10 **Psychiatric Illness**

Only such expenses, incurred as the result of Treatment or medication from the onset of Mental Illness as an Inpatient/Outpatient, which are specifically enumerated in the following list of charges, and which are not excluded, may be considered as Covered Expenses:

a. Charges made by a Hospital or mental institution for room and board, floor nursing and other services inclusive of charges for professional services and with exception of personal services of a non-medical nature, provided, however; that expenses do not exceed the Hospital's or mental institution's average charge for semi-private room and board accommodation.
b. Charges made for diagnosis and Treatment by a Doctor.
c. Charges made for the cost and administration of anesthetics.
d. Charges for medication, x-ray services, laboratory tests and services, oxygen, and Medical Treatment.
e. Drugs and medicines that can only be obtained upon a written prescription from Doctor.
f. Mental Illness must first manifest itself during the Insurance Period.

This benefit must be approved by the Assistance Service. Failure to utilize the Assistance Service to arrange for these Services will result in the denial of benefits.

7.1.11 **Emergency Dental Coverage (in case of an accident)**

This insurance will pay benefits as described in the Schedule of Benefits for expenses for emergency dental treatment due to Injury to natural teeth. We will pay benefits as described in the Schedule of Benefits for expenses incurred during the Insured Person's Trip for emergency dental treatment. Only expenses for emergency dental treatment to natural teeth incurred during the Trip will be reimbursed. Expenses incurred after the Trip are not covered.

7.1.12 **Palliative Dental**

This insurance will pay benefits as described in the Schedule of Benefits for eligible expenses for Palliative Dental. An eligible Palliative Dental condition will mean emergency pain relief treatment to natural teeth.

7.1.13 **Emergency Treatment of a Pre-Existing Condition Benefit**

In the event of a Medical Emergency resulting from a Pre-Existing Condition suddenly changing from a stable to an acute form, this Policy will cover costs for the immediate relief of an acute symptom of the Pre-Existing Condition, to the limit shown on the Schedule of Benefits, provided such Pre-Existing condition meets the following criteria:

a. The Insured Person must not be traveling against or in disregard of the recommendations, established Treatment programs, or medical advice of a Doctor or other healthcare provider; and
b. The Insured Person must not be traveling with the intent or purpose to seek or obtain Treatment for the Pre-existing Condition; and
c. The Insured Person must not be traveling during a period of time when the Insured Person is preparing or waiting for, involved in, or undertaking a new, changed, or modified Treatment program with respect to the Pre-existing Condition, and is not traveling subsequent to any such new, changed, or modified Treatment program having been advised or recommended; and
d. The Pre-existing Condition must have been stabilized for at least thirty (30) days prior to the Effective Date without change in Treatment; and
e. A Pre-existing Condition that is a chronic or congenital condition, or that gradually becomes worse over time will not be considered as Emergency Treatment.

There are no benefits for continued care or Hospitalization beyond the treatment of the acute symptom of the Pre-Existing condition.

Special Conditions under this Benefits section:

1. The Urgent Medical Treatment coverage reduces to Accidental Injuries only up to a maximum of 100,000 EUR per Person and per Policy Period upon reaching the age of 71 up to age 79. This reduction of the benefit applies at the start of the Policy Period following reaching of the specified age.
2. The Urgent Medical Treatment coverage reduces to Accidental Injuries only up to a maximum of 100,000 EUR per Person and per Policy Period caused by the practice of non-professional motor sports including motorcycles, mopeds, scooters, all-terrain vehicles (ATVs), any two or three wheeled motorized vehicles, wave runners, jet skis or other watercraft sports.

7.2 Medical Transportation Benefits

7.2.1 **Emergency Medical Evacuation, Medical Repatriation and Return of Remains (or Burial)**

7.2.1.1 Emergency Medical Evacuation: If the local attending Doctor authorized by the Assistance Service determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Assistance Service will arrange and pay for transportation to the closest Hospital or medical facility capable of providing that treatment.

7.2.1.2 Medical Repatriation: After initial treatment or diagnosis of a covered injury or sickness, the Assistance Service will determine if the Insured Person can be repatriated, provided that the Medically Necessary treatment can be performed in the Home Country. In this instance, if the Assistance Service and the attending Doctor determine the Insured Person may be medically repatriated and the Insured Person chooses not to travel back to Your Home Country for treatment, any further costs beyond that point cannot be claimed under this Policy for the same injury or sickness. The Assistance Service will make the needed arrangements to ensure the appropriate level of medical care and mode of transportation is provided during the return Trip home.

7.2.1.3 Return of Remains or Burial: In the event of the Insured Person's Accidental Death during a Trip, the expense incurred within 30 days from the date of the Covered Loss will be paid for minimally necessary casket or air tray, preparation, and transportation of the remains to the Insured Person's Home Country

or to the place of burial. The Insured Person's hairs or their legal representatives have the right to request either the Insured Person's body to be transported to his/her Home Country, or to be buried locally or cremated, and all relevant arrangements and expenses shall be paid under the Contract.

