GLOBALITY HEALTH
premium health insurance worldwide

Xtend
International Occupational Health Insurance

General Conditions of Insurance

Contents

A. Contractual Basis

The Insurer underwriting the Insurance Policy is Foyer Global Health S.A., a health insurance company established in Luxembourg under the form of a public limited liability company (société anonyme) having its registered office at 12, Rue Léon Laval L-3372 Leudelange, registered under no. B134471 in the Luxembourg Trade and Companies Register, supervised by the Commissariat aux Assurances (11, rue Robert Stumper, L-2557 Luxembourg; +352226911-1; caa@caa.lu).

The mutual rights and obligations of the Insurer, the Policyholder and the Insured Person under the Insurance Policy are governed by the following documents, as amended from time to time, which, together, constitute the Insurance Policy:

- the Insurance Certificate;
- any subsequent written agreements concluded between the Insurer, the Policyholder and, where relevant, the Insured Person;
- the present General Conditions of Insurance;
- the Glossary included at the end of the present General Conditions of Insurance;
- the Group Contract;
- any relevant applicable statutory rules and regulations.

In case of any discrepancy between these General Conditions of Insurance and the Group Contract, the provisions set out in the Group Contract shall prevail.

Within the scope of the maximum reimbursement amount agreed for the Insured Person in the Group Contract, the Insurer will refund up to 100 % of the eligible expenses up to the annual overall limit listed in the scope of Benefits set out below, unless reflected otherwise in these General Conditions of Insurance, the Group Contract, the Insurance Certificate, or any subsequent written agreement between the Insurer, the Policyholder and, where relevant, the Insured Person.

Any information provided by the Insurer to the Policyholder via the Insurance Policy is deemed to remain valid unless otherwise stated to the contrary.

B. Special Conditions

1. Scope of cover

1.1 The Insurer provides Benefits for Diseases and Bodily Injuries. There is also insurance cover for:

- Routine health checks, vaccinations, immunizations,
- Pregnancy and childbirth,
- Professional teeth cleaning.

1.2 Upon the occurrence of a Claim, the Insurer shall reimburse expenses for Medical Treatment.

2. Benefits

Benefits	Xtend 300	Xtend 600	Xtend 900	Xtend 1200
Annual overall limit	€ 300.00	€ 600.00	€ 900.00	€ 1,200.00
Outpatient treatment				
Methods of alternative medicine	✓	✓	✓	✓
Drugs/dressings/remedies	✓	✓	✓	✓
Therapeutic aids (including visual aids and hearing aids)	✓	✓	✓	✓
Refractive eye surgery	✓	✓	✓	✓
Routine health checks/vaccinations/ health courses	✓	✓	✓	✓
Dental treatment	✓	✓	✓	✓
Professional teeth cleaning				
Root and periodontal treatment	✓	✓	✓	✓
Dental fillings, dentures and dental crowns	✓	✓	✓	✓

✗ not covered ✓ covered/paid in full

The specified annual overall limit applies per insured person and per insurance year.

2.1 Methods of alternative medicine

The Insurer will reimburse the eligible expenses for Medical Treatment carried out by a Doctor using alternative medicine methods.

The prerequisite is that the methods are state-recognized or in the currently valid fee schedule for state-recognized alternative practitioners.

2.2 Drugs, Dressings, and remedies

The Insurer will reimburse the eligible expenses for Drugs, Dressings and remedies prescribed by a Doctor. This also includes Drugs, Dressings and remedies prescribed in connection with methods of alternative medicine in accordance with section 2.1. above.

The Insured Person must obtain the Drugs and Dressings from a pharmacy (including mail-order or internet pharmacies). They can also be obtained from another officially authorized dispensing point.

The Insurer will reimburse expenses for medically prescribed tube feeds if normal food intake is not possible due to a medical indication.

The Insurer does not reimburse expenses – not even in the case of an existing prescription for:

- Drugs that are prescribed solely for the purpose of contraception (e.g. ovulation inhibitors),
- Preparations for the treatment of erectile dysfunction and preparations to increase sexual potency,
- A means of slimming, suppressing appetite and regulating body weight,
- Preparations to improve hair growth,
- Preparations for smoking cessation,
- Preparations that are used in anti-ageing treatment, lifestyle treatment or cosmetic treatment (e.g. wrinkle smoothing),
- Vitamin preparations other than vitamin mono-preparations for the targeted treatment of vitamin deficiency diseases,
- Tonic,
- Cosmetic products, care products and disinfectants, bath additives,
- Mineral water and nutrients other than tube feeds (see above).

The following are considered remedies and are thus covered:

- physical-medical services (e.g. physiotherapy, massages),
- medicinal baths,
- speech therapy, podiatry, occupational therapy, and osteopathy services,
- nutritional therapy measures for rare congenital metabolic diseases, provided the Insurer has given written confirmation of Benefits before the start of treatment. Such a commitment is not required for cystic fibrosis/cystic fibrosis, insofar as they are calculated reasonably according to a usual, customary, and reasonable rate of fees typical for the country where the Insured Person receives the treatment.

The remedies must be provided by therapeutic professions that are licensed in the country in which the Insured Person needs treatment.

The Insurer does not reimburse additional expenses incurred for treatment in the Insured Person's home.

2.3 Therapeutic aids and appliances (including visual aids and hearing aids)

The Insurer reimburses the eligible expenses for medical aids prescribed by a Doctor.

The following are considered aids:

- Visual aids, hearing aids,
- Bandages, canes for the blind, hernia bands, insoles for foot correction, crutches,
- Inhalation devices,
- Compression stockings, corrective splints,
- Customised orthopaedic shoes,
- Orthopaedic adjustments to ready-made shoes,
- Speaking devices (electronic larynx).

Expenses for the repair and maintenance of medical aids are also eligible for reimbursement. This also applies to the necessary instruction on the use of aids.

Visual aids include spectacle lenses and frames as well as contact lenses, including daily and monthly disposable lenses.

The Insurer does not reimburse the expenses:

- for the repair of soles and heels of customised orthopaedic shoes,
- for the use (e.g. batteries) and care (e.g. cleaning agents or disinfectants) of aids,
- for products that belong to the fitness or wellness sector.

2.4 Refractive eye surgery (operations on the eye to correct defective vision)

The Insurer will reimburse the eligible expenses for medical services in the context of refractive eye surgery such as Lasik or lens replacement.

2.5 Routine health checks, vaccination and immunizations, preventive courses (health courses)

The Insurer will reimburse the eligible expenses for outpatient routine medical check-ups, vaccinations and immunizations including vaccination counselling and preventive courses.

Routine medical check-ups qualify as outpatient examinations for the early detection of Diseases.

