GlobalHealth

Journey

Special Conditions

Applicable to Plans Basic, Extensive, Advanced and Premium

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1. Insurance cover

Special Conditions – Contractual basis

1.1 Scope of cover

Terms capitalized in this document, unless explicitly defined otherwise, will bear the meanings specified in the Glossaries outlined in the Special and the General Conditions of Insurance.

In the event of discrepancy between the General Conditions of Insurance, the Special Conditions and the Particular Conditions, the Particular Conditions shall prevail over the Special Conditions and the General Conditions of Insurance, and the Special Conditions shall prevail over the General Conditions of Insurance. The English version of all relevant literature and documentation shall prevail over any other language or translation.

The Insurer offers insurance cover for Diseases, Bodily Injuries, and other occurrences leading to insured events as outlined in the Insurance Policy.

Upon the occurrence of an insured event, the Insurer reimburses the expenses related to Medically Necessary Treatment and other agreed Benefits, contingent upon the conditions set forth in the Insurance Policy and statutory regulations.

Under the current Special Conditions and within specified limits, the Insurer covers the medical expenses for each of the Insured Persons identified in the Insurance Policy.

Treatment abroad is excluded from Benefits if such Treatment was the sole reason or one of the reasons for travelling abroad.

1.2 Eligibility

The Insurance Policy is designed for expatriates. Anyone who stays abroad for at least 3 (three) months is eligible for insurance cover unless the Insurer agrees otherwise. Should the Insured Person decide to return to their Home Country and establish it as their Country of Residence, the continuity of their policy can be maintained with the Insurer's approval.

For changes of residence, the Insurer will assess each case individually, determining whether to issue, modify, or terminate the insurance cover.

The Policyholder is responsible for ensuring compliance with local social security laws and regulations for all Insured Persons covered by the Insurance Policy. The Insurer reserves the right to terminate the entire Insurance Policy or the insurance cover for specific Insured Persons in the event of legal changes in a country that would result in a violation of laws or regulations.

1.3 Pre-Existing Conditions

Pre-Existing Conditions are excluded from insurance cover, and their status is governed by the moratorium clause. However, in the Application Form, the Policyholder may opt for the inclusion of Pre-Existing Conditions on the basis of a health risk assessment and subject, as the case may be, to Waiting Periods.

To facilitate the Insurer in deciding whether to incorporate Pre-Existing Conditions from the commencement of the Insurance Policy, it is crucial to provide truthful and thorough answers to the questions in the Application Form.

The Insured Person must accurately complete a medical questionnaire to the best of its knowledge and, if necessary, share medical files with the Insurer. In some cases, an applicant may also undergo a medical evaluation. Based on the information provided in the medical questionnaire and the comprehensive risk assessment conducted by the Insurer, adjustments to the Insurance Policy may be required. This could entail modifying Terms and Conditions, introducing new ones, imposing an additional or increased premium, adding an exclusion, or, in certain instances, declining to conclude the Insurance Policy for the respective Insured Person. Any illness that arises between the signing of the Application Form and the signing of the Particular Conditions will be considered a Pre-Existing Condition.

1.4 Moratorium clause

Insured Persons aged 55 (fifty-five) or younger, who choose not to undergo the medical examination and comprehensive risk assessment outlined in the preceding Article 1.3 of the Special Conditions to include Pre-Existing Conditions in the cover provided under the Insurance Policy, may, with the Insurer's agreement, opt for a "moratorium."

If an Insured Person, eligible for a moratorium as per the preceding paragraph, chooses the moratorium to include Pre-Existing Conditions in the Insurance Policy, following conditions will apply:

i. Insurance cover for any Medical Condition that the Insured Person had in the 5 (five) years before the Policy started will only become eligible after a continuous 2 (two)-year waiting period from the Policy start date.
ii. During this 2 (two)-year period, the Insured Person must not show any signs or symptoms, take Medication, have medical consultations, or receive Treatment for the Pre-Existing Condition.
iii. If the Insured Person experience symptoms or receives Treatment during this period, a new 2 (two)-year Waiting Period will start from that date. The Insured Person must remain symptom and Treatment free during this new period.
iv. Also, the condition must be reversible to be covered. If it is not reversible, it will not be covered at all.

New and unrelated Medical Conditions will be covered immediately, subject to Terms and Conditions of the Insurance Policy.

1.5 Waiting Periods

The Waiting Periods shall commence from the Effective Date, as set out in the Special Conditions.

Waiting Periods apply to maternity care and childbirth, including complications related to maternity care and childbirth, psychiatric Treatment, psychotherapy, prophylactic mastectomy surgery, infertility Treatment and major dental services.

- A 10 (ten)-month Waiting Period applies to psychiatric Treatment, psychotherapy, and major dental services.
- A 12 (twelve)-month Waiting Period applies to maternity care and childbirth, including complications related to maternity care and childbirth, regardless of the number of Insured Persons.
- A 24 (twenty-four)-month Waiting Period applies to prophylactic mastectomy surgery.
- A 24 (twenty-four)-month Waiting Period applies to infertility Treatment for both spouses or partners.

Symbols used

✔ Insured, i.e. the Insurer will reimburse 100 % of the Eligible Expenses, unless specified otherwise in the documents/description of Benefits.

✘ Reimbursement is excluded from the scope of Benefits.

2. Geographical scope

2.1 Geographic Area

Insurance cover applies to insured events occurring in the following areas, as selected by the Policyholder in the Application Form:

Geographical Area I: Worldwide including United States of America
Geographical Area II: Worldwide excluding United States of America

2.2 Temporary cover for Geographical Area I

If the Insurer has agreed to provide insurance cover under the Insurance Policy for Geographical Area II: Worldwide excluding United States of America, and the Insured Person is temporarily residing in the United States of America, the Insurer will still provide insurance cover for medical Emergencies, Accidents, and death occurring within Geographical Area I: Worldwide including United States of America, for trips lasting up to 6 (six) weeks.

Should an insured event occur within such 6 (six)-week period, and the Insured Person requires Emergency Treatment in the United States of America, there is no specific time limit on the Treatment itself. However, if a medical Emergency arises, the Insurer may relocate the Insured Person to another country for Treatment if deemed medically appropriate and feasible.

The Insurance Cover provided under the Insurance Policy will not extend to journeys undertaken solely for the purpose of obtaining Treatment in Geographical Area I.

If any Insured Person relocates to a Geographical Area different for the one agreed to be covered under the Insurance Policy for any duration, such relocation must be immediately notified to the Insurer, and this change will impact the premium due and any Benefits to be granted under the Insurance Policy.

2.3 Double Benefits for Geographical Area I

If the Insured Person is covered under Geographical Area I: Worldwide including United States of America, the Insurer will double the maximum sums and lump sums shown in 3.5, 3.6, 3.7, 3.8, 3.9 and 3.10 (whether the Treatment takes place in the United States of America or not). If a Benefit is limited to a certain number of days or sessions, this limit will not change. If the Insurer has agreed to a Deductible, and/or Co-Payment, Out-of-Pocket Maximum, it will not change.

3. Benefits

3.1 General information

The Plan level, as selected by the Policyholder in the Application Form, is defined by the nature and extent of Benefits set out in the Special Conditions. Based on the selected Plan, the Insurer will reimburse Eligible Expenses up to 100% of the Annual Overall Limit specified in the scope of Benefits, unless expressly stated otherwise in the Terms and Conditions of Insurance.

3.2 Insured event

An insured event is characterized by the Medically Necessary Treatment required for an illness, an Accident, or other events specified in the Special Conditions (refer to 3.5 to 3.12 – scope of Benefits).

The commencement of the insured event is marked by the initiation of Treatment formalised by a prescription of a Doctor and concludes when medical findings indicate that further Treatment is not Medically Necessary. In the event that the Insured Person requires Treatment for an illness, an Accident, or other occurrences detailed in the Special Conditions (refer to 3.5 to 3.12 – scope of Benefits) unrelated to the original insured event, it will be treated as a distinct new insured event.

3.3 Deductibles, Co-Payment and Out-of-Pocket Maximum

Deductible represent the amount the Insured Person is responsible for paying towards the cost of Treatment until the Deductible for the Insurance Year is met. Co-Payment is the percentage of Treatment costs that the Insured Person must contribute. The Out-of-Pocket Maximum is the highest amount of Co-Payment that the Insured Person is required to pay per Insurance Year.

The Insurer has established the following Deductibles:

Basic Plan:
Not applicable

Extensive Plan:
EUR 0, EUR 250, EUR 500 and EUR 1,000 /
USD 0, USD 325, USD 650, USD 1,300 /
GBP 0, GBP 210, GBP 420, GBP 840 /
CHF 0, CHF 232.50, CHF 465, CHF 930

Advanced and Premium Plans:
EUR 0, EUR 250, EUR 500, EUR 1,000, EUR 3,000, EUR 5,000 and EUR 7,000 /
USD 0, USD 325, USD 650, USD 1,300, USD 3,900, USD 6,500 and USD 9,100 /
GBP 0, GBP 210, GBP 420, GBP 840, GBP 2,520, GBP 4,200 and GBP 5,880 /
CHF 0, CHF 232.50, CHF 465, CHF 930, CHF 2,790, CHF 4,650 and CHF 6,510

The Insurer has established the following Co-Payments:

Basic Plan:
Fixed 20%

Extensive Plan:
0%, 10% or 20% with an Out-of-Pocket Maximum of EUR 1,500 / USD 1,950 USD / GBP 1,260 / CHF 1,395

Advanced and Premium Plans:
0%, 10% or 20% with an Out-of-Pocket Maximum of EUR 2,500 / USD 3,250 USD / GBP 2,100 / CHF 2,325

Deductibles and Co-Payments apply on the basis of the Insurance Year for each Insured Person, specifically for expenses related to all Outpatient Treatment, including outpatient Benefits, Outpatient Treatments for mental health and well-being, and Outpatient Treatments for maternity. If a Deductible and/or Co-Payment has been agreed upon, the Insurer will reimburse up to 100% of Eligible Expenses, exceeding the Deductible and/or Co-Payment, up to the Annual Overall Limit/Maximum Outpatient Limit.

Expenses are allocated to the Insurance Year during which the Doctor or Therapist was consulted and when Drugs, Dressings, and therapeutic aids and appliances were provided.

3.4 Criteria for obtaining Benefits

Insured Persons have the flexibility to select any licensed Doctors, Dentists, or Therapists within the country where they need medical or dental Treatment, and this choice extends to other healthcare Practitioners.

The Insurer will reimburse expenses solely for Medically Necessary medical or dental Treatments within the scope of medical or dental practice. Reimbursement for such Treatments and services from other Therapists is subject to reasonable fees aligned with Usual, Customary and Reasonable rates. 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 illness and/or injury.

Additionally, the Insurer may reimburse expenses that surpass the maximum fees based on Usual, Customary and Reasonable rates if they are incurred due to difficulties arising from the illness or medical findings, provided the expenses are reasonably determined.

For services by other Therapists, such as masseurs, midwives, or Practitioners of complementary medicine (where there may not be a separate Usual, Customary and Reasonable rate in the country of Treatment), reimbursement will be based on comparable fees for Doctors and customary prices in the country where the Treatment occurs.