7.2.2 Emergency Medical Reunion Benefit

When an Insured Person is traveling alone and is hospitalized for more than 5 days, the Assistance Service will arrange and pay for round-trip economy-class transportation for one individual selected by the Insured Person from his/her Home Country to the location where the Insured Person is hospitalized and return to the current Home Country. The benefits payable will include:

a. The cost of a round trip economy air fare up to the maximum stated in the Schedule of Benefits;
b. Reasonable travel and accommodation expenses incurred in relation to the Emergency Medical Reunion up to the maximum stated in the Schedule of Benefits;
c. Hotel and meals to a maximum of €/$100 per day.

The period of Emergency Medical Reunion is not to exceed 10 days, including travel.

All transportation in connection with an Emergency Medical Reunion must be pre-approved and arranged by an assistance company representative appointed by the Coverholder.

7.2.3 Continuation

The policy will cover expenses, if the insured person is medically able, to continue with the originally booked itinerary by the most economical means.

7.2.4 Compassionate Repatriation

This policy will cover repatriation of the Insured Person to their Home Country in the event there is a Sickness, serious Injury or death of a spouse, domestic partner, parent, parent-in-law, child, grandchild, brother, sister, or fiancé. The Family Member must be a resident in the Home Country of the Insured Person

7.3 Non-Medical Benefits

7.3.1 Trip Delay

The Insurer will reimburse costs incurred due to the departure of aircraft in which the Insured person had arranged to travel on, being delayed for at least 12 hours from the time specified in the travel itinerary due to the following reasons:

a. Strike, bankruptcy, or mechanical breakdown of the aircraft;
b. loss or theft of your traveling documents (passport etc.);
c. hijacking;
d. accident or traffic accident to the insured person on the direct route to the airport;
e. unannounced strike;

The reimbursement shall be made of the necessary and proven additional costs for necessary accommodation, meals and subsequent travel up to the agreed insured sum.

7.3.2 Hospital Daily Allowance Benefit

This policy will cover up to 50 EUR for every 24 hours period spent in a hospital and up to 1.000 EUR per policy period when the insured person has been hospitalized for more than 48 hours. The insured must be hospitalized to receive medical treatment for an eligible medical condition covered with this Policy. This is a cash benefit and is provided to serve for any miscellaneous expenses such as taxi fares, phone calls etc.

7.3.3 Missed Connection

7.3.3.1 The Insurer will reimburse costs incurred due to the Insured person's missing the tour departure as the result of the cancellation or delay of or 12 more hours of the regulary scheduled airline flights due to inclement weather.

7.3.3.2 The Insurer will reimburse the following:

a. additional transportation expenses incurred to join the departed tour;
b. reasonable additional accommodation and meal expenses incurred in route to catch up to the tour;
c. nonrefundable tour payments for the unused portion of your air travel arrangements.

7.3.3.3 This coverage is available if no other coverage is provided by a Common Carrier or another party at no cost to you or as covered elsewhere in this Policy.

7.3.4 **Loss of luggage**

7.3.4.1 This insurance will cover damage sustained due to theft or loss of luggage during a trip by airplane. The Insured Person is obliged to immediately, or no later than within 24 hours from the moment of theft/loss of luggage being found out, report such incident to the airline company concerned, i.e., to the authorized person at the airport as well as to the police, and immediately, or no later than within 5 calendar days from the moment of theft/loss to the Assistance Service.

7.3.4.2 An authorized person of the Assistance Service shall provide advice in searching for luggage or in reporting relevant claim to the Insurer. The following documents shall be attached to the loss of luggage Claim form that must be completed by the Insured Person:

- Insured Person's copy of passport, and/or identity card;
- airplane ticket and boarding bass as the evidence of travel;
- certificate issued by the police, containing details of the reported event and measures undertaken by the police, including clear description of circumstances under which such theft took place;
- certificate issued by the airline company or the airport (Property Irregularity Report (PIR)) with details about loss of luggage and clear explanation of circumstances under which the luggage was lost;
- list of luggage contents with approximate date of purchase of the possessions therein and approximate value of the same;
- all other documents required by the Insurer and necessary for determining rights to indemnity.

7.3.4.3 Upon the expiry of the 30 (thirty) day period from the day of damage report, the Insured Person is obliged to submit to the Insurer the certificate issued by the airline company or the airport, stating that the respective luggage was not found. If the Insured Person fails to do so, the Insurer shall not be obliged to indemnify the damage.

7.3.4.4 The Insurer shall indemnify the approximate value of the possessions lost by the Insured Person due to theft or loss of his luggage, taking into account how much they were worn out at the moment of theft/loss occurrence. The maximum Benefit payable for all losses resulting from any one incident shall not exceed 100% of the Loss of luggage limit indicated in the Schedule of Benefits.