The Insurer will provide Benefits regardless of the age limits and intervals that apply to examinations under statutory programs. Routine health check may include, for example: prenatal care, bone density measurement (osteoporosis screening), skin cancer screening with reflected light microscope, supplementary cancer screening such as sonography (ultrasound) of the breast in women.

The Insurer does not reimburse expenses for preventive examinations for the early detection of dental, oral and jaw diseases or dental prophylaxis services (excluding professional teeth cleaning). Costs associated with vaccinations acknowledged by the appropriate and recognized national authority, in the covered country of treatment, are eligible for reimbursement.

The insurance cover also applies to appropriately recommended travel vaccinations and medicinal malaria prophylaxis.

Expenses eligible for reimbursement include prevention courses in the covered country of treatment. The Insurer will reimburse expenses incurred for accredited programs aimed at fostering healthy habits. Courses focusing on pain prevention, stress management, healthy eating, or sleep improvement are eligible for reimbursement. Courses should be certified by the appropriate and recognized national authority. The provider of the prevention course must confirm this certification on the attendance certificate.

2.6 Professional teeth cleaning

The Insurer will reimburse the eligible expenses for professional dental cleaning.

2.7 Periodontological services, root canal treatments

The Insurer will reimburse the eligible expenses for:

- Periodontological services (e.g. local antimicrobial therapy, mucosal transplantation), and
- Root canal treatments (e.g. electrometric length determination).

2.8 Dental fillings, dental crowns, dentures

The Insurer will reimburse the eligible expenses for:

- Filling therapies, e.g. resin fillings using the dentin adhesive technique, inlays,
- Dental crowns including partial crowns, e.g. onlays, overlays, veneers,
- Dentures, e.g. bridges, prostheses,
- Implantological services,

This also includes surgical measures in this context, such as bone reconstruction.

- Veneers up to tooth 6,
- Restoration of dental crowns and dentures,
- Functional-analytical and functional-therapeutic services that are part of the dental services listed above,

- Accompanying services, such as local anesthesia and x-rays, which are required for the dental services listed above,
- Material and laboratory costs incurred for the dental services listed above, insofar as they are calculated within the framework of the usual, customary, and reasonable fees typical for the covered country of treatment.

2.9 Which Doctors can the Insured Person choose?

The Insured Person is free to choose its Doctor. The Insured Person can also go to facilities that are intended for the care of people with statutory health insurance. These are, for example, approved medical care centers.

The Insured Person can also make use of alternative practitioners acknowledged by the appropriate and recognized national authority within the covered country of treatment.

2.10 According to which fee regulations are the expenses for services provided by Doctors reimbursable?

Reimbursement is subject to usual, customary and reasonable rates that are applicable in the covered country of treatment. These rates refer to expenses associated with approved and covered medical services or supplies, not exceeding the standard fees charged by other providers of similar standing in the same geographical area, offering comparable treatment for a similar Disease and/or Bodily Injury.

2.11 According to which fee regulations are expenses for services provided by alternative practitioners eligible for reimbursement?

For services by masseurs, midwives, or practitioners of complementary medicine (where there may not be a separate usual, customary and reasonable rate in the covered country of treatment), reimbursement will be based on comparable fees for Doctors and customary prices in the country where the treatment occurs.

2.12 Reimbursement of expenses

Upon the occurrence of a Claim, the Insurer reimburses the eligible expenses for Medical Treatment at 100 %, up to the annual overall limit insured in the selected Plan per Insured Person and per insurance year, contingent upon the conditions set forth in the Insurance Policy and statutory regulations.

Expenses are allocated to the insurance year by reference to:

- the day of treatment, or the day on which the Doctor was consulted,
- the day on which the Drugs, Dressings or medical aid was obtained, or
- for prevention courses, the day on which the Insured Person took part in the course for the first time.

Any benefits paid in advance by the statutory health insurance, substitutive private health insurance, statutory accident or pension insurance, private accident or pension insurance or contributions for civil servants towards the cost of health care are offset against our benefits and must be proven on request.

3. Exclusions and Limitations

3.1 The Insurer does not cover expenses for the following Medical Treatments under the Insurance Policy unless they are covered in any other written addendum:

There is no insurance cover for illnesses and their consequences or for the consequences of accidents and deaths caused by war, civil unrest or acts of terrorism. However, there are exceptions depending on the situation of the insured person staying in the area of conflict concerned. The area of conflict may be a region, a country, an area within a country, or an area that crosses one or more country boundaries:

1. insured persons who are already in the area of conflict:

- If the insured person is already in the area of conflict when the war, civil unrest or acts of terrorism break out, insurance cover is only provided in the above cases if the insured person is an uninvolved third party who has not wilfully or negligently disregarded the danger and if it is necessary to remain in the area for a justified professional interest.
- If there is no justified professional interest, insurance cover is only provided for emergency treatment (e.g. life-saving measures) and only for

as long as the insured person is unable to leave the area of conflict through no fault of his own, but for a maximum of 28 days.

2. insured persons who enter the affected conflict area after the outbreak of war, civil unrest or acts of terrorism:

- If the insured person enters the area of conflict after the outbreak of war, civil unrest or acts of terrorism, there is no insurance cover unless the insured person is an uninvolved third party who has not wilfully or negligently disregarded the danger and if it is necessary to go into the area for a justified professional interest.

Coverage is strictly denied if the insured person enters an area of direct warfare or provides services to any of the warring parties.

The exclusion of benefits shall apply regardless of whether or not war has been declared.

3.2 The Insurer will not cover Diseases and Bodily Injuries, nor their consequences, if the latter have been caused fraudulently or intentionally ("de manière intentionnelle ou dolosive"). The Insurer considers in particular that a a Disease or Bodily Injury is caused intentionally if the Insured Person had at least some idea of the consequences of its actions and accepted these consequences.

3.3 The Insurer does not reimburse expenses incurred for Medical Treatment provided in the Insured Person's home. In particular, the Insurer will not refund the costs if the Insured Person is treated by its wife, husband, non-marital partner, parents, or children or any other person that is not a Doctor in the covered country of treatment. However, the Insurer will refund the proven cost of materials needed for the Insured Person's Medical Treatment in line with the Plan.

3.4 The Insurer will not provide coverage for any form of treatment or drug therapy that it deems to be experimental or investigational.

3.5 The Insurer will not provide coverage for any form of genetic testing unless particular genetic tests are explicitly mentioned as part of the Insured Person's Plan or the Insurer expressly gives prior written approval.