Insurance cover includes dental materials and laboratory work based on average prices in the country of Treatment. **Dental procedures like dentures, Implants, dental surgery, and orthodontic Treatment, even when performed by a Doctor in a Hospital, are not considered part of inpatient or Outpatient Treatment.**

Under the Insurance Policy, the Insurer will reimburse expenses for examinations, Treatment methods, and Drugs widely accepted in Conventional Medicine. Additionally, costs for methods and Drugs proven in practice or used due to the unavailability of Conventional Medicine are eligible for reimbursement. However, Benefits may be limited to amounts equivalent to what would have been paid if Conventional Medicine had been accessible.

3.5 Annual Overall Limit

	Basic	Extensive	Advanced	Premium
Benefits				
Annual Overall Limit	EUR 1,500,000 / USD 1,950,000 / GBP 1,260,000 / CHF 1,395,000	EUR 3,000,000 / USD 3,900,000 / GBP 2,520,000 / CHF 2,790,000	Unlimited	Unlimited

3.6 Scope of Benefits: Inpatient Benefits

	Basic	Extensive	Advanced	Premium
Inpatient Benefits				
Accommodation in a private or semi-private room	✓	✓	✓	✓
Consultations and diagnostic services, including pathology, radiology, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) and Palliative Medicine	✓	✓	✓	✓
Hospital charges, including operating theatres, anaesthesia, intensive care wards and laboratories	✓	✓	✓	✓
Surgery and anaesthetics	✓	✓	✓	✓
Outpatient surgery instead of inpatient Treatment	✓	✓	✓	✓
Drugs and Dressings	✓	✓	✓	✓
Physiotherapy, including massages	✓	✓	✓	✓
Therapies, including occupational therapy, light therapy, Hydrotherapy, inhalation, packs, medical baths, cryotherapy, thermotherapy, electrotherapy	✓	✓	✓	✓
Therapeutic aids and appliances	only if needed as a life-saving measure, such as cardiac pacemakers	only if needed as a life-saving measure, such as cardiac pacemakers	if needed as a life-saving measure, such as cardiac pacemakers; in addition, reimbursement for non life-saving therapeutic aids and appliances, such as artificial limbs/prostheses up to EUR 2,000 / USD 2,600 / GBP 1,680 / CHF 1,860	✓
Congenital Conditions	✓ Up to a maximum of EUR 100,000 / USD 130,000 / GBP 84,000 / CHF 93,000 per lifetime	✓ Up to a maximum of EUR 100,000 / USD 130,000 / GBP 84,000 / CHF 93,000 per lifetime	✓ Up to a maximum of EUR 150,000 / USD 195,000 / GBP 126,000 / CHF 139,500 per lifetime	✓ Up to a maximum of EUR 200,000 / USD 260,000 / GBP 168,000 / CHF 186,000 per lifetime
Cancer Treatment, oncological Drugs and Treatment, including reconstructive surgery for breast Cancer	✓	✓	✓	✓

	Basic	Extensive	Advanced	Premium
Inpatient Benefits				
Prophylactic mastectomy surgery	✗	✗	✗	✓ 50% Up to EUR 10,000 / USD 13,000 / GBP 8,400 / CHF 9,300. Waiting Period of 24 months
Dialysis	✗	✓ Up to a maximum of EUR 1,000,000 / USD 1,300,000 / GBP 840,000 / CHF 930,000 per lifetime	✓ Up to a maximum of EUR 1,500,000 / USD 1,950,000 / GBP 1,260,000 / CHF 1,395,000 per lifetime	✓ Up to a maximum of EUR 2,000,000 / USD 2,600,000 / GBP 1,680,000 / CHF 1,860,000 per lifetime
Bone marrow and organ transplants (costs for donor and receiver)	✓ Up to a maximum of EUR 150,000 / USD 195,000 / GBP 126,000 / CHF 139,500 per lifetime	✓ Up to a maximum of EUR 150,000 / USD 195,000 / GBP 126,000 / CHF 139,500 per lifetime	✓ Up to a maximum of EUR 250,000 / USD 325,000 / GBP 210,000 / CHF 232,500 per lifetime	✓
Parent accommodation during inpatient Treatment of a minor child	✓	✓	✓	✓
Nursing care at home, instead of a Hospital stay	✗	✓ Up to 30 days after written pre-approval	✓ Up to 60 days after written pre-approval	✓ Up to 90 days after written pre-approval
Substitute Hospital Cash Plan Benefit	✓ EUR 50 / USD 65 / GBP 42 / CHF 46.50 per day	✓ EUR 75 / USD 97.50 / GBP 63 / CHF 69.75 per day	✓ EUR 150 / USD 195 / GBP 126 / CHF 139.50 per day	✓ EUR 200 / USD 260 / GBP 168 / CHF 186 per day
Inpatient Follow-Up Rehabilitation	✓ Up to 14 days after written pre-approval	✓ Up to 21 days after written pre-approval	✓ Up to 28 days after written pre-approval	✓ Up to 35 days after written pre-approval
Hospice	✗	✓ Up to 5 weeks	✓ Up to 7 weeks	✓ Up to 9 weeks
Daycare	✓	✓	✓	✓
Transport to the nearest suitable Hospital for initial Treatment following an Accident or an Emergency	✓	✓	✓	✓
Inpatient dental Treatment	✗	✗	✓	✓
Emergency dental Treatment	✗	✓	✓	✓

The specified maximum sums, maximum periods and lump sums apply per Insured Person and per Insurance Year.

3.7 Scope of Benefits: Outpatient Benefits

	Basic	Extensive	Advanced	Premium
Outpatient Benefits				
Maximum Outpatient Limit	EUR 2,000 / USD 2,600 / GBP 1,680 / CHF 1,860	EUR 12,000 / USD 15,600 / GBP 10,080 / CHF 11,160	Unlimited	Unlimited
Consultations and diagnostic services, including pathology, radiology, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) and Palliative Medicine	✓ 80%*	✓ Max. outpatient limit applies	✓	✓
Outpatient surgery	✗	✓ Max. outpatient limit applies	✓	✓
Chemotherapy, oncological Drugs and Treatment (e.g. for Cancer patients)	✓	✓	✓	✓
Acupuncture (needle technique), Homeopathy, Osteopathy, Traditional Chinese Medicine and Chiropractic, including Drugs and Dressings	✗	✓ Up to EUR 750* / USD 975* / GBP 630* / CHF 697.50*	✓ Up to EUR 2,500 / USD 3,250 / GBP 2,100 / CHF 2,325	✓ Up to EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650
Speech therapy	✗	✗	✓ Up to 20 sessions, after written pre-approval	✓ After written pre-approval
Drugs and Dressings	✓ 80%*	✓ Max. outpatient limit applies	✓	✓
Over-the-counter Drugs	✗	✓ Up to EUR 50* / USD 65* / GBP 42* / CHF 46.50*	✓ Up to EUR 75 / USD 97.50 / GBP 63 / CHF 69.75	✓ Up to EUR 100 / USD 130 / GBP 84 / CHF 93
Physiotherapy, including massages	✗	✓ Up to 15 sessions (including 5 non-pre-scribed sessions)*	✓ Up to 20 sessions (including 5 non-pre-scribed sessions)	✓ (including 5 non-pre-scribed sessions)
Therapies, including occupational therapy, light therapy, Hydrotherapy, inhalation, packs, medical baths, cryotherapy, thermotherapy, electrotherapy	✗	✗	✓ Up to 10 sessions	✓

	Basic	Extensive	Advanced	Premium
Outpatient Benefits				
Therapeutic aids and appliances	✗	✓ Up to EUR 1,000* / USD 1,300* / GBP 840* / CHF 930*	✓ Up to EUR 2,000 / USD 2,600 / GBP 1,680 / CHF 1,860	✓
Wigs and prosthetic bras following Cancer Treatment	✗	✓ Up to EUR 300* / USD 390* / GBP 252* / CHF 279*	✓ Up to EUR 300 / USD 390 / GBP 252 / CHF 279	✓ Up to EUR 500 / USD 650 / GBP 420 / CHF 465
Podiatry	✗	✗	✓ Up to EUR 100 / USD 130 / GBP 84 / CHF 93	✓ Up to EUR 200 / USD 260 / GBP 168 / CHF 186
Transport to the nearest suitable Doctor or Hospital for initial Treatment following an Accident or an Emergency	✓	✓	✓	✓
Infertility Treatment	✗	✗	✗	✓ 50% up to EUR 10,000 / USD 13,000 / GBP 8,400 / CHF 9,300 for each insured couple, after written pre-approval per lifetime, Waiting Period of 24 months

The specified maximum sums, maximum periods and lump sums apply per Insured Person and per Insurance Year.
*Max. outpatient limit applies

3.8 Scope of Benefits: Mental Health and Wellbeing Benefits

	Basic	Extensive	Advanced	Premium
Mental Health and Wellbeing Benefits				
Inpatient Treatment				
Psychiatric Treatment	✕	✓ Up to 30 days, after written pre-approval	✓ Up to 40 days, after written pre-approval	✓ Up to 60 days, after written pre-approval
Inpatient psychotherapy	✕	✕	✓ Up to 20 sessions, after written pre-approval	✓ Up to 40 sessions, after written pre-approval
Outpatient Treatment				
Psychiatric Treatment	✕	✓ Up to EUR 1,000 / USD 1,300 / GBP 840 / CHF 930, after written pre-approval	✓ Up to EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650, after written pre-approval	✓ Up to EUR 10,000 / USD 13,000 / GBP 8,400 / CHF 9,300, after written pre-approval
Outpatient psychotherapy	✕	✕	✓ Up to 10 sessions, after written pre-approval	✓ Up to 20 sessions, after written pre-approval
Routine health checks or screening tests conducted in the absence of clinical symptoms	✕	✓ Up to EUR 250 / 325 USD / GBP 210 / CHF 232.50	✓ Up to EUR 500 / USD 650 / GBP 420 / CHF 465	✓ Up to EUR 1,000 / USD 1,300 / GBP 840 / CHF 930
Vaccinations of every kind, including the vaccines and Prophylactic Measures, insofar as these are recommended for the applicable Country of Residence	✕	✕	✓ Up to EUR 500 / USD 650 / GBP 420 / CHF 465	✓
Nutritional consultation	✕	✕	✕	✓ Up to EUR 400 / USD 520 / GBP 336 / CHF 372

10 (ten)-month Waiting Period applies to psychiatric Treatment and psychotherapy.
The specified maximum sums, maximum periods and lump sums apply per Insured Person and per Insurance Year.

