swisscare

expatline

International Health Insurance

General Insurance Conditions
Version EXP15

International health insurance
General Insurance Conditions (GIC)
For expatriates around the world

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1. General Information concerning the insurers and service providers

The Insurer

Tokio Marine Kiln Europe SA, on behalf of A J. Kiln / Syndicate n° 510, Westendstrasse 28, D-60325 Frankfurt (Germany), registered in Germany (hereinafter referred to as TMKiln),

covers illness and accidents as well as, from a medical point of view, their direct economic consequences. The coverage consists of the reimbursement of the costs of medical treatments and other costs according to the General Insurance Conditions (GIC's). The coverage and the conditions are determined by the insurance contract, any additional written agreements, the GIC's as well as the applicable legal provisions in force.

The Assistance Provider

SOS Evasan S.A. (hereinafter referred as Evasan)

SOS Evasan S.A. Route de L' Etraz 12c CP 5, CH-1267 Vich, Commercial registry: CH-660-0168995 is responsible for the coverage and the benefits for medical assistance during the insurance period or in the frame of other events enumerated in the insurance contract. The coverage and the conditions are determined by the insurance contract, any additional written agreements, the GIC's as well as the applicable legal provisions in force.

The GIC's are to be applied unless a written agreement states otherwise. All amendments must be made in writing.

Kiln cannot be held responsible for coverage offered by Evasan, and Evasan cannot be held responsible for coverage offered by Kiln. Kiln and Evasan are separate entities and do not recognize any joint liability; each insurer can only be held responsible and liable for the coverage that lies within their scope.

Claims Department and Alarm Center

SOS Evasan S.A. (hereinafter referred as Claims Department)

On behalf and on request of Kiln, Evasan provides emergency assistance and access to their emergency assistance center (alarm center) to those insured by Kiln.

Evasan will, on their own behalf as well as according to the mandate received from Kiln, take over the administration of the insurance documents, as well as receive messages from the insured. Evasan manages all claims arising from the medical coverage provided by Kiln, as well as the claims arising from the emergency assistance coverage provided by Evasan

Final decisions as well as the responsibility for the medical coverage are solely the responsibility of Kiln. Final decisions as well as the responsibility concerning emergency assistance coverage are solely the responsibility of Evasan.

When hereafter «the insurer» is mentioned, this applies to both Kiln and Evasan, within their individual scope.

Legal notice: The policy is underwritten by the Swiss insurer SOS Evasan S.A.. Route de L' Etraz 12c, CP 5, 1267 Vich (Switzerland). The company is registered by the Swiss Financial Market Supervisory Authority FINMA. Swisscare Services Ltd, Landstrasse 8, 9496 Balzers (Principality of Liechtenstein) is a registered insurance broker under the license nr. 10095 by the financial authority in the Principality of Liechtenstein (FMA).

Insurance administration

Swisscare Services Ltd. (hereinafter "Swisscare")

Swisscare Services Ltd., Altelandstrasse 6, 9496 Balzers (LI) is an independent insurance provider. The company is authorized and regulated in the Principality of Liechtenstein by the financial market supervisory authority, reference number 10095. Registered in the company index in the Principality of Liechtenstein under the number FL-0002.465.148-2.

Swisscare ™ is a registered Trademark owned by Swisscare Services Ltd. Expatline is a product line provided by Swisscare. The use of Swisscare name or logo is strictly prohibited without prior written authorization of Swisscare Services Ltd., Altelandstrasse 6, 9496 Balzers (LI).

Swisscare Customer Care Unit (hereinafter "Swisscare")

If the policyholder has any queries concerning his/her policy, he/she can contact the customer care unit by telephone during the office hours at +423 384 05 05, by fax at +423 384 05 06, by email at info@swisscare.com or by postal mail at the above company address.

Compliance

The insurers products and services may not be available in all jurisdictions and are expressly excluded from this policy where prohibited by applicable law, including but not limited to, anti-corruption laws and economic sanctions programs. Any such coverage will be null and void. The Expatline policy does not replace participation in a state-run or local health insurance scheme or compliance to any other legislative requirements of any country whatsoever. Expatline insured should not stop contributing to a state-run insurance scheme unless they have been given advice about the risks of doing so.

The insurer and policyholder/insured agree that, except as explicitly stated in the present GIC's of the insurance policy, nothing of value has been offered or provided by either of them or anyone acting on their behalf, in relation with this insurance policy.

Order of precedence of the clauses of the GIC's

The general clauses are only valid insofar as they are not contradicted by or in conflict with the provisions and clauses of the different types of coverage. In case of contradictions or conflict, the clause of the specific coverage shall prevail over the general clause.

2. Insured

The insured is the person that will benefit from the insurance coverage. The insurance applies only to the person or group of persons who are named as beneficiaries in the insurance contract or in an enclosed list that is part of the insurance contract.

2.1. Eligibility

The Swisscare Expatline insurance is available for individual expats (private individuals and their dependents) and for employers to cover their expatriated employees (and their dependents) sent on assignment abroad (group policy).

For group policies, if the number of enrolled staff decreases to 1 (one) employee, the insurer has the right to terminate the policy.