3.6 The Insurer's obligation to cover Medical Treatments under the Insurance Policy may also be limited or excluded in the following cases:

- If the Medical Treatment or other measure for which Benefits have been agreed is more than is medically necessary or if the amount claimed for is not within the usual, customary and reasonable cost range, the Insurer will be entitled to reduce the paid Benefits and the Insured Person shall bear all costs, which are not within the usual, customary and reasonable cost range in the covered country of treatment.
- In the event of an entitlement to benefits from statutory health insurance, substitutive private health insurance, statutory accident or pension insurance, private accident or pension insurance or contributions for civil servants towards the cost of health care, the following applies: The Insurer will only reimburse the remaining eligible expenses that are not covered by foregoing.

The maximum reimbursement amount is limited to the total expenses incurred by the Insured Person, regardless of whether they are eligible for benefits from multiple sources.

Further restrictions may apply:

- before the start and after the end of the insurance cover (see section 5),
- for stays outside the area of cover (see section 19),
- in the event of breaches of obligations under the Insurance Policy (see section 17).

C. General Conditions

4. Insured Persons

To qualify as an Insured Person under the Policy, employees of the Policyholder shall be registered by the Policyholder with the Insurer in accordance with the provisions of the Group Contract. By accepting to be registered in accordance with the Group Contract, the Insured Persons are deemed to also accept to be bound by the terms of the Insurance Policy and any rights and obligations deriving therefrom.

Any Insured Person shall receive a Globality Service Card.

5 When does the insurance cover begin and end?

5.1 The Insurance Policy is deemed to have been concluded as of the date of the signature of the Group Contract by the Insurer and the Policyholder.

5.2 The insurance cover provided under the Insurance Policy shall enter into force and take effect on the Effective Date.

5.3 The insurance cover provided under the Insurance Policy runs for a period of 12 (twelve) months until the renewal date of the Group Contract. At each renewal date of the Group Contract, the Insurance Policy is tacitly renewed year after year for a period of a maximum of 12 (twelve) months per renewal, if none of the parties opposes such renewal in accordance with the formalities and notice periods provided for under section 17 below.

5.4 If an employee of the Policyholder is not registered as being covered as an Insured Person by the Insurance Policy at the date of the signature of the Group Contract, the insurance cover begins for such employee on the first day of the month following the registration of the relevant employee as an Insured Person by the Policyholder with the Insurer.

5.5 No Benefits are granted for Claims occurring before the Insurance Policy takes effect.

6. Declarations

6.1 Upon entering into the Insurance Policy

The Policyholder undertakes to answer truthfully, exhaustively and in writing all the questions that the Insurer asks and to cause, where relevant, the Insured Person to do the same.

The Policyholder furthermore undertakes to declare accurately, at the time of conclusion of the Insurance Policy, all circumstances known to it and which it may reasonably consider as constituting elements that are relevant for the Insurer's assessment of the insured risk and to cause, where relevant, the Insured Person to do the same.

The insurance premium applicable to the Insurance Policy shall be set accordingly.

6.2 Intentional omission or inaccuracy

Notwithstanding other statutory grounds for nullity, the Insurance Policy shall be void in case of any intentional omission or inaccuracy affecting the aforementioned responses and declarations, which have misled the Insurer in its risk assessment. In such circumstances, the Insurer shall remain entitled to premiums already paid.

6.3 Unintentional omission or inaccuracy

If the omission or inaccuracy is unintentional, the Insurance Policy shall not be void. In such case, the Insurer may, however, within 1 (one) month from the date on which the Insurer becomes aware of the relevant omission or inaccuracy, propose an amendment to the Insurance Policy that would take effect at the date on which Insurer became aware of such omission or inaccuracy.

If the Insurer proves, in such circumstances, that the Insurer would never have insured the relevant risk if it had received the required full and accurate information when underwriting the Insurance Policy, the Insurer may terminate the Insurance Policy within 1 (one) month from the date on which it became aware of the relevant omission or inaccuracy.

If the Policyholder refuses the proposed amendment of the Insurance Policy or if such proposal is not accepted within 1 (one) month from the date on which the relevant proposal was received, the Insurer may terminate the Insurance Policy within 15 (fifteen) calendar days. If the omission or inaccuracy is the fault of the Policyholder and if a Claim arises before the amendment or termination of the Insurance Policy referred to in the preceding paragraphs becomes effective, the Insurer is only required to grant Benefits in accordance with the proportion of the premium actually paid by the Policyholder to the premium that the Policyholder would have been required to pay if the risk had been fully and accurately declared. However, if the Insurer proves that it would never have insured the relevant risk whose real nature was revealed by the Claim, the Benefits to be paid by the Insurer shall then be limited to the reimbursement of all premiums paid.

6.4 Other declaration obligations during the term of the Insurance Policy

The Policyholder and/or the Insured Person or Insured Persons is/are required to declare any circumstances that may result in a perceptible and lasting increase in the insured risk.

Where, during the performance of the Insurance Policy, the risk of the occurrence of a Claim is aggravated in such a way that, if the aggravating circumstance had existed at the time of underwriting the Insurance Policy, the Insurer would have concluded the Insurance Policy only on different terms, the Insurer shall, within 1 (one) month of the date on which the Insurer became aware of the relevant aggravating circumstance, propose an amendment to the Insurance Policy with retroactive effect to the date of the aggravation.

If the Insurer proves that it would never have insured the aggravated risk, it may terminate the Insurance Policy within the same period of time.

If the Policyholder refuses the proposal to amend the Insurance Policy submitted by the Insurer or if, after a period of 1 (one) month from the receipt of the relevant proposal, the proposal has not been accepted, the Insurer may terminate the Insurance Policy within 15 (fifteen) calendar days.

If a Claim occurs before either the amendment of the Insurance Policy or the termination of the Insurance Policy has taken effect, and if the Policyholder has complied with the requirement to declare all circumstances that may result in a perceptible and lasting increase in the insured risk, the Insurer shall be obliged pay the agreed Benefit.

If a Claim arises and the Policyholder has not complied with the requirement to declare all circumstances that may result in a perceptible and lasting increase in the insured risk:

a) the Insurer shall be obliged to pay the agreed Benefit, if the failure to declare is not the fault of the Policyholder;
b) the Insurer shall only be obliged to pay compensation in accordance with the proportion of the premium actually paid by the Policyholder to the premium that the Policyholder would have been required to pay if the aggravation had been taken into account, if the failure to declare is not the fault of the Policyholder. However, if the Insurer proves that it would never have insured the aggravated risk, its liability in the event of a Claim shall be limited to the reimbursement of the premiums paid in respect of the period following the occurrence of the relevant aggravation;
c) if the Policyholder has acted with fraudulent intent, the Insurer may refuse all Benefits. Premiums due up to the time when the Insurer became aware of the fraud shall be due to the Insurer as damages.

The provisions of the present clause shall not apply in the event where the state of health of the Insured Person changes.

7. Plan

The details of the Plan covered in the Insurance Policy are set out in the Group Contract.