3.9 Scope of Benefits: Maternity Benefits

	Basic	Extensive	Advanced	Premium
Maternity Benefits				
Inpatient Treatment				
Maternity care and childbirth, services of a midwife or obstetric nurse in the Hospital	✗	✗	✓ Up to EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650	✓ Up to EUR 20,000 / USD 26,000 / GBP 16,800 / CHF 18,600
Complications of pregnancy and childbirth	✗	✗	✓	✓
Nursing care at home after childbirth, instead of a Hospital stay	✗	✗	✓ Up to 5 days, after written pre-approval	✓ Up to 5 days, after written pre-approval
Newborn care	✗	✗	✓	✓
Outpatient Treatment				
Maternity care and childbirth, services of a midwife or obstetric nurse	✗	✗	✓ Up to EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650	✓ Up to EUR 10,000 / USD 13,000 / GBP 8,400 / CHF 9,300
Complications of pregnancy and childbirth	✗	✗	✓ Up to EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650	✓
Outpatient childbirth cash Benefit	✗	✗	✓ Lump sum of EUR 250 / USD 325 / GBP 210 / CHF 232.50 per newborn baby without proof of costs on presentation of the birth certificate	✓ Lump sum of EUR 500 / USD 650 / GBP 420 / CHF 465 per newborn baby without proof of costs on presentation of the birth certificate

12 (twelve)-month Waiting Period applies to pregnancy and childbirth.
The specified maximum sums, maximum periods and lump sums apply per Insured Person and per Insurance Year.

3.10 Scope of Benefits: Vision Aids and Dental Benefits

	Basic	Extensive	Advanced	Premium
Vision Aids and Dental Benefits				
Vision aids				
Vision aids, including an eye test	✗	✗	✓ Up to EUR 300 / USD 390 / GBP 252 / CHF 279 every 2 years.	✓ Up to EUR 750 / USD 975 / GBP 630 / CHF 697.50 every 2 years.
Dental Treatment				
Maximum dental limit	n.a.	EUR 250 / USD 325 / GBP 210 / 232.50 CHF	n.a.	n.a.
Minor dental services				
Screenings for early detection of disorder of the teeth, mouth and jaw	✗	✓ Up to 2 screenings per year*	✓ Up to 2 screenings per year	✓ Up to 2 screenings per year
X-rays	✗	Max. dental limit applies	✓	✓
Scale-and-polish cleaning	✗	Max. dental limit applies	✓	✓
Treating oral mucosa and paradontium	✗	Max. dental limit applies	✓	✓
Simple fillings related to cavity	✗	Max. dental limit applies	✓	✓
Surgery, extractions, root-canal Treatment	✗	Max. dental limit applies	✓	✓
Inclusion of an occlusal splint	✗	Max. dental limit applies	✓	✓
Accidental dental Treatment	✗	Max. dental limit applies	✓	✓

	Basic	Extensive	Advanced	Premium
Vision Aids and Dental Benefits				
Major dental services			Reimbursement for the following Benefits up to EUR 2,000 / USD 2,600 / GBP 1,680 / CHF 1,860	Reimbursement for the following Benefits up to EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650
Dentures (e.g. prostheses, inlays, bridges and crowns)	✗	✗	✓	✓
Implants	✗	✗	✓	✓
Orthodontic Treatment (up to age 18)	✗	✗	✓	✓
Dental laboratory work and materials	✗	✗	✓	✓
Treatment plan	✗	✗	✓	✓

10 (ten)-month Waiting Period applies to major dental services.
The specified maximum sums, maximum periods and lump sums apply per Insured Person and per Insurance Year.
*Max. dental limit applies

3.11 Scope of Benefits: Medical Assistance Benefits

	Basic	Extensive	Advanced	Premium
Medical Assistance Benefits				
24-hour phone and e-mail service with experienced counsellors, own Doctors and specialists	✓	✓	✓	✓
Medical evacuation and Repatriation	✓ After written pre-approval	✓ After written pre-approval	✓ After written pre-approval	✓ After written pre-approval
Information on medical infrastructure (local medical care and names and addresses of multilingual Doctors)	✓	✓	✓	✓
Support and information by our medical service (Second Opinion, monitoring of the course of the illness)	✓	✓	✓	✓
Guarantee of payment (GOP) (preparing for a stay in Hospital)	✓	✓	✓	✓
Return of mortal remains	✓ Up to EUR 2,500 / USD 3,250 / GBP 2,100 / CHF 2,325	✓ Up to EUR 5,000 / USD 6,500 / GBP 4,200 / CHF 4,650	✓ Up to EUR 10,000 / USD 13,000 / GBP 8,400 / CHF 9,300	✓ Up to EUR 25,000 / USD 32,500 / GBP 21,000 / CHF 23,250
Additional appropriate medical support (information on the nature, possible causes and possible Treatment of an illness)	✓	✓	✓	✓
Online services	✓	✓	✓	✓

The specified maximum sums, maximum periods and lump sums apply per Insured Person and per Insurance Year.

3.12 Scope of Benefits: Additional Assistance Benefits

	Basic	Extensive	Advanced	Premium
Additional Assistance Benefits				
Compassionate family visit	✗	✗	✓ Up to EUR 1,500 / USD 1,950 / GBP 1,260 / CHF 1,395	✓ Up to EUR 3,000 / USD 3,900 / GBP 2,520 / CHF 2,790
Return to Country of Residence after Repatriation	✗	✗	✓ Up to EUR 1,500 / USD 1,950 / GBP 1,260 / CHF 1,395	✓ Up to EUR 3,000 / USD 3,900 / GBP 2,520 / CHF 2,790
Delayed return trip	✗	✗	✓ Up to EUR 1,000 / USD 1,300 / GBP 840 / CHF 930	✓ Up to EUR 2,000 / USD 2,600 / GBP 1,680 / CHF 1,860
Getting hold of and shipping vital Medication	✗	✗	✓	✓
Return transport or care for children	✗	✗	✗	✓
Organizing help if you have legal difficulties	✗	✗	✗	✓
Help with psychological problems possibly caused by the stay abroad	✗	✗	✓ Psychological and therapeutic help by telephone; up to 3 calls	✓ Psychological and therapeutic help by telephone; up to 5 calls
Telemedicine	✓	✓	✓	✓

The specified maximum sums, maximum periods and lump sums apply per Insured Person and per Insurance Year.

3.13 Description of Benefits

Note: „Please be aware that the Benefits outlined in section 3.13 may vary or may not be covered by the insurance, depending on the selected Plan level."

Inpatient Benefits

The Insurance Policy provides insurance cover for the inpatient Benefits described below:

Accommodation in a private or semi-private room

The Insured Person has the flexibility to select the Hospital for receiving Medical Treatment. Medical Treatment in a Hospital encompasses any Treatment, during which the Insured Person is admitted to a Hospital in the country where they are undergoing Treatment, for a minimum duration of 24 (twenty-four) hours.

In cases where the Treatment is conducted in Hospitals offering Sanatorium Treatment, the Insurance Policy exclusively covers Treatments meeting the criteria for Conventional Medicine/Medically Necessary Treatment, unless alternative Treatments have been explicitly approved in writing by the Insurer prior to the Start of Treatment. Accommodation is restricted to standard private or semi-private rooms, as specified in the scope of Benefits. A standard private room is defined as a basic single occupancy room with an adjoining private bath or shower room in a Hospital. **It explicitly excludes rooms with upgraded amenities, including but not limited to deluxe rooms, executive rooms, or suites that may have additional facilities such as kitchens, dining areas, or sitting rooms.**

The Insurance Policy covers the entire inpatient Treatment without a specific time limit. However, it is imperative to contact and inform the Insurer or the Service Centre regarding the Hospital stay and Treatment before or within 3 (three) calendar days of admission to the Hospital. Failure to do so may result in the Insurer not fully covering the Claim.

Consultations and diagnostic services, including pathology, radiology, CT, MRI, PET and Palliative Medicine

The Insurance Policy will encompass all costs related to Medically Necessary inpatient Treatment, covering examinations, diagnostics, and therapy as well as expenses related to pathology, radiology, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Palliative Medicine.

Hospital charges, including operating theatres, anaesthesia, intensive-care wards, laboratories

This pertains to additional expenses associated with the utilisation of specialised facilities, including operating theatres, intensive care units, and laboratories.

Surgery and anaesthetics

The Insurer will reimburse costs incurred for Medically Necessary services in this context, such as medical services, anaesthesia, and the utilisation of specialised facilities, if prescribed by a specialist Doctor.

Outpatient surgery instead of inpatient Treatment

This pertains to elective surgery typically conducted in a Doctor's office or Hospital setting, without the necessity for an overnight stay. **However, it excludes grade 1 or minor surgeries (invasive procedures involving only the resection of skin, mucous membranes, and connective tissue) and invasive operative procedures for obtaining tissue samples or bodily fluids, such as biopsies and colonoscopies.**

Drugs and Dressings

To qualify for insurance cover under the Insurance Policy, these Medications must be prescribed by a Hospital Doctor or Dentist in conjunction with inpatient Treatment. Additionally, the Drugs must be dispensed by a pharmacy, Hospital pharmacy, or another dispensary officially approved by competent authorities.

Nutritional food, tonics, mineral water, cosmetics, products for personal hygiene, as well as bath salts, are

not deemed as Drugs eligible for insurance cover under the Insurance Policy as part of Medical Treatment.

Physiotherapy, including massages

To qualify for cover under the Insurance Policy, physiotherapy and massages must be prescribed by a Hospital Doctor as integral components of inpatient Treatment. Furthermore, these procedures must be administered by a Doctor or a qualified, certified Therapist. The prescription should be provided prior to the Start of Treatment and should specify the diagnosis along with details about the type and number of required sessions.

Therapies, including occupational therapy, light therapy, Hydrotherapy, inhalation, packs, medical baths, cryotherapy, thermotherapy, electrotherapy

To qualify for cover under the Insurance Policy, physical-medical therapies must be prescribed by a Hospital Doctor as a component of inpatient Treatment. Furthermore, these therapies must be administered by a Doctor or a qualified, certified Therapist. The prescription must be provided before the Start of Treatment and should include details such as the diagnosis and the specific type and number of required sessions.

Therapeutic aids and appliances within the framework of inpatient Treatment

The Insurance Policy covers expenses related to therapeutic aids and appliances designed as life-saving measures or those directly addressing or compensating for physical disabilities, such as cardiac pacemakers and artificial limbs/prostheses (excluding dentures). These aids must be fitted or adjusted during the inpatient stay and should remain in or on the body of the Insured Person.

Additionally, the Insurer will reimburse costs for repairing therapeutic aids and appliances within the specified conditions during the Policy Period.

Congenital Conditions

The Insurer will reimburse expenses for Congenital Conditions. Additionally, the Insurer covers complications arising from assisted conception, including childbirth, premature or multiple births.

Cancer Treatment, oncological Drugs and Treatment, including reconstructive surgery for breast Cancer

Within the scope of inpatient Hospital care, the Insurance Policy includes insurance cover for Eligible Expenses related to Medical Treatment for Cancer and direct consequences, including diagnostic tests, radiation therapy, chemotherapy, Drugs, and Hospital costs associated with inpatient Treatment. Additionally, reconstructive surgery for breast Cancer is covered.

Prophylactic mastectomy surgery

A prophylactic mastectomy involves the surgical removal of one or both breasts to decrease the likelihood of developing breast Cancer.

The Insurer will only reimburse the expenses associated with preventive surgery aimed at reducing the risk of breast Cancer. A Waiting Period of 24 (twenty-four) months applies.