7.3.4.5 The Insurer will not pay reimbursements in the following cases:

a. Loss, theft, or damage to personal items during transport that is not reported within 24 hours of the incident. The incident report must be sent along with the request for compensation (in the case of baggage, a report on the damage is needed). It is necessary to attach a ticket and baggage claim tag.
b. Request for compensation of a part or parts of a kit, the Insurer will not pay the value of the remaining undamaged parts.
c. Damage to fragile items unless they are damaged by fire caused by aircraft accident.
d. Loss, theft, or damage to any equipment for that Insured used within their profession or occupation.
e. Damage that is not reported to the police or airline company, nor received written confirmation of the submitted report / report on specific cases, or as a result of a seizure by customs or other authorities.

f. Loss, theft, or damage to contact or other lenses, hearing aids, dental or medical equipment, cosmetics, antiques, musical instruments, documents, securities, manuscripts, perishable goods, bicycles, and suitcases (unless they are completely useless).
g. Claims requests without the accompanying original receipts, proof of ownership or certificate of the value of the lost, stolen, or damaged items.
h. Claims arising from damage caused by leakage of powder or fluids that are part of the personal baggage of the Insured Person.
i. Loss that happened during the airplane transportation of personal items that were borrowed, leased, or rented by the insured.
j. If the required compensation is higher than a reasonable proportion of the total value of the set(s) and the value of lost or damaged item that is part of the set(s).

7.3.5 **Luggage Delay**

The Insurer will reimburse cost of purchase of necessary personal effects, if the Insured's luggage is delayed or misdirected by an airline company for more than 24 hours while on the trip.

7.3.6 **Lost or stolen passport**

7.3.6.1 This insurance reimburses expenses incurred if the Insured Person's travel documents are lost or stolen during his/her trip, for example, the official processing fees to obtain a replacement travel document which are over and above that he/she will normally pay in their Home Country.

7.3.6.2 To claim the benefit, the Insured Person must obtain a written police report as soon as possible upon the discovery of any theft, comply with all conditions of any issuing body and provide receipts for all costs incurred.

7.3.6.3 The maximum benefit payable for all expenses resulting from any one incident shall not exceed 100% of the Lost or stolen passport limit indicated in the Schedule of Benefits.

7.3.7 **Third Party Liability**

7.3.7.1 Subject to the limit stated in the Schedule of Benefits, this Policy will indemnify each Insured Person against legal liability for bodily Injury to persons other than employees or other members of his/her family and/or damage to property excluding that owned by or in the custody or control of the Insured during the Period of Insurance inclusive of legal expenses.

7.3.7.2 The Insurer will pay reimbursement under the following conditions:
a. The insurance limit is for any one Policy, even if multiple losses are incurred by multiple Insured Persons carrying the Policy;
b. The Insured Person cannot make statements nor admit liability for any loss, damage or Injury caused by themselves.

7.3.7.3 The insurer will not pay reimbursements in the following cases:
a. Employers' liability, contractual liability, or liability to a member of a family or a Traveling Companion;
b. Animals belonging to or in the care, custody, or control of an Insured Person;
c. Any willful, malicious, or unlawful act;
d. Pursuit of trade, business, or profession;
e. Ownership or occupation of land or buildings;
f. Ownership, possession or use of vehicles, aircraft, or motor-powered watercraft;
g. The influence of intoxicating liquor, or the use of firearms;
h. Legal costs resulting from any criminal proceedings.

7.3.8 **Legal Expenses**

7.3.8.1 Legal costs and expenses incurred by an Insured Person up to the limit in pursuit of compensation and/or damages against a third party arising from the death or personal Injury of the Insured Person during the Period of Insurance.

7.3.8.2 Conditions:

a. The Insurer shall have complete control over the legal proceedings and the appointment and control of a lawyer;
b. An Insured Person must follow the legal representative's advice and provide any and all information and assistance as required. Failure to do so will entitle the Insurer to withdraw cover;
c. The Insured must have access to legal documentation to support the claim;
d. Failure by the Insured Person to comply with all or any of these conditions will entitle the Insurer to render the legal expenses aspect of this Policy void and thereby withdraw cover;
e. The insurance will not extend to covering an Insured Person in the pursuit of any appeal except at the Insurer's sole discretion;
f. Where there is a possibility of a claim being brought in more than one country the Insurers shall not be liable for the cost if an action is brought in more than one country.

7.3.8.3 Exclusions:

The Insurer shall not be liable for:

a. Costs incurred in pursuit of any claim against a Travel Agent, Tour Operator, Common Carrier, Accommodation provider, the Insurer or Insurer's Agent, or any other commercial entity;
b. Legal expenses incurred prior to the granting of support by the Insurer;
c. Any claims reported more than 90 days after the commencement of the incident, giving rise to such claim;
d. Any claim where the law, practices, and/or financial regulations of the country in which the proposed action will take place indicate that the costs of such action are likely to be unreasonably greater than the anticipated value of the compensation award;
e. Costs incurred in pursuance of a claim against any person with whom an Insured Person had arranged to travel;
f. Any claim where, in the Insurer's opinion, there is insufficient prospect of success in obtaining a reasonable benefit;
g. Any claim where legal costs and expenses are based directly or indirectly on the amount of an award.