8. Cumulative insurance

If another health Insurance Policy with mandatory Benefits exists in addition to this Insurance Policy, such mandatory health insurance shall take precedence over the Insurance Policy.

9. Right of withdrawal

In case the Insurance Policy is entered into remotely and qualifies as a "distance contract" within the meaning of the applicable rules and regulations, the Policyholder shall have a period of 14 (fourteen) calendar days to withdraw from it, without penalty and without providing an explanation or reason.

The period during which this right of withdrawal may be exercised begins to run:

- from the date on which the Insurance Policy is entered into remotely; or
- from the date on which the Policyholder receives the Insurance Policy if this date is subsequent to the date referred to in the first indent.

If the Policyholder exercises his/her right of withdrawal, such exercise shall be notified before the expiry of the 14 (fourteen) day withdrawal period by registered letter to the registered office of the Insurer indicated in these General Conditions of Insurance. This deadline is deemed to have been met if the notification is postmarked before the expiry of the withdrawal period.

The withdrawal shall have the effect of releasing the Policyholder for the future from any obligation under the Insurance Policy.

Where the Policyholder exercises its right of withdrawal, it may only be required to pay, as soon as possible, for the insurance cover actually provided by the Insurer under the Insurance Policy, and provided that the amount due has been duly communicated to the Policyholder. The execution of the Insurance Policy may only begin after the Policyholder has given its consent. The amount to be paid:

- shall not exceed an amount proportionate to the insurance services already provided in relation to the entirety of the services provided for under the Insurance Policy;
- shall in no case be such as to be construed as a penalty.

The Insurer shall not be entitled to request any payment if, before the expiry of the withdrawal period, it began execution of the Insurance Policy without previously being requested to do so by the Policyholder.

The Insurer shall be obliged to reimburse to the Policyholder, as soon as possible and at the latest within 30 (thirty) calendar days, all sums received from the Policyholder in accordance with the Insurance Policy, with the exception of the amount due by the Policyholder for the insurance cover actually provided referred to in the previous paragraphs. Such 30 (thirty) days period shall begin to run on the date on which the Insurer receives notification of the withdrawal. If reimbursement is not made within 30 (thirty) calendar days, the amount due shall be increased by operation of law at the statutory interest rate applicable from the first day after expiry of the relevant payment period.

The Policyholder shall return to the Insurer, as soon as possible and at the latest within 30 (thirty) calendar days, any sums and/or property received from the Insurer, with the exception of insurance Benefits due for the period of insurance cover if such cover has already commenced at the request of the Policyholder. Such 30 (thirty) day period shall begin to run on the date on which the Policyholder's notification of withdrawal is postmarked. If the reimbursement is not made within 30 (thirty) calendar days, the sum due shall be increased by operation of law, at the legal interest rate in force, from the first day after the expiry of the payment period.

10. Premiums

10.1 Payment method, amount and due date

Unless otherwise stipulated, the premiums, fees and taxes due under the Insurance Policy must be paid in advance to the head office of the Insurer and/or the agent designated by the Insurer for this purpose. Payment is required from the Policyholder.

In case the Insurance Policy covers several insured risks, the total amount of premiums due under the Insurance Policy is considered to constitute one single indivisible premium.

The payment terms for the premiums, the due date and the amount of the premium are specified in the Group Contract. Any amendment to these terms requires the express written agreement of the Insurer.

10.2 Consequences of the late or non-payment of premiums

In the event of non-payment of premiums or of a fraction of a premium within 10 (ten) calendar days of the due date, the Benefits of the Insurance Policy shall be suspended after a grace period of 30 (thirty) calendar days subsequent to the sending, by the Insurer, of a registered letter to the Policyholder at his/her last known place of domicile. The Insurer shall also send the relevant registered letter to the last known email address of the Policyholder.

The registered letter contains a formal notice from the Insurer for the attention of the Policyholder to pay all premiums that are due. In addition, the letter specifies the due date and the total amount of the unpaid premiums, as well as the consequences of non-payment at the end of the aforementioned 30 (thirty) day grace period.

Claims occurring during the suspension period following the grace period shall not give rise to the granting of any Benefits from the insurer.

The Insurer has the right to cancel the Insurance Policy 10 (ten) calendar days after the expiry of the aforementioned 30 (thirty) day grace period.

If it is not cancelled, the Insurance Policy shall resume its effects for future Claims only as of the first hour of day following the date on which the Insurer or the agent appointed by the Insurer for this purpose receives the payment of the premiums that are due or, where the total amount of the annual premium is fractioned, the payment of the relevant fractions that have been notified as unpaid to the Policyholder, as well as the premiums that have expired during the suspension period and, where applicable, any legal and recovery costs.

The suspension of the Benefits does not affect the right of the Insurer to claim the premiums that become subsequently due, provided that the Policyholder has been sent formal notice notifying the Policyholder of the fact that the premiums have become due and that the Insurance Policy and the Benefits granted thereunder remain suspended. However, this right is limited to premiums pertaining to 2 (two) consecutive years.

If the Insurance Policy is suspended due to the non-payment of premiums or fractions of premiums for an uninterrupted suspension period of 2 (two) years, it shall terminate automatically upon expiry of that period.

10.3 Calculation of premiums

The method for the calculation of premiums is set out in the Group Contract.

10.4 Change of tariff

Any change, by the insurer, of the tariff of the premium shall occur in accordance with the provisions of the law of 27 July 1997 on the insurance policy as amended from time to time, and the terms of the Group Contract.

11. Service quality

The service quality applicable to the Insurance Policy shall be governed by the terms of the Group Contract.

12. Timeline for the reporting of Claims

Without prejudice to the provisions of the present General Terms and Conditions, the Policyholder and/or the Insured Party must report any Claim to the Insurer within 30 (thirty) days or as soon as reasonably possible. Claims shall be reported through "My Globality Online Portal".

13. Obligations and formalities to be completed when making a Claim

The Insured Person must take all the necessary measures to avoid or limit the consequences of any Claims.

The Policyholder and/or the Insured Person must without delay provide all relevant information and documents to the Insurer and/or its agent, where relevant, and respond to all of the latter's inquiries, in order to enable the Insurer to determine the circumstances and the extent of the Claim.

At the request of the Insurer, the Insured Person is required to be examined by a Medical Authority appointed by the Insurer.

14. Payment of insurance Benefits

If the Policyholder or Insured Person is also entitled to Benefits from a national health insurance fund or from another insurance body or institution, the Insurer is only required to cover the costs incurred by the Policyholder or Insured Person, which exceed the Benefits already received from such other fund, body or institution .

The Insurer shall only pay Benefits if the supporting documents and information requested from the Policyholder and Insured Person are provided to the Insurer. Said documents shall thereafter become the property of the Insurer. The Insurer further reserves the right to archive the relevant documents according to the applicable rules and regulations.