Dialysis

The Insurer will reimburse Eligible Expenses for Dialysis, encompassing essential Medication and all associated costs. These Eligible Expenses cover Treatment on an inpatient Treatment, Outpatient Treatment, and Daycare. This insurance cover extends up to the lifetime limit, as indicated in the scope of Benefits.

Bone marrow and organ transplants within the framework of inpatient Treatment

In instances of bone marrow or organ transplantation (such as heart, kidney, liver, pancreas), the Insurance Policy provides cover for medical expenses incurred by an Insured Person, serving in the dual role of both recipient and donor. This insurance cover extends up to the lifetime limit, as indicated in the scope of Benefits.

Eligible Expenses encompass the costs linked to organ procurement from a donor, expenses for transporting the organ to the recipient's location, and potential inpatient stay costs for the donor. **However, it does not include expenses associated with the search for an organ or a suitable donor.**

Parent accommodation during inpatient Treatment of a minor child

The Insurance Policy includes cover for the supplementary accommodation expenses for one parent staying with a child under the age of 18 (eighteen) who is admitted for inpatient Treatment.

Nursing care at home instead of a Hospital stay

The Insurance Policy includes cover for Medically Necessary nursing care provided at home by qualified nursing staff. This option serves as an alternative to a Hospital stay as medically advised or aims to shorten the duration of Hospitalisation. Home nursing care is applicable in conjunction with medical Treatment and is eligible for reimbursement, subject to prior written approval from the Insurer before the Start of Treatment.

Substitute Hospital Cash Plan Benefit

In cases where the Policyholder refrains from seeking reimbursement from the Insurer for an Insured Person undergoing a covered inpatient Treatment, the Insurance Policy provides payment in the form of a daily Hospital allowance per prescribed day in the Hospital. The amount is contingent on the Plan level and is subject to the maximum sum insured as outlined in the scope of Benefits.

Inpatient Follow-Up Rehabilitation

The Insurer will reimburse the costs associated with Inpatient Follow-Up Rehabilitation, which is essential for continuing Medically Necessary inpatient Treatment. This applies specifically to cases such as post-bypass surgery, cardiac infarction, transplants, and surgeries involving large bones or joints, subject to prior written approval from the Insurer before the Start of Treatment. Inpatient Follow-Up Rehabilitation must commence within 2 (two) weeks of Hospital discharge. **However, the Insurance Policy does not cover expenses related to Sanatorium Treatments, cures, stays in cure establishments, spas, convalescent homes, or nursing homes.**

Hospice

The Insurer will reimburse expenses related to accommodation, nursing care, and support if outpatient care at home or in a family member's residence is not feasible. This reimbursement is contingent upon the Hospice meeting specific criteria, including collaboration with experienced nursing staff and Doctors specializing in Palliative Medicine. Additionally, the Hospice must operate under the professional supervision of a nurse or another adequately qualified individual with several years of experience in Palliative Medicine or relevant qualifications, along with a supervisory nursing care or management qualification. The Insurer will cover accommodation, nursing care, and support expenses based on the patient's health condition.

The Insurer provides Benefits exclusively for full- or part-time inpatient Hospice care if the Insured Person is afflicted with an illness that is progressive, has reached an advanced stage, is incurable necessitating inpatient Palliative Medicine, and offers a life expectancy of weeks or a few months.

The Insurer extends Hospice Benefits for various illnesses, including but not limited to:

- Cancer in advanced stages,
- Fully developed infectious AIDS,
- Disorders of the nervous system leading to unstoppable progressive paralysis,
- Terminal stages of chronic kidney, liver, heart, digestive, or pulmonary illnesses.

Daycare

The Insurance Policy covers Treatment received in a Hospital that does not require an overnight stay. It also covers partial inpatient Treatment involving a visit to a day or night clinic or Hospital where the patient is present during the day or night, but where a fullday (24 (twenty-four)-hours) inpatient arrangement is no longer Medically Necessary.

In both scenarios, the duration of the Hospital stay ranges from 8 (eight) to 24 (twenty-four) hours and must not surpass the 24 (twenty-four)-hour limit.

Transport to the nearest suitable Hospital for initial Treatment following an Accident or an Emergency

The Insurer will cover the Usual, Customary and Reasonable expenses for transporting to the closest suitable Hospital or medical facility. Unless otherwise agreed, the provision of transportation services must be carried out by a duly licensed service provider.

Inpatient dental Treatment

The Insurer will cover expenses for complex oral surgical procedures associated with a higher-than-average risk of life-threatening complications. Examples include congenital jaw deformities (e.g. cleft jaw), jaw fractures, and tumours.

Emergency dental Treatment

Emergency inpatient dental Treatment pertains to a severe Accident necessitating Hospitalisation, such as the reconstruction of the jaw following accidental injury. This Treatment should be administered within 24 (twenty-four) hours of the Emergency incident. **This Benefit does not encompass subsequent dental Treatment, dental surgery, dental prostheses or Implants, orthodontics, or periodontics.** The attending physician must explicitly confirm that the inpatient dental Treatment results from a significant Accident, and the incident's occurrence must be substantiated by a corresponding medical or police report.

Outpatient Benefits

The Insurance Policy provides insurance cover for the following Benefits in relation with Outpatient Treatment:

Maximum Outpatient Limit

The Benefits for Outpatient Treatment shall not exceed the Maximum Outpatient Limit, unless otherwise specified in the scope of Benefits.

Consultations and diagnostic services, including pathology, radiology, CT, MRI, PET and Palliative Medicine

The Insurance Policy includes cover for incurred expenses related to Outpatient Treatment, encompassing examinations, diagnostics, and therapy.

The Benefits offered include reimbursements for a range of services, including but not limited to pathology, radiology, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Palliative Medicine.

Surgery qualifying as Outpatient Treatment

The Insurance Policy covers surgery that may be conducted by a Doctor or within a Hospital setting, which does not require an overnight Hospital stay and does not require subsequent Hospitalisation.

Cancer Treatment, oncological Drugs and Treatment

The Insurance Policy covers eligible Medically Necessary measures for examination, diagnosis, and therapy in the context of Outpatient Treatment for Cancer and direct consequences, including chemotherapy, and other oncological procedures.

Acupuncture, Homeopathy, Osteopathy, Chiropractic and traditional Chinese medicine

The Insurance Policy will cover expenses associated with Acupuncture, Homeopathy, Osteopathy, Chiropractic and traditional Chinese medicine only if these Treatments are administered by Doctors or other Practitioners who can demonstrate certified and appropriate training in the country where the Treatment takes place, and they are duly approved or

authorised to provide such Treatment. Additionally, the Drugs and Dressings prescribed by the treating Doctors or Practitioners during the relevant Treatment are also included in the insurance cover under the Insurance Policy.

Speech therapy

For speech and voice disorders, the Insurer will reimburse Eligible Expenses for medically prescribed exercises and therapy aimed at treating these disorders, under the condition that such interventions are conducted by a Doctor or a speech Therapist. Insurance cover is applicable under the Insurance Policy, subject to obtaining prior written approval from the Insurer before the Start of Treatment.

Drugs and Dressings

To qualify for cover under the Insurance Policy, prescriptions for Drugs and Dressings must be issued by a Doctor, Practitioner, Dentist, or a person authorised to do so under their supervision. These Drugs and Dressings must be obtained from a pharmacy or an officially approved supplier.

Items such as Nutritional food, tonics, mineral water, cosmetics, products for personal hygiene, and bath salts are not categorized as Drugs. Consequently, they do not meet the criteria for Treatment covered under the Insurance Policy.

Over-the-counter Drugs – OTC

Non-prescription, over the counter (OTC) Drugs can be purchased without a prescription and are typically used to alleviate symptoms of common Diseases that may not require a Doctor's visit for the Insured Person.

The Insurance Policy provides insurance cover for expenses related to these over-the-counter Drugs, up to the maximum sum insured specified in the scope of Benefits for each Insurance Year.

Physiotherapy, including massages

The Insurance Policy covers physio-medical services, including physiotherapy and exercise therapy, as well as massages, that are accessible through a prescription and that are administered by a Doctor or a qualified and certified Therapist. The prescription should be provided prior to the Start of Treatment and must specify the diagnosis, as well as the type and number of sessions required.

Therapies, including occupational therapy, light therapy, Hydrotherapy, inhalation, packs, medical baths, cryotherapy, thermotherapy, electrotherapy

The Insurance Policy covers physio-medical services such as occupational therapy, light therapy, Hydrotherapy, inhalations, packs, medical baths, cold and/or heat Treatment, electrotherapy, and exercise therapy, provided they are administered by a Doctor or a certified Therapist and have been prescribed by the Doctor as part of Outpatient Treatment. The prescription must be issued prior to the Start of Treatment and should specify the diagnosis, along with the type and number of sessions required.

Therapeutic aids and appliances in conjunction with Outpatient Treatment

The Insurance Policy covers therapeutic aids and appliances provided they have been prescribed by a Doctor. Eligible Expenses encompass costs related to artificial limbs and organs, as well as orthopaedic and other therapeutic aids designed to prevent or alleviate physical disabilities.

In the context of Outpatient Treatment, therapeutic aids and appliances include bandages, trusses, insole supports for shoes, walking aids, hearing aids, compression stockings, corrective splints, artificial limbs and prosthetics **(excluding dentures),** plaster shells for lying and sitting, and orthopaedic braces for arms, legs, and the entire body.

Wigs and prosthetic bras for women undergoing Cancer Treatment qualify for reimbursement under the Insurance Policy, with the amount contingent on the Plan level and subject to the maximum sum insured outlined in the scope of Benefits. All other therapeutic aids and appliances require prior written approval from the Insurer for eligibility.

Expenses for reasonable maintenance, such as an annual service or battery replacement, and repairs of therapeutic aids and appliances are reimbursable within the scope of these provisions. **However, expenses for sanitary supplies, such as pads and massage devices, as well as their use and maintenance, are not covered under the Insurance Policy.**

Podiatry

The Insurer will cover qualifying expenses for Medically Necessary podiatry Treatment. To be eligible, these services must be prescribed by a Doctor, and the prescription must be issued before the Start of Treatment. It should clearly specify the diagnosis, nature of the condition, and the required number of sessions.

Transport to the nearest suitable Doctor or Hospital for initial Treatment following an Accident or an Emergency

The Insurer will reimburse Usual, Customary and Reasonable expenses for Emergency transportation to the nearest appropriate Doctor, Hospital, or facility following an Accident or Emergency. Unless otherwise agreed, the provision of services must be carried out by a duly licensed service provider.

Infertility Treatment

Within the defined scope of Benefits, and with prior written approval, the Insurer will reimburse expenses related to various Usual, Customary and Reasonable fertility-enhancing diagnostics and Treatments. This insurance cover includes measures to prevent future miscarriages, investigations into miscarriage, and assisted reproduction, along with associated complications. The covered expenses include:

- Diagnostic investigations, consultations, tests, and invasive procedures such as hysterosalpingogram, laparoscopy, or hysteroscopy,
- Laboratory work,
- Prescribed drug Treatments (including ovulation stimulation),
- In vitro fertilization (IVF),
- Intracytoplasmic sperm injection (ICSI),
- Artificial insemination (AI).