7.3.9 **Accidental death and dismemberment**

If the Insured Person sustains a major bodily injury caused by an accident during the Insurance Period, which results in death or dismemberment during the Insurance Period, the Insurer will pay up to 100% of the Personal Accident limit shown in the Schedule of Benefits, depending on severity, according to the following table:

Death	100%
Loss of sight of one eye	50%
Loss of one hand or one foot	50%
Loss of one hand and the sight of one eye	100%
Loss of one foot and the sight of one eye	100%
Loss of both hands or both feet	100%
Loss of sight of both eyes	100%
Loss of one hand and one foot	100%

To substantiate a claim for Death or Dismemberment benefit covered by the terms of the Policy, the following initial documents have to be submitted by the Insured Person or by either the Insured Person's heirs or designated beneficiaries as soon as possible in given circumstances:

a. Claim form, completed by the claimant or his legal representative;
b. Copy of the claimant's legal heir ID card or passport;
c. A detailed medical report on the onset and course of the bodily injury resulted in dismemberment or death. In the event of no medical treatment, a medical or official certificate stating the cause and circumstances of death;
d. Any other relevant documents proving the date and circumstance in which the insurance event occurred, such as, but not limited to Police report, GP reports, etc.
e. In case of death: certificate of death issued by competent authorities, indicating the date of birth of the deceased Insured Person, and legal confirmation (made by competent authorities or duly authorised lawyers) of the legal heirs or beneficiary-on-death

7.4 Trip Cancellation and Trip Interruption

7.4.1 The Insurer will reimburse non-refundable costs incurred as a result of the Covered Trip being necessarily and unavoidably cancelled or interrupted due to any of the following reasons which occurred during the Period of Insurance:

a. Sickness, Injury, death, or hospitalization of the Insured person. A Doctor must certify the Injury or Sickness;
b. Sickness, Injury, or death of an immediate family member or Traveling Companion of the Insured Person;
c. the Insured Person is unexpectedly called to the military service or military leave is unexpectedly revoked or reassigned and the competent authority does not recognize the booked journey as a reason for postponing the call-up;
d. loss of job without fault, as a result of notice of termination issued by the employer of the insured person;
e. serious damage to the property of the Insured person at his/her place of residence by Natural Disaster (flood, storm etc.), fire, burst water pipes, vandalism, or burglary, making the Insured person presence absolute necessary;
f. theft of travel tickets, passport (with sufficient validity for the booked trip) or driver's license of the insured person, if these are needed for the trip and replacements cannot be procured in time.

7.4.2 Special Conditions of Trip Cancellation benefit:
Limited to non-refundable expenses only.

- Trip Cancellation benefits can be purchased at every time prior to the trip however the cancellation cover will be applicable maximum 30 days and minimum 48h before the scheduled departure.
- Insured Person must declare total Trip cost at time of claim and provide proof of purchase.Cover under this section is invalid if at the time of scheduling the trip (i.e., accommodation and transportation costs have been incurred), if the local Regulator had specifically cautioned against all travel to that destination.
- Cost of Trip may include airfare, accommodations and any other pre-paid or booked expense related to the journey.
- The vendor policies relating to the Cancellation may be required at time of claim to ascertain if there are any travel credits or compensation offered by the vendor. These will be deducted from the final settlement hereunder.

7.4.2.1 The Insurer will not pay reimbursement in the following cases:

a. The reason of the Trip cancellation already existed or was foreseen by the Insured person at the time of the purchase of Insurance; or the reason of the trip interruption already existed or was foreseen at the start of the Trip;

b. The travel company withdraws from the travel agreement;
c. The reason of the trip cancellation is connected with a pandemic or epidemic.

Benefits payable under this insurance are subject to limits established in the Schedule of Benefits.

8 General exclusions

8.1 If not otherwise expressly indicated in the Policy or Certificate, the following is not covered by this insurance and thus no Claim shall be paid under the Insurance Contract in connection with any of the following:

8.1.1 Medical Treatment, goods, services, and other benefits that are not indicated as covered in the Schedule of Benefits;

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

8.1.3 Treatment of Pre-Existing Medical Conditions after the strong pain has been waived or after the immediate threat to the Insured Person's life has been eliminated;

8.1.4 Any Benign or Malignant Tumor or a Chronic Condition, even if first diagnosed after Insurance Start Date;

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

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

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

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

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

8.1.10 military maneuvers, exercises, or weapon tests;

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

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

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

8.1.14 preparation of or participation in crimes or misdemeanors;

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

8.1.16 Medical tourism;

8.1.17 Expenses made in the Home Country or in a country where the client has a residency;

8.1.18 All expenses incurred after the policy end;

8.1.19 Sunburn;

8.1.20 Any prosthetic implants appliances (e.g., joint, ligament, hearth valves, lens, or cornea of the eye), braces, crutches, wheelchairs, etc.;

8.1.21 Immunisation and Vaccination;

8.1.22 Insured person's self-exposure to needless peril (except in an attempt to save human life);

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

8.1.24 sleep studies and other Treatments relating to sleep apnea;

8.1.25 smoking cessation Treatments whether or not recommended by a Doctor;

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

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

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

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

8.1.30 attending maternity/delivery preparation classes;

8.1.31 circumcision, unless Medically Necessary, and pre-authorized;

8.1.32 genetic counseling, screening, and testing.