The invoices and proofs of payment provided by the Policyholder and/or Insured Person must be original documents, which must comply with the legal provisions of the issuing country. Such invoices and proofs of payment may be provided to the Insurer by e-mail or ordinary mail, provided that the latter are readable and that the transmission quality of the documents is high enough for processing them.

Notwithstanding the foregoing, the Insurer may at any time request to be provided with the original supporting documents.

If another insurer and/or other institution has contributed to reimbursing costs, duplicate invoices and proofs of payment shall be sufficient, provided the Insurer is also provided with a document evidencing the amount reimbursed by the other insurer and/or other institution.

The following information must appear on the invoices: first and last name, as well as the date of birth of the Insured Person (and any potential co-insured persons), an exact statement of the Disease or Bodily Injury by a Doctor (diagnosis) or a precise description of the whole Disease or a reference to the relevant ICD Code 9 and/or 10 (International Classification of Diseases) or the whole Bodily Injury with treatment data and unit prices. For dental care, the designation of the teeth treated or replaced and the services relating thereto must be indicated.

The following information must be included on medical prescriptions: first and last name, as well as the date of birth of the Insured Person (and any potential co-insured persons), the prescribed medication, the price and the payment reference. Prescriptions must be provided with the Doctor's note of fees and/or the bill for Medical Treatment, medications and remedies.

The Insurer is entitled to request that the supporting documents and information be submitted on its own forms. The relevant forms must be duly completed by the Policyholder or the Insured Person and the attending Medical Authority as the case may be.

The Insurer is entitled to pay its Benefits to the person who submits the supporting documents and information in due form to the Insurer. In the event of doubts, the Insurer shall pay the reimbursement

amount to the Policyholder and any such payment shall validly discharge de Insurer from its relevant obligations under the Insurance Policy.

Health care costs incurred in a foreign currency shall be converted into euros at the exchange rate applicable on the day when the supporting documents are submitted to the Insurer.

Any supporting documents or information must be submitted in French, German, Spanish or English. Any fees incurred by the Insurer in relation to translations of documents and information into any other languages may be deducted from the insurance Benefits granted under the Insurance Policy.

15. Subrogation

The Insurer shall be subrogated in any rights and actions that the Policyholder or Insured Person may have against any third party in relation to a Claim, for the amount of Benefits paid by the Insurer under the Insurance Policy in this respect.

If, due to any actions or omissions of the Policyholder or Insured Person, the aforementioned subrogation may no longer produce its effects to the benefit the Insurer, the Insurer may claim repayment of the Benefits paid out under the Insurance Policy in proportion to the loss suffered.

The subrogation shall not adversely affect the Insured Person who would only have been partially compensated by the payment of Benefits under the Insurance Policy. In this case, the Insured Person may exercise its rights, for the amounts that remain owed to the Insured Person, in priority to the Insurer.

Except in the presence of malice from the Insured Person, the Insurer shall have no legal recourse against the Insured Person's descendants, ascendants, spouse and in-laws in direct line, nor against those living in the Insured Person's home, his or her hosts and household employees. However, the Insurer may take legal action against the aforementioned persons to the extent that their liability is effectively covered under an insurance policy.

16. Statute of limitations

The statute of limitation period for any legal actions arising out of or in connection with the Insurance Policy is 3 years.

Such limitation period starts running as of the day on which the event that gives rise to the relevant legal action occurs. If the person who is entitled to take action can prove that he or she became aware of the actionable event only at a later date, the limitation period shall start running only at such later date, without, however, exceeding 5 years from the date of the occurrence of the actionable event, except in case of fraud.

The statute of limitations runs also against minors or other persons deemed incapable under law. The statute of limitations does not run against the Insured Person that is unable to act within the prescribed time limit due to force majeure.

If the Claim has been reported in due time, the statute of limitation is interrupted until the Insurer has informed the Policyholder or Insured Person in writing of its decision pertaining to the Claim.

17. Termination of the insurance cover

17.1 Automatic termination

The Insurance Policy shall terminate automatically if the insurance cover has been suspended continuously for 2 (two) years.

The insurance cover shall further automatically end in the following cases:

a) When the Group Contract is ended by the Policyholder or by the Insurer,
b) If the Insured Person leaves the group of eligible persons to be covered under the Insurance Policy in accordance with the Group Contract,
c) If the Insured Person moves its habitual residence to a country outside the European Union or the European Economic Area,
d) With the Insured Person's death,
e) If the Insurance Policy is declared null and void.

If the Insurance Policy covers more than one Insured Person and the conditions for termination of the Insurance Policy are met only for particular Insured Persons, the exercise of the aforementioned termination rights may be limited to the relevant Insured Persons.

In the aforementioned cases, the insurance cover shall also end if the Medical Treatment has not yet been completed.

17.2 Termination by the Policyholder

The Policyholder may terminate the Insurance Policy in its entirety or terminate the Insurance Policy for certain Insured Persons at each renewal of the Insurance Policy upon receipt of the payment notice from the Insurer advising the Policyholder of the renewal of the Insurance Policy, of the due date of the next premium and of the Policyholder's right to terminate. The relevant termination letter must be sent by the Policyholder to the Insurer no later than 30 (thirty) calendar days after the date on which the aforementioned payment notice is postmarked. The termination shall take effect on the second business day following the date on which the termination letter is postmarked, but no earlier than the date of renewal of the Insurance Policy.

If the present General Conditions of Insurance are amended according to the terms of the present General Conditions of Insurance, the Policyholder may terminate the Insurance Policy within 1 (one) month of the dispatch of the notification letter from the Insurer informing the Policyholder of the relevant amendment. The termination shall take effect after 1 (one) month following the date of the bailiff notification of the termination letter, the date indicated on the receipt for the termination letter or the day following the delivery of the termination letter to the postal services, as the case may be.

If the premiums are increased in accordance with the provisions of the Group Contract, the Policyholder is entitled to terminate the Insurance Policy within 60 (sixty) days of the postmarked date of the Insurer's dispatch of the notification letter informing the Policyholder of the relevant premium increase. The termination shall take effect on the second business day following the postmarked date of dispatch of the termination letter, but no earlier than the date of renewal of the Insurance Policy.

If the Policyholder terminates the entire Insurance Policy or terminates it for one or more of the Insured Persons individually, the Insured Persons may renew the Insurance Policy by appointing a new Policyholder, provided that such appointment is declared to the Insurer within 2 (two) months of the relevant termination. The termination shall only take effect if the Policyholder proves to the Insurer that the relevant Insured Persons have been informed about the Policyholder's notice of termination.