Additionally, the Insurer will only provide Benefits if:

- The woman is aged under 40 (fourty) and the man under 50 (fifty) at the time of Treatment, specifically the first stimulation day in each Treatment cycle or the first cycle day in the case of insemination without hormone stimulation.
- Medical assessment has ascertained a significant possibility of success of over 15% for the selected method.
- The Insured Person's sterile condition is due to organic causes and can only be overcome with the aid of reproductive help.
- Both the man and the woman benefiting from the Treatment are Insured Persons and are eligible for Treatment on their selected Plan level.

A Waiting Period of 24 (twenty-four) months applies.

Mental Health and Wellbeing Benefits

Inpatient Treatment

Psychiatric Treatment

The Insurance Policy includes cover for psychiatric services within the scope of inpatient Medical Treatment, subject to the Insurer granting written approval before the Start of Treatment. A Waiting Period of 10 (ten) months applies.

Inpatient psychotherapy

The Insurance Policy encompasses the costs of psychotherapy as an element of inpatient Treatment, on the condition that the Treatment is administered by a psychiatrist, Psychotherapist, or a Doctor with specialised training in psychiatry, psychotherapy, or psychoanalysis. For inpatient psychotherapy to be covered, prior written approval from the Insurer is required before the Start of Treatment. A Waiting Period of 10 (ten) months applies.

Outpatient Treatment

Psychiatric Treatment

The Insurer will reimburse Outpatient psychiatric Treatment expenses only if a prior written approval has been given to cover these costs before the Start of Treatment. Psychiatric Treatment is administered by psychiatrists, who are medical Doctors with specialised training and education in mental health, possess the skills and expertise to diagnose and address both mental and physical issues associated with psychological disorders. A Waiting Period of 10 (ten) months applies.

Outpatient psychotherapy

The Insurer will reimburse outpatient psychotherapy expenses if the Treatment is administered by a psychiatrist, psychotherapist, or a Doctor with additional training in the specialised fields of psychiatry, psychotherapy, or psychoanalysis. Psychotherapy is a collaborative and interactive Treatment method, focuses on dialogue and depends on the relationship between an individual and a psychologist. Insurance cover is applicable under the Insurance Policy, subject to obtaining prior written approval from the Insurer before the Start of Treatment. A Waiting Period of 10 (ten) months applies.

Routine health checks or screening tests conducted in the absence of clinical symptoms

The Insurance Policy covers routine health checks that involve examinations or screening tests conducted in the absence of clinical symptoms. These tests are conducted based on age to detect anomalies or Diseases, comprise the following examinations:

- Vital signs (blood pressure, pulse, respiration, temperature),
- Lipid profile,
- Cardiovascular examination,
- Neurological examination,
- Cancer screening,
- Well-child test,
- Diabetes test,
- HIV and AIDS test,
- Gynaecological screening.

Vaccinations and immunization

The Insurer will reimburse the costs associated with vaccinations and recommended Prophylactic Measures for the Insured Person's Country of Residence. This insurance cover includes both the consultation fees for administering the vaccine and the cost of the vaccine itself.

Nutritional consultations

The Insurance Policy provides insurance cover for Eligible Expenses related to outpatient consultations with a nutritionist, subject to reimbursement upon the diagnosis of a condition that Benefits from Nutritional advice to effectively manage the identified health issue. Such conditions encompass Cancer, eating disorders, gastrointestinal Diseases, heart Diseases, and food intolerances or allergies.

To qualify for insurance cover, these services must be prescribed by a Doctor, and the prescription must be issued before the Start of Treatment. The prescription should clearly specify the diagnosis, nature of the condition, and the required number of sessions.

Maternity Benefits

Inpatient Treatment

Maternity care and childbirth, services of a midwife or obstetric nurse in a Hospital

The Insurer will reimburse Eligible Expenses related to childbirth, pregnancy, or pregnancy-related illnesses incurred in a Hospital, maternity home, or similar institution. This includes expenses for nursing at home necessitated by pregnancy or related illnesses, as well as midwife or obstetric nurse services.

Insurance cover for midwife services during delivery is applicable only in cases of midwifeled births. **Doctor fees are not covered, unless deemed Medically Necessary due to complications during birth.** Medically prescribed nursing at home is covered post inpatient delivery, following discharge from the Hospital within 24 (twenty-four) hours. The Insurer reimburses such costs for up to 5 (five) consecutive days following the delivery.

For non-Medically Necessary caesarean sections, insurance cover extends up to the cost of an eligible routine delivery in the same Hospital, within the maximum limit specified by the selected Plan level in the scope of Benefits. A Waiting Period of 12 (twelve) months applies.

Complications of pregnancy and childbirth

The Insurer will reimburse Eligible Expenses associated with premature birth, miscarriage, Medically Necessary abortion, stillbirth, ectopic pregnancy, hydatidiform mole, caesarean section, post-partum haemorrhage, retained placental membrane, and complications arising from any of these conditions. A Waiting Period of 12 (twelve) months applies.

Newborn care

The Insurance Policy for the newborn provides insurance cover for the Treatment of routine and acute Medical Conditions occurring within the first 30 (thirty) days following birth. These Treatments are covered exclusively under the "Newborn Benefit" and are not eligible for reimbursement under any other Benefit category within the policy. Newborn babies must be incepted as Insured Person under the Insurance Policy to have access to the Benefit.

Medical Conditions that are congenital in nature, as well as complications resulting from assisted conception or childbirth, including but not limited to premature birth or multiple births, are covered under the "Congenital Conditions" Benefit of the newborn's Insurance Policy.

Outpatient Treatment

Maternity care and childbirth, services of a midwife or obstetric nurse

The Insurer will reimburse Eligible Expenses related to pregnancy or pregnancy-related illnesses, encompassing standard routine maternity scans and tests. Insurance cover extends to all Medically Necessary diagnostic tests, including amniocentesis and Chorionic Villus Sampling (CVS), **while excluding NIPT and other forms of genetic testing.**

In countries where routine prenatal care is commonly provided by a licensed midwife, midwife services are reimbursable. Reimbursement for corresponding examination and Treatment costs by midwives is applicable only if no charges for the same services have been administered by a Doctor.

Additionally, the Insurer will cover 12 (twelve) post-natal midwife home visits per pregnancy. **However, doula services, as well as pre-natal and post-natal classes, are not eligible for reimbursement.** A Waiting Period of 12 (twelve) months applies.

Complications of pregnancy and childbirth

The Insurer will reimburse Eligible Expenses incurred for premature birth, miscarriage, Medically Necessary abortion, stillbirth, ectopic pregnancy, hydatidiform mole, caesarean section, post-partum haemorrhage, retained placental membrane, and complications arising from any of these conditions. A Waiting Period of 12 (twelve) months applies.

Outpatient childbirth cash Benefit

Outpatient childbirth is characterized by delivering at home or departing from the Hospital, maternity home, or a similar institution within 24 (twenty-four) hours of giving birth. The Insurer will provide the lumpsum childbirth allowance per newborn upon receiving a birth certificate and, if applicable, a certificate from the medical provider confirming the duration of stay. A Waiting Period of 12 (twelve) months applies.

Vision Aids and Dental Benefits

Vision aids, including an eye test

The Insurer will cover the costs for eyeglass, frames and lenses, including contact lenses or sunglasses equipped with dioptre lenses, along with one refraction test per Insurance Year. In the event that the Insured Person's visual acuity changes by at least 0.5 diopters during the term of the Insurance Year, a renewed entitlement to Benefits shall arise in respect of such change.

Dental Treatments

Maximum dental limit

The Benefits for dental Treatments shall not exceed the Maximum dental limit, unless otherwise specified in the scope of Benefits.

Minor dental services

The Insurance Policy covers the following:

Screenings

The Insurance Policy covers routine screenings for early detection of disorders of the teeth, mouth and jaw.

General dental services including:

- X-ray examination,
- Intraoral local anaesthesia in connection with minor dental services.

Prophylactic services including:

- Tartar removal and polishing,
- Professional teeth cleaning,
- Assessment of oral hygiene status,
- Local fluoridation for underage person,
- Sealing caries-free tooth fissures for underage person.

Conservative services including:

- Simple fillings related to cavity,
- Root canal Treatment in connection with a following simple filling.

Surgical services including:

- Extraction of teeth,
- Removal of a deeply fractured or tooth with deep destruction,
- Hemisection or partial extraction,
- Removal of a retained, impacted or misaligned tooth in an osteotomy,
- Reimplantation of a tooth including simple fixation,
- Excision of the mucosa or granulation tissue,
- Resection of a root tip/root amputation and Cystectomy.

Services provided for Diseases of the oral mucosa and periodontium include:

- Preparation and documentation of the status of the periodontium,
- Local Treatment of Diseases of the oral mucosa,
- Periodontal surgery (especially removal of subgingival concrements and root smoothing) closed procedure; the pocket depth must be more than 3 (three) millimetres,
- Flap surgery, open curettage including, osteoplasty; the pocket depth must be more than 5 (five) millimetres and the closed procedure has taken already place before.

Insertion of occlusal splints including:

- Inclusion of an occlusal splint without adjusting the surface,
- Inclusion of an occlusal splint with surface adjustment,
- Inspection of an occlusal splint or surface adjustments e.g. additive or subtractive measures.

Functional analysis and functional therapy including:

- Clinical functional analysis including documentation,
- Registration of the joint-related central position of the mandible, including support pin registration (creation of a facebow, and coordination of a facebow with an articulator).

Major dental services

The Insurer will reimburse outpatient major dental Treatment expenses only if a prior written approval has been given to cover these costs before the Start of Treatment.

The major dental Treatment expenses covered under the Insurance Policy are the following:

Prosthetic services including:

- Impression or partial impression of a jaw for a situation model including an assessment for diagnosis or scheduling,
- Preparation of a written schedule of Treatment and charges for prosthetic Treatment,
- Preparation of a destroyed tooth with plastic augmentation materials and pin to receive a crown,
- Inlay/Onlay,
- Adhesive fasting (plastic buildup, pin, inlay, crown, partial crown),
- Restoration of a tooth with a full or partial crown,
- Insertion of a prefabricated crown in a child,
- Provisional crowns/Bridge,
- Restoration of a partially edentulous arch with a bridge or prosthesis,
- Telescopic crown and prosthesis,
- Restoration of an edentulous jaw with a total prosthesis.

Implantological services including:

- Implant-related analysis,
- Use of an orientation splint/positioning splint,
- Implant insertion; only 4 (four) Implants per jaw and supporting dentures,
- Exposure of an Implant,
- Insertion of augmentation material (bone and/or bone substitute material),
- Sinus floor elevation.

Pre- and post-Treatments, e.g. dental Treatments in connection with dental prostheses, are reimbursed as the expenses in the context in which they are prescribed or provided.