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

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

8.1.35 Accident, if the Insured Person was driving after taking illegal drugs or substances;

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

8.1.37 Medical Treatments without Doctor's prescription;

8.1.38 complementary (and/or alternative) and or Experimental Treatment;

8.1.39 rejuvenation and spa treatments, cosmetic treatments, diet resorts, and convalescent rest;

8.1.40 medical Rehabilitation;

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

8.1.42 expenses related to Pregnancy including but not limited to prenatal care, childbirth, abortion,

8.1.43 maternity or delivery preparation classes,

8.1.44 elective Caesarean section,

8.1.45 care or treatment for an individual acting as a surrogate;

8.1.46 out-patient physiotherapy;

8.1.47 sterilization and Infertility Treatment;

8.1.48 taking contraceptive medicine and methods;

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

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

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

8.1.52 undergoing remedial teaching course;

8.1.53 undergoing sex change Surgery and all related Treatments;

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

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

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

8.1.57 expenses and losses suffered before the start of the Insurance Period or after the Insurance Expiry Date; as well as expenses and losses suffered due to reasons that rose before the start of the Insurance Period or after the Insurance Expiry Date;

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

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

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

8.1.61 all costs relating to orthotics for example insoles;

8.1.62 Kidney Dialysis (renal insufficiency);

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

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

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

8.1.66 Expenses for Preventive Care, as well as expenses for incurred taxes and the issue of medical documents;

8.1.67 Palliative Treatment of terminal Illness & hospice care;

8.1.68 Reconstructive Surgery;

8.1.69 Speech Therapy;

8.1.70 HIV/AIDS;

8.1.71 Congenital / hereditary diseases;

8.1.72 Dental treatment other than that specified in the Schedule of Benefits.

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

8.1.74 No medical consultations, Treatments, evacuation and any other Benefit or services shall be paid in case of the Insured Person's violation of the insurance eligibility conditions (Paras 2.1-2.3 of these Rules).

8.1.75 No medical consultations, Treatments, evacuation and any other Benefit or services shall be paid in case of the Insured Person's engagement in **any Professional sport, or** while participating in: Mountaineering; racing by horse; solo scuba diving; mountain skiing and snowboarding outside designated boundaries / marked skiing/snowboarding tracks / areas; jumps, stunts, aerials, half-pipes, moguls or racing while mountain skiing and snowboarding; skiing and snowboarding for hire/compensation.

9 How to introduce amendments into the contract

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

9.2 If the Policyholder would like to cancel the insurance cover for an Insured Person before the Insurance Expiry Date, the Policyholder must notify the Insurer about it accordingly in writing or by e-mail. The Policyholder must also notify the Insurer or the Assistance Service about the Insured Person's death as soon as practically possible in given circumstances. Article 10 "Contract Termination" of these Rules shall be applicable for cases

mentioned in this paragraph of the Rules. Should the Repatriation or Burial locally benefit be indicated as covered by the applicable Schedule of Benefits, the Assistance Service will help with making these arrangements (in this case the Assistance Service should be provided with the circumstances of death and, if available, with the death certificate).

10 Contract termination

10.1 The Contract terminates in the following cases:

10.1.1 expiration of the Insurance Period;

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

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

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

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

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

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

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

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

10.3 In case of the Contract cancellation by the Policyholder prior to the Insurance Period commencement, the Insurer shall refund to the Policyholder 100 % of the paid Insurance Premium within 20 business days from the date when the Policyholder's cancellation notice was received by the Insurer (save for the exceptions foreseen below in paragraph 10.4 and/or elsewhere in the Contract).

10.4 If the Certificate is cancelled by the Policyholder after the Insured Person received some Medical Treatment or assistance covered by the Contract, then no Insurance Premium refund is available under Contract:

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

11 Duty of disclosure

11.1 The Policyholder and the Insured Person must take proper care and concern when answering any questions asked by the Coverholder when entering into the Contract, at its renewals, etc., ensuring that any information provided is accurate and complete. The Policyholder and the Insured Person are liable to disclose to the Coverholder all circumstances known to them (including but not limited to the circumstances declared in the relevant insurance application form), which are significant for the assumption of the insurance risk under

the Contract (i.e., all circumstances that are likely to have an influence on the Insurer's decision to accept the risk/on the conditions subject to which the risk may be accepted). When the Coverholder makes a decision about terms and conditions on which a person could be insured under a Contract (including the level of Insurance Premium, Waiting Period, Underwriting, exclusions, the Schedule of Benefits to be applicable, and other special insurance conditions), it fully relies on the information provided by the Policyholder and the Insured Person.