17.3 Termination by the Insurer

Without prejudice to any other causes for termination provided for in the Insurance Policy, the Insurer may terminate the Insurance Policy with immediate effect if the Policyholder or an Insured Person has obtained or attempted to obtain insurance Benefits fraudulently. This right to terminate shall be forfeited if it has not been used within 1 month from the date on which the Insurer was informed of the facts prompting the termination. If the Insurance Policy covers more than one Insured Person and the conditions for termination of the Insurance Policy are met only for Insured Persons, the exercise of the aforementioned termination rights may be limited to the relevant Insured Persons.

17.4 Termination formalities and notice periods

Any termination of the Insurance Policy must be made by registered letter ("lettre recommandée"), by bailiff notification ("exploit d'huissier") or by delivery of the termination letter against receipt ("remise de la lettre de résiliation contre récépissé").

Unless otherwise provided for herein, the termination shall take effect after a period of 1 (one) month following the date of the bailiff notification of the termination letter, the date indicated on the receipt for the termination letter or the day following the delivery of the termination letter to the postal services, as the case may be.

17.5 Repayment of premiums in the case of termination
Notwithstanding the cause of termination, the premiums that have been paid by the Policyholder in relation to the insurance period that runs after the date on which the termination becomes effective shall be refunded within 30 (thirty) days of the date on which the relevant termination becomes effective. Once this 30 (thirty) day period has expired, statutory interest accrues by operation of law.

18. Voidness of the Insurance Policy
If, in bad faith, a given risk is insured under one or more insurance policies, including the Insurance Policy, with a premium that is too high, the Insurance Policy shall be null and void. In this case, the Insurer acting in good faith may keep the premiums collected as a means to indemnify any loss suffered.

19. Does the insurance cover also apply to stays abroad?
Insurance cover is provided for stays in all the countries of the European Union (EU), the European Economic Area (EEA) excluding Switzerland.

There is no insurance cover for permanent or temporary stays in countries outside the EU and the EEA.

20. Can the Insured Person request information about expert opinions or statements?
The Insurer may obtain expert opinions or statements to verify its obligation to pay Benefits under the Insurance Policy. The Insurer must provide information about their content on request to the Insured Person. The Insured Person is also entitled to inspect these documents.

If, for legal or therapeutical reasons, it is not possible to provide the Insured Person with access to the content of the relevant expert opinions or statements, the Insurer may refer the Insured Person to the Doctor, Medical Authority or lawyer who has prepared the relevant expert opinion or statement.

The claim can only be made by the Insured Person concerned or their legal representative.

21. Can the Insured Person transfer their Benefit entitlements to third parties?
The Insured Person may not pledge, transfer or assign its entitlement to the Benefits to third parties.

22. What consequences can a breach of obligation have?
If the Policyholder or Insured Person fails to comply with the obligations imposed upon them under the Insurance Policy, the Insurer may not be required to pay the Benefits, or may limit the Benefits, in accordance with the terms of the Insurance Policy.

23. Limitation of liability
In the absence of gross negligence (faute lourde) or wilful misconduct (dol) on its part, the Insurer shall not be liable to the Policyholder or the Insured Person for any loss, claim, liability, expense or damage arising from any action taken or omitted by the Insurer in connection with the provision of services or with the taking of any action contemplated under the Insurance Policy.

24. Local legislation
The Policyholder and/or the Insured Person may be subject to mandatory local health insurance legislation and obligations. The insurance cover provided under the Insurance Policy does not purport to comply with such local health insurance legislation and obligations and is not a substitute for any mandatory health insurance scheme that may be imposed upon the Policyholder and/or the Insured Person.

The Policyholder and the Insured Person expressly acknowledge, accept and consent to the fact that the Insurer may not be held liable for breaches of any local health insurance legislation or obligations to which the Policyholder and/or the Insured Person may be subject, and further expressly acknowledge, accept and agree to indemnify and hold harmless the Insurer against any direct or indirect loss, damage, cost, sanction, penalty, fee or other measure incurred in relation to such mandatory local health insurance legislation or obligations.

The Policyholder and the Insured Person undertake to verify and ensure that the conclusion of the Insurance Policy complies with any legal requirements to which they are subject.

25. Force majeure

The Insurer shall not be liable for any action taken, or for failure to take any action required to be taken, in fulfilment of its obligations or in exercise of its rights under the Insurance Policy in the event and to the extent that the such action or such failure arises out of or is caused by events beyond the Insurer's reasonable control (force majeure), including, without limitation, civil or labour disturbances, war, insurrection, riots, civil or military conflict, sabotage, labour unrest, strike, lock-out, fire, flood or water damage, acts of God, act of any governmental authority or threat of any authority (de jure or de facto), legal constraint, fraud or forgery, accident, explosion, mechanical breakdown, computer or systems failure, failure of equipment, failure or malfunction of communications media or interruption of power supplies, local or foreign law, judicial process, decree, regulation, order or other action of any local or foreign government, authority, court, self-regulatory organisation, government agency or instrumentality of government.

26. Disputes

In the event of a dispute regarding the Insurance Policy, the Policyholder is required to submit a written complaint to one of the following entities:

a) The senior management of the Insurer,
   Foyer Global Health S.A.
   12, rue Léon Laval
   L-3372 Leudelange
   Luxembourg
   Telephone : +352 270 444 3501
   Fax : +352 270 444 3599
   E-mail : feedback@globality-health.com
   Internet : www.globality-health.com
b) or to the Insurance Ombudsman, in care of the Association des Compagnies d'Assurances et de Réassurances du Grand-Duché de Luxembourg (Luxembourg Insurance and Reinsurance Association), 12 rue Erasme, L-1468 Luxembourg,
c) or to the Consumer Ombudsman, Union Luxembourgeoise des Consommateurs (Luxembourg Consumer Protection Association), 55 rue des Bruyères, L-1274 Howald,
d) or to the National Consumer Ombudsman Service, Service National du Médiateur de la Consommation, 6 rue du Palais de Justice L-1841 Luxembourg,
e) or to the Luxembourg Insurance Commission, Commissariat aux Assurances, 11 Rue Robert Stumper, L-2557 Gasperich Luxembourg. The opening of the complaint procedure with the Commissariat aux Assurances is subject to the condition that the complaint has been previously dealt with by the Insurer.

This is in addition to the Policyholder's right to pursue legal action in court. For further details on the out-of-court complaint resolution procedure, please refer to the "My Globality" procedure available on the Insurer's website at www.globality-health.com.

27. Notifications

All notifications from the Insurer to the Policyholder are deemed validly made if mailed by post to the Policyholder's last known address as reflected in the Insurer's records.

Notifications from the Insurer to the Policyholder are deemed to have been received by the Policyholder 10 (ten) calendar days after the postmarked date of their dispatch by the Insurer.