Orthodontic Treatment undertaken before the 18th birthday

The Insurance Policy covers orthodontic Treatment for a child, undertaken before its 18th (eighteenth) birthday, which covers the use of metal braces, retainers, and a prescribed Treatment Plan. The determination of whether this Treatment is Medically Necessary relies on the evaluation of the Index of Orthodontic Treatment Needs (IOTN) by the Insurer, referencing the British Orthodontic Society's standards. **However, the Insurer does not cover any additional costs or services, including specialised braces like lingual brackets or clear aligners such as Invisalign.**

Treatment plan

Before initiating Treatment, the Doctor or Dentist must provide a Treatment plan and associated costs, especially if dentures, extensive rehabilitation measures, or orthodontic Treatment are intended. Subsequently, the Insured Person will be notified by the Insurer regarding the reimbursement extent for these costs.

Accidental dental Treatment

Full Benefits will be provided up to the overall limit if the Insured Person requires dental Treatment due to accidental injury to the teeth resulting from direct external impact to the head, such as falls or other Accidents causing injury through external force. **Injuries caused by eating, drinking, or any injury resulting from biting, chewing, clenching, or grinding of teeth are not covered under this Benefit type.** The Dentist's receipt must explicitly confirm that the Treatment is a consequence of an Accident. Additionally, proof of the Accident, supported by a medical or police report, is necessary.
No Waiting Periods apply.

Dental exclusions

The following dental services are not covered under the Insurance Policy:

- **Fluoridation of the tooth surface and fissure sealing for adults,**
- **Veneers, including partial front teeth crowns,**
- **Bleaching or any related cosmetic and aesthetic services,**
- **Sedation/anaesthesia,**
- **Pain and anxiety-relieving measures, such as Acupuncture, hypnosis, general anaesthesia, sedation with laughing gas, twilight sleep anaesthesia.**

For the avoidance of doubt, the following is covered:

- Insurance cover for the costs of children up to the age of 12 (twelve) if diagnosed with an anxiety disorder by a qualified specialist,
- Additionally, in the case of the failure of local anaesthesia,
- Treatment under local anaesthesia deemed impossible due to severe psychological and physical disability in a patient.

Medical Assistance Benefits

The Insured Persons can claim the services offered by the Service Centres in line with the Plan level chosen whenever an insured event or Emergency happens.

The Insurers service and assistance network of competent and experienced partners on the ground offers the Insured Persons individual support worldwide as well as comprehensive, competent consultation for any situation.

This network is represented in more than 180 countries and delivers excellent support, reliability and service.

These services are available 24 (twenty-four) hours a day, 7 (seven) days a week, 365 days a year. If the Insured Person needs help from them, it simply calls the number shown in the insurance documents at any time, day or night.

The Insured Person can claim help services in line with the Plan level chosen whenever an insured event or Emergency happens.

When the insurance cover provided for under the Insurance Policy ends, the Insured Person will no longer be entitled to these services.

24-hour phone and e-mail service with experienced counsellors, Doctors and specialists

Medical assistance is accessible every day of the year, around the clock, either through e-mail or by contacting the medical assistance hotline.

Medical evacuation and Repatriation

This service encompasses a medically justified and necessary ambulance service, either within the Country of Residence or to a cross-border location if the inpatient medical care or hygiene standards in the local Hospital are deemed inadequate. The service also includes the costs of medically justified and necessary medical accompaniment during transport.

The Insurer will cover the expenses for transporting a patient under the following conditions:

- Evacuation or Repatriation must be prescribed by the treating Doctor and deemed Medically Necessary.
- The Insurer or the Service Centre must grant prior approval.

Following consultation with the Insurer or the Service Centre and the attending Doctor, the Insured Person will be transported (within the selected Geographical Area) to:

- A more suitable location for their Treatment in another country.
- The Insured Person's Country of Residence if the insured event occurred outside this country.
- The Insured Person's Country of Departure or Home Country.

If Medically Necessary, the Insurer will also arrange for a Doctor to accompany the Insured Person during the journey. Importantly, the Insurer will only cover transport to a location deemed suitable for Treatment.

Information on medical infrastructure

In the event of an insured incident or Emergency, the Insurer or the Service Centre will inform the Insured Person about the locally available medical care. Information regarding the designation of Doctors, Hospital consultants, Hospitals, and specialised medical facilities in the vicinity of the Insured Person can be provided in English, German, French and Spanish. Additionally, guidance and assistance in choosing a Treatment location, in case of a Medically Necessary transfer or change of care provider, can also be offered.

Support and information, including Second Opinion

The Insured Person can reach out to the Insurer or the Service Centre via phone whenever local medical assistance is needed. Upon the Insured Person's request, the Insurer or the Service Centre can inform the Insured Person's relatives about the occurrence of an insured event or Emergency, provided it is technically feasible.

In cases involving potentially fatal illnesses or serious permanent disabilities, the Insured Person has the option to seek a Second Opinion directly from another Doctor or, if necessary, through the Insurer or the Service Centre. When it comes to planning Hospital admissions or discharges for inpatient Treatment, the Insurer or the Service Centre will assist the Insured Person.

For cases requiring inpatient Treatment, the progress of the illness can be monitored by Doctors associated with the Insurer or the Service Centre. This monitoring also extends to Outpatient Treatments designed to prevent Hospital stays.

Guarantee of payment – GOP

In the event of an Emergency requiring inpatient Treatment, the Insured Person must promptly contact the Insurer or the Service Centre. If there is a planned inpatient Treatment or surgery qualifying as Outpatient Treatment instead of inpatient Treatment, the Insured Person shall notify the Insurer or the Service Centre at least 7 (seven) days before the scheduled Hospital admission. This notification is crucial for proper planning, whether for planned inpatient Treatment or Emergency inpatient Treatment, enabling the Insurer or the Service Centre to handle the necessary formalities and ensure cost cover for Doctors or the Hospital.

These formalities include conducting a medical review of invoices to verify their adherence to Usual, Customary and Reasonable standards. The Insurer will also coordinate with the Hospital on invoice submission addresses and payment terms, ensuring direct payment of invoices. In such cases, the Insured Person will receive written or e-mail notification from the Insurer or the Service Centre regarding the process.

Failure to inform the Insurer or the Service Centre beforehand or immediately in case of an Emergency may result in the Insurer not paying the full Claim.

Return of mortal remains

In the event of a death abroad, the Insurer or the Service Centre can provide assistance:

- Securing the death certificate or Accident report, as permitted by law;
- Liaising with public authorities and consulates in the foreign country;
- Determining which surviving relatives are authorised to make decisions regarding the Repatriation or cremation of the deceased,
- Managing all formalities for Repatriation, cremation, or a local funeral in compliance with the regulations of the relevant country.

The Insurer will reimburse:

- Direct costs incurred for repatriating the deceased to the Country of Departure or Home Country, including all associated formalities. This also covers a family member traveling with the mortal remains if they were accompanying the deceased member at the time of death.
- Costs related to repatriating the urn to the Country of Departure or Home Country if the deceased has been cremated in the Country of Residence. This includes a family member traveling with the mortal remains if they were accompanying the deceased member at the time of death.

However, funeral costs per se will not be eligible for reimbursement.

Additional appropriate medical support

Whether an insured event has occurred or not, the Insurer or the Service Centre will offer to the Insured Persons general information about the destination, local customs, and required formalities. Additionally, they will provide medical information, including advice on vaccinations and medical consultations by phone, to assist in preparing for the journey. Furthermore, guidance will be given on what to include in a personal first-aid kit.

In the event of an insured event, the Insurer or the Service Centre will provide general information about the nature, potential causes, and available Treatments for the illness. They will clarify the medical terminology used and provide details on Drugs, their potential side effects, and interactions.

For cases requiring Outpatient Treatment, the Insurer or the Service Centre will coordinate and monitor the Treatment and progress, facilitating consultations between Doctors if necessary and arranging any additional support needed.

Online services

The Insured Person is entitled to use the dedicated online service in the provided online member area.

Additional Assistance Benefits

Compassionate family visit

The Benefits include the following services:

- In the event that the Insured Person undergoes inpatient Treatment due to a medical Emergency, whether in the Country of Residence or while traveling for leisure or business, the Insurer or the Service Centre will organise for a family member to visit if the Hospital stay exceeds seven days. Arrangements will be made for one family member to travel to the Hospital and return home.
- If an Insured Person is compelled to return to their Home Country due to a severe illness, Accident, or the death of a family member, the Insurer or the Service Centre will provide reimbursement up to the specified maximum amounts.

This cover, known as the compassionate family visit Benefit, includes the reimbursement of transportation expenses (such as a first-class train ticket and/or economy plane ticket) for family members traveling to the Insured Person's Country of Residence, the location of Hospitalisation, or the burial site in their Home Country. Severe illness and serious Accidents are defined as those posing a life-threatening risk to the family member. For the purposes of this cover, relatives are considered to be the spouse or unmarried partner, as well as the parents and children of the Insured Person. Reimbursement for return transport costs due to severe illness and serious Accidents is contingent on advance contact with the Insurer or the Service Centre. Additionally, transport costs due to death are only reimbursable upon submission of the death certificate.

Return to Country of Residence after Repatriation

The Insurer will cover transportation costs (first-class railway travel, economy-class flight) up to the maximum amount specified in the scope of Benefits, but only if the Insured Person has contacted the Insurer or the Service Centre in advance.

Delayed return trip

If an Insured Person's return from the Country of Residence is postponed due to a medical Emergency, rendering them unfit to travel, the Insurer will cover the additional expenses incurred for modifying hotel

accommodation and flight reservations, up to the maximum limit specified in the scope of Benefits.

Getting hold of and shipping vital Medication

If an Insured Person depends on essential Medications that are unavailable in their Country of Residence, they can request the Insurer or the Service Centre to procure these legally approved Drugs and send them, as long as importing them in this manner is not prohibited by law.

Return transport or care for children

In the case of a medical Emergency requiring both parents to undergo inpatient Treatment in the Country of Residence, the Insurer will arrange for a child welfare service to care for the children throughout the duration of the inpatient Treatment. If both parents experience a medical Emergency while traveling on holiday (up to 6 (six) weeks) and require inpatient Treatment, the Insured Person is entitled to claim return transport for the child (under the age of 18 (eighteen)) with a companion to the Country of Residence.

Organising help in case of legal difficulties

The Insurer or the Service Centre has the capability to connect the Insured Person with lawyers or experts globally who are proficient in English, German, French or Spanish. When required, the Service Centre can facilitate an advance payment for lawyers' fees, court costs, or bail. It's important to note that the advance payment is not directly provided by the Insurer or the Service Centre; instead, they coordinate with banks or relatives and assist in transferring the funds if necessary.

Help with psychological problems caused by the stay abroad

If the time spent abroad causes psychological conflicts for the Insured Person, the Insurer or the Service Centre will provide psychological assistance via phone and will also arrange for appropriate local support if deemed necessary.

Telemedicine

The Insurer grants all Insured Persons access to telemedical services. In collaboration with a third-party provider, the Insurer offers a complimentary app, available on both iOS and Android platforms. Access is open to all Insured Persons aged 18 (eighteen) and above, actively covered under this Insurance Policy, and who have given consent for the processing of personal data. Stringent security measures are employed to safeguard both access and data, mitigating any potential security breaches.

The available services include telephone consultation, video consultation, and chat, all provided in English, German, and Spanish. These services are accessible around the clock, 7 (seven) days a week.