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

a. treat such Contract void from the start;
b. decline all Claims thereunder; and
c. retain the Insurance Premium received; and
d. demand reimbursement of all the Benefits as paid by the Coverholder under such Contract;
e. demand reimbursement of all other cost and damages as suffered by the Coverholder in relation thereto.

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

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

a. treat the Contract void from the start, refuse to pay any Claim thereunder and return the Insurance Premium received; or
b. propose changes to the conditions of the Contract with due regard to the accurate and complete information that has become available.

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

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

a. decline all Claims under such Contract;
b. retain the Insurance Premium received;
c. demand reimbursement of all the Benefits as paid by the Coverholder under such Contract;
d. demand reimbursement of all other cost/damages suffered by the Coverholder in relation thereto.

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

a. will not be liable to pay such Claim; and
b. any amount paid by the Coverholder in respect of such Claim will become immediately due and owing to the Coverholder; and

c. should the Insured Person be insured by the Policyholder (as its employee, member or else), the Coverholder reserves the right to inform the Policyholder about such fraudulent acts of the Insured Person or his/her representatives;
d. may by notice to the Policyholder treat the Contract as having been terminated with effect from the time of the fraudulent act.

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

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

12 Data privacy

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

12.2 Processing of Personal data under the Contract shall be subject to the Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the Processing of Personal data and on the free movement of such data and repealing Directive 95/46/EC (General Data Protection Regulation). Therefore, all the definitions and terms as used in this Contract in respect of Processing of Personal data shall be interpreted with regards to this General Data Protection Regulation.

12.3 The following Personal data of data subjects will be processed based on the Contract:
a. full name;
b. age/date/place of birth;
c. gender;
d. address and other contact details (Home Country, data related to planning on moving out of the Home County, e-mail address, telephone numbers);
e. identification data — identification document number (i.e., passport number), identification document;
f. social security-related data (including social security card number and other related data);
g. travel-related data;
h. IP addresses when visiting the Insurer's/Coverholder's webpage without disabling cookies;
i. nationality, citizenship;
j. marital status;
k. education-related data — data pertaining to name of the overseas educational establishment to which the Policyholder has enrolled.;
l. signature, photo;
m. results of Criminal Checks relating to prevention of Fraud and/or Terrorist Activities — if mandatory and requested by applicable laws;
n. Dependents/Spouse/Partner/Family Details;
o. bank and related financial/taxation data (including copies of bank cards, credit/debit card, and bank account details);
p. health and medical history, medical condition related Personal data, such as data on Medical Treatment, goods, and services as provided to data subjects; data resulting from medical reports or from death

certificates; medical and medical Claims history; details of physical and psychological health or medical conditions; etc.;

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

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

12.4 Full information about how Personal data shall be processed under the Contract is provided in the Privacy Policy, which can be viewed by clicking on the site terms and conditions at the website www.dhig.net.

12.5 The Controller of Personal data of the persons to be insured, Persons Insured and Dependents shall be the Insurer. The contact details of the Insurer are as indicated in the Certificate.

12.6 The Coverholder is the processor of Personal data as appointed by the Insurer. The Coverholder is entitled to engage other processors as may be necessary for Processing of Personal data for the purposes as set in paragraph 12.8 of these Rules.

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

12.8 The contact of the data protection officer: dpo@dhig.net.

12.9 The Personal data is collected by the Coverholder or on its behalf and may be used by the Coverholder and/or persons engaged by it (when acting under the Coverholder's instructions) for the purposes of the execution and administration of the Contract (including but not limited to Underwriting and Claims handling), administration of debt recoveries, insurance mediation, research or for statistical purposes, fraud prevention, meeting legal obligations, and arranging redistribution of the insurance risk (for arranging reinsurance and/or co-insurance).

12.10 Legal grounds for Processing of Personal data under the Contract may be as follows:

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

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

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

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

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

12.11 Personal data may be processed both inside and outside of the European Economic Area (EEA) by the parties specified in paragraph 12.6 above, subject always to contractual restrictions regarding confidentiality and

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

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

a. to access his/her Personal data to learn the origin of the data, the purposes and ends of the Processing, the details of the data controller(s), the data processor(s), and the parties to whom the data may be disclosed;
b. to withdraw his/her given consent at any time where his/her Personal data is processed based on such a consent;
c. to update or correct his/her Personal data so that it is always accurate;
d. to delete his/her Personal data from the records if it is no longer needed for the purposes indicated above, subject to regulatory Personal data retention requirements;
e. to restrict the Processing of his/her Personal data in certain circumstances, for example where the data subject has contested the accuracy of his/her Personal data, for the period enabling verifying its accuracy;
f. to obtain his/her Personal data in an electronic format;
g. to exercise the right to data portability;
h. to file to the relevant data privacy authority.
i. The data subject may exercise his/her rights by contacting the Coverholder at data@dhig.net, while providing his/her name, Contract number, the Policyholder, e-mail address, and the purpose of the request. Where permitted by applicable law or regulation, the data subject shall have the right to object to Processing request stopping Processing of his/her Personal data under the Contract. Under such circumstances, the Processing of Personal data will be stopped, unless permitted by applicable laws and regulations.