Notifications made to the Insurer must be sent to the Insurer's registered office, the address of which is stated in these General Conditions of Insurance.

28. Applicable law and competent court

The Insurance Policy shall be governed by and construed in accordance with Luxembourg law. Matters not expressly provided for in the Insurance Policy shall be governed by the applicable provisions of Luxembourg law.

For any dispute arising under or in connection with to the Insurance Policy, only the courts of Luxembourg, Grand Duchy of Luxembourg shall be competent, without prejudice to the application of relevant European regulations or of international treaties or agreements.

For any claim in tort against the Insurer, the courts of Luxembourg, Grand Duchy of Luxembourg, shall have exclusive jurisdiction.

29. Amendment of the General Conditions of Insurance

The Insurer may amend or change the General Conditions of Insurance. The Insurer shall notify the Policyholder in writing about the contemplated amendments or changes at least 3 (three) months before the beginning of the next insurance year. The amendment or change of the general conditions of insurance will then apply from the beginning of the next insurance year.

If the Policyholder does not agree to the proposed amendment or change of the General Conditions of Insurance, it may terminate the insurance policy by written notice addressed via registered letter to the Insurer within 2 (two) months of receiving the notice. The Insurance Policy shall in such case end on the date on which the change would otherwise become effective.

If no objection to the proposed amendment or change of the General Conditions of Insurance from the Policyholder is received by the Insurer within the aforementioned 3 (three) months deadline, the Policyholder shall be deemed to have tacitly approved the relevant amendment or change.

30. Change of contract data

Declarations of intent, conversions and notices concerning the Insurance Policy and any change of contact data pertaining to the Policyholder or the Insured Person must always be addressed to the Insurer in writing without delay.

Any information provided by the Insurer to the Policyholder in relation to the Insurance Policy is deemed to remain valid unless otherwise stated to the contrary.

The Insurer shall not be liable for any loss suffered as a consequence.

30.1. New address or new name

The Policyholder and/or the Insured Person must inform the Insurer of their new address or new name without delay, otherwise important information from the Insurer may not reach them on time or not at all.

30.2 New bank account

The Insured Person must let the Insurer know their new account number without delay so that the Insurer can remit payments to the correct account.

30.3 Change of credit card data

The Policyholder must let the Insurer know if they have a new credit card data and the Insurer will send them a new SaferPay link to update their details.

31. Language and communications

The Policyholder and the Insured Person expressly require that these General Conditions of Insurance and, more generally, the Insurance Policy and all supporting documents and information be submitted to the Policyholder and the Insured Person in English or German, unless otherwise specified in the Group Contract.

Correspondence and, more generally, all other types of communications between the Insurer, the Policyholder and the Insured Person shall be in English, German, French or Spanish, unless otherwise specified in the Group Contract.

The Policyholder and the Insured Person expressly acknowledge that they fully understand the language(s) chosen in the Group Contract.

32. Solvency and financial condition report

The solvency and financial condition report of the Insurer is available on the Insurer's website under the following address: Imprint - Globality Health (globality-health.com)

33. Guarantee Fund

Under Luxembourg law, the Benefits granted under the Insurance Policy are not subject to a specific statutory guarantee fund. Any claims to the payment of Benefits occurring under the Insurance Policy are, however, protected under the triangle of security (triangle de sécurité) constituted by the mandatory Luxembourg law provisions governing the deposit of the technical provisions underlying the Insurance Policy, the related supervision by the Commissariat aux Assurances and the applicable statutory liens (privilèges).

34. Professional secrecy, sub-contracting, and sub-contracting to cloud computing service providers

The Insurer attaches great importance to respecting the professional secrecy and the confidentiality of its customer's data and undertakes at all times to implement all necessary and required measures to ensure the confidentiality of data according with the highest quality standards and in compliance with the regulations in force.

To guarantee a high level of quality of services and to provide the most advanced technologies to its customers, The Insurer may use service providers, sub-contractors and technologies using cloud computing. In any case, the data communicated will be protected according to high quality standards and in compliance with the regulations including those provided by the GDPR.

When the communication of data protected by professional secrecy in insurance matters takes place within the framework of sub-contracting and technologies using cloud computing are set up at the initiative of the Insurer within the meaning of Article 2bis paragraph 2 of Article 300 of the amended law of 7 December 2015 with a third-party service provider other than those referred to in this Article 300, the Policyholder expressly consents to any subcontracting, including cloud computing.

The Policyholder can access the details of these sub-contracting (sub-contracting table) at any time under the link https: //www.foyer.lu/en/transparency. The Policyholder can also request a hard copy of the sub-contracting table.

The Policyholder will find on the sub-contracting table, the existence of current sub-contracts, the type of information that is transmitted and the country of establishment of the service provider(s). Should this service provider not be subject to an obligation of professional secrecy similar to that of the Insurer, the latter commits to enter into a confidentiality agreement with the service provider in order to require it to comply with such a confidentiality obligation as part of the sub-contracting concerned.

In the event of a change in the sub-contracting table (examples: addition of a sub-contractor, use of cloud computing), the Policyholder will be validly informed of the change by email and/or his client area and/or any other appropriate means (example: due date notice).

If within two months of a change in the sub-contracting table the Policyholder has not objected in writing, the Policyholder shall be deemed to have irrevocably accepted the subcontracting in question. In case of an objection by the Policyholder, this must be notified to the insurer by registered letter. This will be valid as a cancellation at the next expiry of the contract only.

As an exception, if the insurance contract cannot be cancelled annually, the Policyholder's consent shall be valid for the entire duration of the insurance contract, including any subsequent modifications.

The Policyholder shall be duly informed that:

- If he objects to a change in the sub-contracting table, this opposition will have consequences on an optimal management of the insurance contract(s) and on the level of service provided, and therefore the opposition is valid as a cancellation on the next due date.

- If he holds several insurance contracts with the Insurer, it is required for the Policyholder to notify one objection per insurance contract.

35. Data protection

In accordance with Regulation EU 2016/679 of the European Parliament and of the Council of April 27, 2016 on the protection of individuals with regard to the processing of personal data and on the free movement of such data and in accordance with the Act of August 1, 2018 organizing the National Data Protection Commission and implementing Regulation (EU) 2016/679 of the European Parliament and of the Council of April 27, 2016 on the protection of individuals with regard to the processing of personal data and on the free movement of such data, The Insurer collects, records and processes the data that the Policyholder and the insured(s) have communicated to them, as well as those that they will communicate to them subsequently, in order to assess risks, prepare, establish, manage, execute the insurance contract(s), settle any claims and prevent any fraud.