4. Plan

The premium will be determined following the completion of the Application Form, taking into account factors such as the Country of Residence.

1. **Change from Geographical Area II to Geographical Area I:**

If the Country of Residence changes during the term of the Policy that initially covered Geographical Area II, resulting in a transition to Geographical Area I, the premiums applicable to Geographical Area I – including those for U.S. insurance cover – shall apply immediately.

2. **Change from Geographical Area I to Geographical Area II:**

If the Country of Residence changes during the term of the Policy that initially covered Geographical Area I, resulting in a transition to Geographical Area II, the premiums applicable to Geographical Area II shall apply as of the next Insurance Year. Premiums for U.S. insurance cover shall remain payable until that time.

Should the Insured Person transition to a different age category after a birthday, the premium will be adjusted to reflect the new age category upon next renewal.

These adjustments will be carried out in accordance with the provisions outlined in the Terms and Conditions of Insurance and the applicable legal regulations.

The specific premium amount applicable to the Insurance Policy is detailed on the invoice or the Particular Conditions (where applicable).

5. Exclusions

The Insurer does not cover expenses for the following Treatments or Medical Conditions under the Insurance Policy, unless they are explicitly listed in the scope of Benefits or any other written addendum to the Insurance Policy.

Nursing Home

The Insurance Policy excludes insurance cover for expenses associated with staying at home or receiving non-medical care at home, in a convalescence home, psychiatric home, or similar facilities.

Acting against medical advice

The Insurer does not cover Treatments resulting from the Insured Person's failure to seek or follow medical advice, or from traveling against medical recommendations.

Complications caused by excluded cover

The Insurer will not provide cover for expenses resulting from complications directly arising from an illness, injury, or Treatment that are excluded or have limited cover.

Cosmetic/plastic surgery

Expenses incurred for cosmetic or plastic surgery and Treatment will not be reimbursed.

Detoxification programmes including therapies

Detoxification programs, including Treatments for drug addiction and alcoholism, are not covered by the Insurance Policy. However, Benefits for an initial detoxification will be paid if the Insured Person is unable to claim a refund elsewhere, and in the case of inpatient detoxification, the Insurer will only reimburse expenses related to basic Hospital services, including medical Treatment and Drugs.

Any subsequent Treatment resulting from or directly associated with harmful, hazardous, or addictive use of any substance, including alcohol and Drugs, will not be covered.

Developmental disorders

The Insurer does not provide cover for services, therapies, educational testing, or training associated with learning disabilities or disorders of psychological development. This includes conditions such as developmental delays, scholastic skills, pervasive disorders, mental retardation, perceptual handicap, brain damage not caused by accidental injury or illness, minimal brain dysfunction, dyslexia, or apraxia.

Epidemics, pandemics and Disease outbreaks

Expenses associated with Treatment, medical evacuations, and/or Repatriations, whether directly or indirectly resulting from epidemics, pandemics, or Disease outbreaks of comparable scale that have been brought under the control of local public health authorities, will not be reimbursed unless otherwise approved by the Insurer in writing.

Experimental and investigational Treatments

The Insurer will not provide cover for any form of Treatment or drug therapy that it deems to be experimental or investigational. A service, technology, supply, procedure, Treatment, drug, device, facility, equipment, or biological product is considered experimental or investigational when it does not meet all of the following requirements:

- It must have a final license and clear approval from at least one of the following: EMA (European Medicines Agency), FDA (Food and Drug Administration – phase III completed), European network for Health Technology Assessment (EUnetHTA). Interim approval is not sufficient. The approval is only valid for the corresponding medical indications and conditions. In the case of procedures and approved clinical pathway guidance, it must be clearly stated as such on one of the following guidelines: NICE (National Institute for Health and Care Excellence), AWMF (Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften), AHRQ National Guideline (Agency for Healthcare Research and Quality – National Guideline Clearinghouse).
- All approvals and guidance must be conclusive and must not indicate the need for more research, be under a research environment, have limited

evidence, insufficient evidence, or lack clinical utility.

Extreme sport and high-risk activities

Extreme sport and high-risk activities are not covered under the Insurance Policy.

Extreme sports and high-risk sporting activities encompass any form of sport or athletic pursuit characterized by a heightened level of inherent danger.

This includes activities demanding advanced expertise, extraordinary physical exertion, specialised equipment, performance of daring stunts and activities in which the Insured Person has signed a liability waiver, such as inter alia the following:

- Abseiling, mountaineering (apart from indoor climbing and low mountain areas fully equipped for sports climbing) and racing of any kind,
- Bobsleigh, luge, skeleton, off-piste skiing, and off-piste snowboarding,
- Bungee and cliff jumping,
- Combative sports,
- Downhill mountain biking and cross-country cycling,
- Extreme tourism (e,g, tours to Antarctica),
- Horseback hunting, horse jumping, polo, steeplechasing, or any form of horse racing,
- Motorcycle sports, including motorcycle riding and quad biking,
- Microlight flying, wingsuit flying, ballooning, hang gliding, paragliding, parascending, and parachute jumping,
- Solo caving (potholing) or cave diving, scuba diving beyond 10 meters, high diving, white water rafting, and canyoning,
- Ultra marathons or activities similar in nature,
- Any other hazardous activity similar in risk to the before mentioned ones, such as e.g. train surfing.

Search and rescue services for extreme sport and high-risk activities, including but not limited to cave, sea and mountain rescue, are excluded from cover provided for under the Insurance Policy.

Eyesight

The Insurer will not provide cover for any Treatment or surgery aimed at correcting an Insured Person's eyesight, including procedures such as laser Treatment, refractive keratotomy (RK), and photorefractive keratectomy (PRK). Cover does apply to the correction of the Insured Person's vision when this is Medically Necessary (e.g., cataract or detached retina).

Genetic testing

The Insurance Policy does not cover the expenses related to 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.

Illnesses, Accidents and their consequences caused by intent or gross negligence

The Insurer will not provide insurance cover for illnesses, Accidents, and their ensuing consequences that are intentionally caused or caused by gross negligence. The Insurer defines an illness or Accident as intentionally caused or caused by gross negligence when the individual involved had a reasonable understanding of the outcomes of their actions and willingly accepted the resulting harm. This includes, but it is not limited to

- self-inflected injuries,
- attempted suicide,
- stays in an institution for drug withdrawal and
- injuries caused in the context of criminal acts.

Injuries caused by military service

The Insurer will not provide insurance cover for illnesses, Accidents, and their resulting consequences that occur while the Insured Person is engaged in military operations, military service, riot and civil commotion.

Need for long-term care and custody

The Insurer will not reimburse any expenses related to accommodation necessitated by long-term care and custody.

Non-medical Hospital expenses

The Insurance Policy does not cover expenses caused by any person accompanying the Insured Person, and does further not cover non-medical consumables, catering, and any media-related expenses (such as TV and radio).

Nuclear, chemical and biological contamination

The Insurer does not provide cover for illnesses, Accidents, and their consequences caused by nuclear energy (including nuclear reactions, radiations, and contamination), as well as illnesses, Accidents, and their consequences resulting from chemical or biological weapons.

Post-natal classes

The Insurer will not provide cover for post-natal classes aimed at addressing the physical effects on the body resulting from pregnancy and childbirth.

Professional Sports

The Insurer does not provide cover for Treatments or diagnostic procedures related to injuries or illnesses resulting from participation in Professional Sports.

Gender reassignment

The Insurer will not provide cover for the alteration of biological sexual characteristics through surgery and hormone Treatment to transition to the characteristics of the opposite sex.

Sleep disorder

The Insurer does not provide cover for examinations or Treatment related to sleep disorders, including insomnia. This encompasses CPAP (continuous positive airway pressure machine) and BIPAP (bilevel positive airway pressure machine).

Sterilisation, sexual dysfunction and contraception

The Insurer will not provide cover for procedures intended to render a person incapable of reproduction, any procedures, Treatments, or Medications aimed at preventing pregnancy, or any Treatment for sexual dysfunction (unless part of infertility Treatment).

Spa and wellness massages

The Insurer will not provide cover for stays or Treatments in a cure centre sanatorium, spa, health resort, or recovery centre, even if medically prescribed. This restriction also includes thermal baths, saunas, and various wellness massages.

Surrogacy

The Insurer will not reimburse expenses associated with Treatments directly related to surrogacy, regardless of whether the Insured Person is serving as a surrogate or are the intended parent. Children born to a surrogate mother are not covered under the Insurance Policy.

Termination of pregnancy

The Insurer will provide insurance cover for the termination of pregnancy in the event of a life-threatening danger to the pregnant woman or if the foetus is non-viable, the prerequisite is, that the chosen Plan includes reimbursements for maternity Benefits. This cover is subject to prior written approval from the Insurer. The specified conditions must be substantiated with required medical investigation reports, along with a medical report from the Doctor outlining the reasons for the termination of the pregnancy.

Treatment in sanatoriums, convalescent and nursing homes

The Insurer does not provide cover for therapies and Treatments in sanatoriums or convalescent and nursing homes. However, based on the selected Plan level, the Insurer may partially refund expenses for Follow-Up Rehabilitation.

Transport costs

Transport costs, other than Emergency ambulance services, will not be refunded unless the Insurer expressly gives prior written approval.

Treatment by certain Doctors, Dentists and other Therapists, as well as in certain Hospitals

The Insurance Policy does not cover Treatments administered by physicians, Dentists, and other Therapists, as well as Hospital services whose invoices the Insurer has declined to settle for substantial reasons.

Nevertheless, this release from the obligation to provide Benefits is applicable solely to insured events occurring subsequent to the Insured Person's notification of Benefit exclusion. If an insured event has already occurred at the time of notification, the Insurer's exemption from Benefits will only pertain to expenses incurred more than 1 (one) month after receiving notice.

Treatment by marital or non-marital partners, parents or children

The Insurer will not reimburse expenses if the Insured Person receives Treatment from its spouse, husband, non-marital partner, parents, or children. However, the documented cost of materials required for the Treatment, in accordance with the Plan, will be eligible for reimbursement.

Unlawful Acts and Hazardous Behaviour

The Insurer will not cover any illnesses, accidents, or resulting consequences that arise from unlawful acts or hazardous behaviour. This includes, but it is not limited to:

- Activities undertaken in violation of explicit warnings or prohibitions issued by medical professionals, public health authorities, or law enforcement agencies,
- Consequences of drunkenness and/or intoxication,
- Disturbances and measures taken to combat such disturbances, unless the Policyholder and/or Insured Person proves that the Insured Person did not actively participate in them,
- Quarrels and/or heated arguments, except in case of legitimate self-defence (a report from the authorities will be used as proof), and
- Betting and/or defiance.

Vitamins and minerals

The Insurer will not reimburse expenses for items categorized as vitamins or minerals, with the exception of Medically Necessary instances during pregnancy or for the Treatment of diagnosed, clinically significant vitamin-deficiency syndromes.

This also applies to Dietary Supplements, including special infant formula and cosmetic products, even if they are medically recommended, prescribed, or acknowledged for therapeutic effects.

Products such as nutriments, tonics, mineral water, cosmetics, hygiene and bodycare products, and bath additives are not considered Medically Necessary, and costs incurred for them will not be refunded.