12.13 The Personal data collected under the Contract will be retained for a period of time equal to the duration of relevant Insurance Period (including any renewals thereof) and for the following 10 years from the date the Contract expires, save for cases where a longer retention period is required for possible disputes, requests of the competent authorities or pursuant to the applicable laws. Once the retention period is over the data will be deleted or anonymized.

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

12.15 The Coverholder may also conduct credit reference checks in certain circumstances. Further details can be found in our full Privacy Policy explaining how the information held by fraud prevention agencies may be used.

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

13 Complaints

Should the Insured Person have questions or complaints (including but not limiting to complaints regarding the Assistance Service or Providers as engaged by the Coverholder), he/she may firstly call the helpline phone as set in

the Certificate. If the question/complaint is not resolved to the satisfaction of the Insured Person, then he/she is entitled to contact the Coverholder per e-mail: complaints@dhig.net. The Coverholder will handle the complaint as soon as practicably possible and present the complaining person with an answer within a reasonable period of time from the moment of receipt of a complaint, but not later than 60 calendar days.

14 Amateur sports and active leisure activities covered by this insurance

The following table confirms the sports and activities that this policy will cover on an incidental basis (which means that the sport or activity the Insured is taking part in on his/her trip is on a strictly amateur basis and is purely for leisure purposes).

Abseiling Cover Limitation: under supervision of a qualified instructor or guide	Aerobics
Angling / Fishing	Archery
Badminton	Banana Boating / Donuts / Inflatables Cover Limitations: under supervision of a qualified instructor or guide
Bar and restaurant work Cover Limitation: excludes manual work	Baseball Cover Limitation: amateur only
Basketball Cover Limitation: amateur only	Beach Games
Billiards, snooker, and pool	Blade skating
Board Sailing	Body Boarding
Bowls / Bowling	Bridge Walking Cover Limitation: under supervision of a qualified instructor or guide
Camel Riding Cover Limitation: under supervision of a qualified instructor or guide	Canoeing Cover Limitation: up to grade 2 on rivers only
Cave tubing Cover Limitation: under supervision of a qualified instructor or guide and organized through a licensed operator	Catamaran Sailing Cover Limitation: under supervision of a qualified instructor or guide
Charity or conservation work Cover Limitations: strictly voluntary basis and organized by a registered charity or conservation organisation. Excludes manual work	Clay Pigeon Shooting Cover Limitation: under supervision of a qualified instructor or guide and organized through a licensed operator
Climbing Cover Limitation: indoor climbing walls only	Cricket
Croquet	Cross Country Running Cover Limitation: no racing

Curling	Cycling Cover Limitations: leisure only, no racing and to a maximum of 1,000 metres altitude
Deep Sea Fishing Cover Limitation: under supervision of a qualified instructor or guide	Dingy Sailing Cover Limitation: no racing and within sight of land at all times
Dingy Sailing Cover Limitation: no racing	Dodge ball
Driving any motorcycle / moped / scooter (up to 250 cc) or a car, for which you are licensed to drive in your Home Country. Cover Limitations: no motor rallies or racing. For scooter, mopeds or motorcycles you must wear a crash helmet and appropriate protective clothing	Elephant Riding Cover Limitation: under supervision of a qualified instructor or guide
Falconry Cover Limitation: under supervision of a qualified instructor or guide	Fell Walking / Running / Rambling / Trekking Cover Limitation: under 1,500 metres altitude
Fencing	Fishing
Flotilla Sailing Cover Limitation: under supervision of a lead skipper and within 20 miles of coastland or inland water	Flying Cover Limitation: as a passenger in a fully licensed passenger aircraft only
Football Cover Limitation: amateur only	Fruit picking Cover Limitation: no manual work
Geocaching Cover Limitation: under 1,500 metres altitude	Glass-bottom boats and bubbles
Go Karting Cover Limitation: under supervision of a licensed operator	Golf
Handball	Helicopter Rides / Tours Cover Limitation: as a fare paying passenger in a fully licensed helicopter only
Hiking Cover Limitation: under 1,500 metres altitude	Hill Walking Cover Limitation: under 1,500 metres altitude
Hockey Cover Limitation: field hockey only	Horse Riding Cover Limitation: no polo, hunting, jumping, or racing and you must wear a helmet