Special categories of personal data relating to health are processed by the Insurer strictly within the scope of the purpose of Article 9 paragraph (2) g) of the GDPR for reasons of substantial public interest or on the basis of the Policyholder's prior and explicit consent unless there is a specific legal basis or legal exceptions such as the preservation of vital interests or the safeguarding of a legitimate interest.

No personal data will be processed for commercial prospecting purposes without the express consent of the data subjects, who retain a right of withdrawal.

The data controller is the Insurer. It may communicate this data to third parties, in particular to the reinsurer, medical consultants, lawyers or other service providers, as well as in the context of legal and regulatory obligations. This transmission will take place in accordance with the terms and conditions set out in Article 300 of the Law of December 7, 2015 on the insurance sector.

The Policyholder has a right of access, limitation, deletion within the legal limits, rectification and portability concerning it's data, which it may exercise by sending a written request to the address of the data controller using the form available on the website.

The Insurer will keep the personal data only for the duration of the contract and for as long as it is necessary for the Insurer to meet its obligations under statute of limitations or other legal requirements.

The Insurer has appointed a Data Protection Officer who can be contacted by post at the address of the data controller or by e-mail at bc-dataprotectionfgh@foyer.lu.

Glossary

Benefit:
The reimbursement of health care costs and expenses by the Insurer to the Insured Person subsequent to a Claim covered by the Insurance Policy.

Bodily Injury:
A sudden event affecting the Insured Person, which is beyond the control of the Insured Person and results in bodily harm, the cause of which is external to the Insured Person's body and the symptoms of which can be determined and objectively ascertained by a Medical Authority in order to diagnose and administer a medical treatment.

Claim:
Medical treatment of an Insured Person following a Disease or Bodily Injury prescribed and administered by a Medical Authority. The following events are deemed to give rise to Claims:

- Bodily Injury,
- Disease,
- Routine health checks, vaccinations, immunizations,
- Pregnancy and childbirth,
- Professional teeth cleaning.

Disease:
The deterioration of the state of physical or mental health of the Insured Person, the origin and symptoms of which can be determined and objectively ascertained by a Medical Authority in order to diagnose and administer a necessary treatment; the deterioration must not, however, be due to a Bodily Injury.

Doctor:
A physician (general practitioner or specialist) or holder of a medical diploma that is recognised by law in the country in which the treatment is provided, who is authorised to provide medical care.

For the purposes of this Insurance Policy, the term shall also include dentists, alternative practitioners, therapists licensed and/or recognized as such in the country of treatment.

The Insured Person is free to choose a Doctor, who meets the above criteria.

Dressings:
Sterile material or substance applied to a wound or injury to protect it, promote healing, and prevent infection

Drugs:
Active substances which are used, alone or mixed with other substances, in the diagnosis or treatment of disease, ailment, bodily injury or pathological complaint.

Food, cosmetics and toiletries are not considered to be Drugs.

Drugs must be prescribed by a Doctor and must be delivered by a pharmacy.

Drugs are commonly referred to as: "medicines"; "pharmaceuticals".

Effective Date:
Date on which the Insurance Policy and the cover ("garantie") and Benefits provided for therein enter into effect, i.e. the date and time indicated in the Insurance Certificate or the date of the payment of the first insurance premium, whichever is later, without prejudice to any applicable waiting periods.

General Conditions of Insurance:
The present terms and conditions governing the risks insured by the Insurer.

Globality Service Card:
Document issued by the Insurer to the Insured Person in accordance with the Group Contract, bearing the individual insurance number and data relevant for contacting the Insurer.

Glossary:
The present glossary of defined terms, which forms an integral part of the General Conditions of Insurance.

Group Contract:
The Globality Xtend – Obligatory International Occupational Health Insurance Group Contract concluded between the Insurer and the Policyholder.

ICD Codes:
The classification codes used under the International Classification of Diseases, an international system for coding and classification of all known diagnoses.

Insurance Certificate:
The Globality Xtend health Insurance certificate issued to the attention of the Policyholder and the Insured Person and confirming the scope, and the effective date of the insurance cover provided under the Insurance Policy.

Insurance Policy:
The contractual framework for health insurance constituted by the General Conditions of Insurance, together with the present Glossary, the Group Contract, the Insurance Certificate, and any subsequent written agreements between the Insurer, the Policyholder and, where relevant, the Insured Person.

Insurer:
The Insurer underwriting the Insurance Policy is Foyer Global Health S.A., a health insurance company established in Luxembourg under the form of a public limited liability company (société anonyme) having its registered office at 12, Rue Léon Laval L-3372 Leudelange, registered under no. B134471 in the Luxembourg Trade and Companies Register, supervised by the Commissariat aux Assurances (11, rue Robert Stumper, L-2557 Luxembourg; +352226911-1; caa@caa.lu).

Insured Person:
The person designated and registered in accordance with the Group Contract as the person whose health is insured under the Insurance Policy.

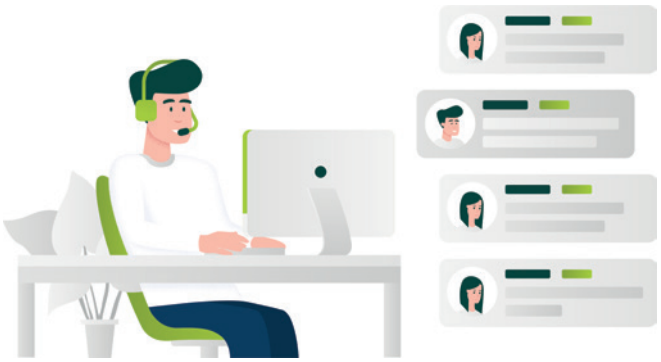
Medical Authority:
A person authorised to practice medicine on the basis of a recognised and official medical degree. He/she can make a diagnosis related to a Disease and/or a Bodily Injury.

Medical Treatment:
The diagnostic and therapeutic measures classified as medical services, including medical advice, aids and interventions as well as Drugs and Dressings, which serve to recognize or alleviate and cure a Disease or Bodily Injury and which are deemed medically necessary on the basis of objective medical findings and scientific knowledge at the time of treatment or which are deemed necessary for carrying out Routine health checks, vaccinations, immunizations, medical assistance during Pregnancy and childbirth and professional teeth cleaning.

Plan:
The Globality Xtend plan agreed with the Policyholder and Insured Person, which defines the extent of the cover provided under the Insurance Policy.

Policyholder:
The legal person who enters into the Insurance Policy.

GLOBALITY HEALTH
premium health insurance worldwide



Get in touch with us

Please feel free to contact us in case of any questions on our General Terms and Conditions of Insurance or products:

Lines are open
Monday to Friday: 8am to 5pm (CET)

Phone +352 270 444 35 01
Fax +352 270 444 35 99

Or contact us anytime at:
service-businesstravel@globality-health.com

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