War, civil unrest, acts of terrorism

The Insurance Policy does not cover illnesses or Accidents and their consequences, as well as death attributable to acts of war, civil unrest or acts of terrorism, unless the Insured Person is injured as an uninvolved third party who has not wilfully or negligently disregarded the danger and the Insured Person has not deliberately entered the area of conflict.

Insurance cover shall not be granted under any circumstances if the Insured Person enters an area of direct warfare or renders services for one of the warring parties. The exclusion of Benefits shall apply regardless of whether or not war has been declared. If the Insured Person acquires knowledge of the war, civil unrest or terrorist acts while in the country, the Insurance Policy will only cover Emergency, lifesaving Treatment and only for as long as the Insured Person is prevented from leaving the country or region concerned, but for not more than 28 (twenty-eight) days at most.

Other limitations to pay Benefits

If the Treatment or other agreed-upon measure exceeds what is Medically necessity or the claimed amount falls outside the Usual, Customary and Reasonable range, the Insurer reserves the right to reduce the payment/reimbursement. The Insured Person will be responsible for any costs that do not align with the Usual, Customary and Reasonable standards, as the Insurer does not cover amounts beyond this threshold. The Insurer retains the right to assess any cost or estimate with the input of medical professionals to determine its conformity with Usual, Customary and Reasonable standards.

If the Insured Person can claim Benefits from a statutory health insurance fund or any other provider, the Insurer will only reimburse expenses that remain Medically Necessary despite those Benefits. **Complications arising from excluded conditions are not covered.**

6. Glossary

This Glossary is to be read together with the Glossary included in the General Conditions of Insurance.

Acupuncture
Acupuncture is a method in ancient Chinese traditional medicine that cures Diseases and Bodily Injuries or reduces pain with the help of fine needles placed into the body. Conventual medicine recognises this primarily as a method for pain relief.

Annual Overall Limit
The maximum which will be paid for all Benefits in total for each Insured Person, for each Insurance Year.

Cancer
The general term used for all malignant disorders caused by the uncontrolled multiplication of mutated cells (new growths or tumours). These cells can destroy the surrounding tissue and produce metastases (secondary growths).

Chiropractic
A system of diagnosis and Treatment based on the idea that the nervous system coordinates all the body's functions, and that Disease results from a lack of normal nerve function. A chiropractor uses manipulation to change body structures, such as the spinal column, to relieve pressure on nerves coming from the spinal cord caused by a vertebra being displaced.

Co-Payment
A Co-Payment is the portion of the cost of a covered medical service that the Insured Person is required to pay, as a percentage of the total eligible expense for every Claim up to the Out-of-Pocket Maximum – if applicable. The remaining balance is paid by the Insurer, subject to the Terms and Conditions of the policy.

Computed Tomography (CT)
Computed Tomography (CT) is a diagnostic procedure that uses special x-ray equipment to get cross-sectional pictures of the body. The CT computer displays these pictures as detailed three-dimensional images of organs, bones, and other tissues. This procedure is also called CT scanning, computerized tomography, or computerized axial tomography (CAT).

Congenital Conditions
Any Disease or illness, abnormality, birth defect, premature birth or malformation present at birth including any related condition, whether diagnosed or not.

Conventional Medicine
The form of medicine based on accepted scientific methods which are taught at universities and so are generally acknowledged and used.

Country of Departure
The last country in which the Insured Person had his habitual residence.

Daycare
Daycare refers to the Treatment received in Hospital without involving an overnight stay. The length of stay in Hospital is between 8 (eight) and 24 (twenty-four) hours.

Deductible
The effect of a Deductible is that the Insured Person bears a certain portion of the costs. The Deductible is the share to be borne by the Insured Persons, up to an agreed limit. If a Deductible has been agreed, this will be shown in the Insurance Policy.

Dentist
A Doctor or Practitioner who focuses on Diseases of the teeth and mouth.

Dialysis
Dialysis is primarily used to provide an artificial replacement for lost kidney function (renal replacement therapy) due to kidney failure. Dialysis may be used for sudden but temporary loss of kidney function (acute renal failure) or for persons who have permanently lost their kidney function (end-stage kidney Disease). Dialysis is done in Dialysis units which are part of Hospitals and clinics or at home.

Eligible Expenses
The costs incurred for Medically Necessary healthcare services, Treatments, and procedures that are covered under the Terms and Conditions of this Insurance Policy. These expenses typically include charges for Hospitalisation, physician consultations, diagnostic tests, surgical procedures, prescribed Medications, and other approved medical interventions. To qualify as eligible, the services must be provided by licensed healthcare professionals or accredited medical facilities, and must align with the Insurance Policy's

cover guidelines, exclusions, and any applicable Waiting Periods or pre-authorization requirements.

Inpatient Follow-Up Rehabilitation
A medical Treatment aiming at recovering the initial state of health after an illness or serious surgery, for example following bypass surgery, cardiac infarction, transplants and surgery involving large bones or joints, or after a serious Accident.

Geographical Area
The following Geographical Areas to which the insurance cover provided under the Insurance Policy may apply:

Geographical Area I: Worldwide including United States of America
Geographical Area II: Worldwide excluding United States of America

Glossary
The Glossary of defined terms, which forms an integral part of the Special Conditions.

Home Country
The country where the Insured Person is a citizen or national of or has habitual/permanent residence or where their mortal remains will be sent if they die.

Homeopathy
A homeopath proceeds on the assumption that an illness which produces certain symptoms can be healed with remedies which produce similar symptoms in healthy people.

Hospice
An institution where the only purpose is to care for patients with limited life expectancy for whom curative Treatment is no longer available. It aims to offer the best possible quality of life by using palliative care.

Hydrotherapy
Hydrotherapy is the targeted Treatment by external application of water.

Implants
Dental Implants (metal or ceramic) which are embedded as a substitute for the root of a tooth or in the toothless jaw.

Magnetic Resonance Imaging (MRI)
A diagnostic technique in which radio waves generated in a strong magnetic field are used to provide images of the body's tissues and organs.

Maximum Outpatient Limit
The maximum amount the Insurer will reimburse for the total of all outpatient Benefits per Insured Person and per Insurance Year under a specific insurance Plan, as stated in the Scope of Benefits.

Medical Condition
Any illness, Disease, injury or any physical, mental or psychological abnormality as well as pregnancies.

Nutritional and/or Dietary Supplements
Products used to boost the Nutritional content of the diet, including vitamins, minerals, herbs, meal supplements, sports nutrition products, natural food supplements.

Osteopathy
The osteopathic approach to medicine includes comprehensive manual diagnostics and therapy of the malfunctioning of the body's musculoskeletal framework, internal organs and the nervous system. It is mainly used in chronic pain of the vertebral column and the peripheral joints.

Out-of-Pocket Maximum
The Out-of-Pocket Maximum is the maximum cumulative amount that the Insured Person is required to pay in the form of Co-Payments for Eligible Expenses during an Insurance Year. Once this threshold is reached, the remaining balance is paid by the Insurer, subject to the Terms and Conditions of the policy.

Outpatient Treatment
Any Treatment given by a qualified and licensed medical professional which does not need an overnight stay (also Hospital stays for less than 8 (eight) hours).

Palliative Medicine
Palliative Medicine is the extensive and active Treatment of patients with a limited life expectancy for which curative therapy is no longer possible in their condition. This type of Treatment provides the best possible quality of life for the patient and its family.

Policy Period
The Policy Period is the period in time during which the insurance cover is granted under the Insurance Policy, which the Policyholder has selected for the Insured Persons in the Application Form.

Positron Emission Tomography (PET)
A non-invasive imagery process based on the detection and imagery of a substance with positron emitters spread inside the patient's body. The concentration of these "markers" in a tumour can then be quantified, the substance is injected intravenously, and the radiation is detected with external detectors. With the help of PET important biological processes can be visualised in tumours.

Practitioner
A person who, besides Doctors, also has recognised and well-founded training in their area of Treatment and are authorised for Treatment in that speciality in the country in which the Treatment is to be provided. The following are understood to be Practitioners: naturopaths, speech Therapists and midwives as well as independent Practitioners practicing in state approved medical ancillary professions (for example massage Therapists and medical attendants, physiotherapists). The Insured Persons are free to choose a Practitioner who meets these criteria.

Pre-Existing Conditions
Pre-Existing Conditions refer to any Medical Conditions, Diseases, Bodily Injuries, or their consequences that the Policyholder or any Insured Person was aware of, or received medical advice, diagnosis, or Treatment for, prior to signing the Application Form.

This includes:

i. Any condition for which the Insured Person underwent diagnostic testing (including preventive screenings or routine health check-ups) that resulted in abnormal findings, regardless of whether a formal diagnosis was made.
ii. Any signs or symptoms, whether diagnosed or not, as well as any physical or organic abnormalities, congenital anomalies, disabilities, or deformities.
iii. The presence of any medical devices such as Implants, stents, prostheses, or any other devices permanently or temporarily attached to the body.

Additionally, any illness, injury, or Medical Condition that arises between the date of signing the Application Form and the date of signing the Particular Conditions will also be considered a Pre-Existing Condition.

Professional Sports
Any sports the Insured Person is being paid for taking part in.

Prophylactic Measures
Preventive measures which include individual and general measures to avoid the threat of illness (for example, vaccinations, passive immunisation, preventive Medication when travelling to dangerous areas, preventing Accidents and so on).

Repatriation
If a Medical Necessary Treatment for which the Insured Person is covered is not available locally, the Insurer covers the return to the Home Country for Treatment, rather than to the nearest appropriate medical centre. This only applies when the Home Country is located within the Insured Persons Geographical Area of cover.

Sanatorium Treatment
A cure or Treatment different from a Medical Treatment that serves to rehabilitate a person's state of health or Fitness.

Second Opinion
The medical advice given by a second independent Doctor not involved in the Treatment.
The Insured Person can also consult a second Doctor through the relevant Service Centre to get a Second Opinion if potentially fatal illnesses or serious permanent disabilities are involved.

Start of Treatment
The date on which a Medical Treatment, prescribed and administered by a Medical Authority subsequent to a Disease or Bodily Injury, commences.

Substitute Hospital Cash Plan Benefit
If the Insured Person does not claim any Benefits from the Insurer for Medically Necessary inpatient Treatment covered by the insurance, the Insurer will instead pay a Substitute Hospital Cash Plan Benefit for every day actually spent in Hospital for the medically

recommended inpatient Treatment. This is in line with the Plan level chosen.

Therapist
A Doctor, but also anyone who has received in-depth training in their field and is licensed or authorised to give Treatment in the country in which Treatment is provided. This includes Practitioners of complementary medicine, speech Therapists and midwives and obstetric nurses, as well as members of state-approved assistant medical professions with their own practice, such as masseurs and physiotherapists. The Insured Person can choose any Therapist who meets these conditions.

Usual, Customary and Reasonable
Usual, Customary and Reasonable charges refer to the average fee charged for a specific medical service by licensed medical Practitioners within a defined geographic region (e.g. city or country), based on publicly available fee schedules or databases maintained by recognized health authorities or insurance industry benchmarks.

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