Hot Air Ballooning Cover Limitation: As a passenger under supervision of a licensed operator	Hydro Zorbing Cover Limitation: under supervision of a licensed operator
Ice Skating Cover Limitation: In a rink and no hockey or speed skating	Jet Boating Cover Limitation: no racing and as a passenger with a licensed operator
Jogging	
Kayaking Cover Limitation: under supervision of a licensed operator and up to grade 2 on rivers only	Kite surfing
Korfball	Marathon running Cover Limitation: no competitions
Motor Boating Cover Limitation: as a passenger under supervision of a licensed operator	Mountain Biking Cover Limitations: wearing a helmet and only casual or off road. No endurance, downhill, freeriding, four- cross, dirt jumping, trials, stunting or racing
Narrowboat / Canal Cruising Cover Limitation: inland waters only	Netball
Office Work Cover Limitation: purely office based managerial, supervisory, sales or administrative	Orienteering Cover Limitation: under 1,500 metres altitude
Paint Balling Cover Limitation: you must wear eye protection and appropriate safety clothing	Parascending Cover Limitation: towed by a boat over water only and with a licensed operator
Pony Trekking Cover Limitation: you must wear a helmet	Rackets / Racquetball
Rambling / Walking Cover Limitation: under 1,500 metres altitude	Rifle Range Shooting Cover Limitation: under supervision of a qualified instructor or guide and with a licensed operator
Ringos Cover Limitation: under supervision of a qualified instructor or guide and with a licensed operator	River Tubing Cover Limitation: under supervision of a qualified instructor or guide
Roller Blading	Roller Skating
Rounders / Softball	Rowing Cover Limitation: no racing and within sight of land at all times

Running Cover Limitation: no racing	Safari Cover Limitation: under supervision of a qualified instructor or guide and organised with a licensed operator
Sail Boarding	Sailing / Yachting Cover Limitation: No racing and within sight of land at all times
Sandboarding / Sand Dune Surfing	Sand Yachting
Scuba Diving Cover Limitation: to a maximum depth of 18 metres. No solo diving. If unqualified you must be accompanied by a qualified instructor or dive master. No commercial or professional or technical diving (such as cave or cavern, ice, enriched air, free, tutor or wreck diving)	Shark Diving Cover Limitation: in a cage only and under supervision of a qualified instructor or guide. Organised through a licensed operator
Skateboarding Cover Limitation: you must wear a helmet	Snooker, Pool or Billiards
Snorkelling	Squash
Stand-up Paddle-boarding	Surfing
Swimming Cover Limitation: within sight of land at all times	Swimming with dolphins Cover Limitations: under supervision of a qualified instructor or guide and organised through a licensed operator
Table Tennis	Tennis
Tenpin Bowling	Track Events Cover Limitation: amateur athletic events that take place on a running track
Trampolining	Tree canopy walking
Trekking Cover Limitation: under 1,500 metres altitude	Tubing Cover Limitation: under supervision of a qualified instructor or guide
Tug of War	Volleyball
	Walking Cover Limitation: under 1,500 metres altitude
Water Polo	
Wind Surfing	Whale Watching
Yoga	Zip Lining Cover Limitation: under supervision of a qualified instructor or guide
Zorbing Cover Limitation: arranged with a licensed operator	

14.1 If the Insured person participates in any sports or activities not mentioned in the above table, he/she will not be covered by this policy.

14.2 If the Insured person participates in any sports or activities mentioned in the above table, he/she is always required to wear the appropriate safety equipment for that activity (e.g. protective clothing and / or suitable head protection). Otherwise, this insurance becomes invalid.

14.3 If the Insured person uses a motorized vehicle during the Trip, he/she should ensure that he/she holds a full and valid driving license that permits him/her the use of such a vehicle. Otherwise, this insurance becomes invalid.

15 Final provisions

15.1 Confidential information

In accordance with these Rules, the following information shall be deemed to be confidential:

a. the amount of the Insurance Premium paid under the Contract and special conditions of insurance, if any has been agreed between the parties to the Contract;
b. the Personal data as processed under the Contract:
c. other data that is acknowledged to be confidential under the applicable laws and/or common sense/common business practice.
   Save for the exceptions foreseen in the Contract, the Coverholder, the Policyholder, the Insured Person, and Dependents shall take sufficient measures to prevent disclosure of the confidential information to un/authorized third parties.

15.2 Applicable law

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

15.3 Correspondence

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

15.4 Language of correspondence

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

15.5 Changes in taxation regulation

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

15.6 Circumstances beyond reasonable control

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

For the avoidance of any doubts, the Coverholder/Insurer is released from its obligations under the Contract, if execution of such obligations becomes impossible as a result of international sanctions.

15.7 Submitting a Claim

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

15.8 Sanctions Compliance

No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the Republic of Bulgaria, the Slovak Republic, the European Union, the United Kingdom, the United States of America (provided that this does not violate any regulation or specific national law applicable to the undersigned (re)insurer).