2.2. Acceptance into the insurance

Individual expats (individual policy)

A medical questionnaire has to be completed for each insured (including each dependent) and has to be sent at the time of application by the applicant to the medical consultant of the Claims Department. The medical consultant can define partial exclusions, total exclusion from coverage (refusal of coverage), or, at his/her discretion, propose an additional premium to waive exclusions.

The information provided on the medical questionnaire is valid for one month. If the policy enters into effect later than one month after the date of signature of the questionnaire, a new medical questionnaire needs to be completed and signed or the state of health needs to be reconfirmed.

2.3. Expatriated employees (group policy)

In case of compulsory enrolment by the employer of a group of ten (10) or more employees and after an assessment of the risk profile of the group, the health declarations for the Expatline plan can be waived at the discretion of the insurer, meaning that there will be immediate and full acceptance into the Expatline plans. of both employees and dependents. However for temporary incapacity / disability coverage, the insurer can still

define partial or total exclusion from coverage, or, at his discretion, propose an additional premium in order to waive exclusions.

Adding/removing employee's to/from the group insurance

The minimum insurance period for new employees who join a group insurance is three months.

Requests to add or remove employees can be processed retroactively up to a maximum of 60 days after receipt of the notification to the insurer.

3. Territory

The contractual territory is the geographical or political area as defined in the insurance contract in which the contractual obligations come into force.

3.1. Health insurance territory

The coverage is worldwide, with exclusions as defined in the insurance contract.

3.2. Travel insurance and assistance territory

a) Travel means that insured leaves their place of residence temporarily as well as the bordering municipalities, regardless of the reason for leaving.

b) If the insured returns occasionally to the home country for a short holiday while still being a resident somewhere else - as foreseen in the insurance policy - and suffers an incident, the stay in the home country will be considered as travel.

3.3. Excluded territories

The right to benefits of health insurance coverage and medical assistance ceases as soon as the insured enters a territory excluded from the insurance contract.

4. Definitions

4.1. Insurance application and obligations

1 An insurance application is the application submitted by the applicant to the insurer with the aim of concluding an insurance contract. The application is not binding and does not mean that the contract has been concluded. Applications can be submitted by letter, e-mail, or fax. **If, when concluding the insurance contract, the person who is obliged to notify omits to notify or incorrectly notifies a significant risk factor which he knew or ought to have known or about which he was questioned in writing, the insurer is entitled to terminate the contract by written notice. The termination becomes effective upon delivery to the policyholder. The termination right expires four weeks after the insurer has come to know the violation of the obligation to notify. If the contract is terminated the insurer's obligation to indemnify damages already occurred terminates, provided that the omitted or incorrect notification of the significant risk factor has influenced the occurrence or extent of damages. If the obligation has already been fulfilled, the insurer is entitled to restitution.**

Insurance applications are only acceptable if all questions are answered honestly and completely. An insurance contract based on disinformation or a lack of information will be terminated by the insurer, all indemnifications that the insured has already received that have any connection with the disinformation or lack of information will not be reimbursed, if they have already been reimbursed the insurer will demand a refund for any and all payments made. Premiums that have already been paid shall not be reimbursed in this case.

2 The fact that the insurer has sent out the insurance application forms to the applicant does not constitute an offer to conclude an insurance contract. It is merely a request for information from the applicant in order to ascertain if the insurer can make an offer and this does not replace an insurance offer by the insurer or an actual insurance contract.

4.2. Application with full medical underwriting

An application with full medical underwriting is a procedure during which the applicant declares his/her medical history on the application form. The insurer, based on the medical history declaration can accept or refuse pre-existing conditions. Full medical underwriting is not possible should any pre-existing conditions not have been declared or should anything relevant to the acceptance by the insurer have been omitted or false.

Pre-existing conditions disclosed during application for full medical underwriting, which the insurer has accepted to cover, or for which limitations have been introduced, will be subjected to a 12-month waiting period. This means that they will not be covered during the first 12-months from the start date of the insurance policy.

The insurer can review the 12-month waiting period for pre-existing conditions if the insured submits satisfactory proof of recovery. The insurer's agreement must be in writing.

4.3. Pre-existing conditions

1 Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been shown at any point prior to commencement of coverage, irrespective of whether any medical treatment or advice was sought.

Any change in health, disease, illness or infirmity, be it physical or psychological that objectively existed prior to the signature of the insurance contract and whose manifestation, consequences or complications require treatment, professional examination, tests or a medical intervention during the period of coverage by the insurance is considered to be a pre-existing condition.

Pre-existing conditions, which have not been explicitly declared on the relevant application form for full medical underwriting, are not covered.

4.4. Application excluding pre-existing conditions

An application excluding pre-existing conditions is a procedure with which the applicant accepts on the application form that all medical conditions that exist or have existed before the start date of the insurance policy will be excluded. No claims arising from pre-existing conditions are consequently going to be reimbursed by the insurer.

4.5. Waiting period

An initial waiting period, which begins at the same time as the start date of the insurance policy, during which the insured cannot claim certain benefits as defined in the insurance contract.

4.6. Policyholder and beneficiary

1 The physical person or legal entity applying for and concluding the insurance contract on his own behalf or on behalf of another person and who as a result is liable to pay the premiums.

2 In the event the insurance is concluded on behalf of another person, the insured, excluding the policyholder, is considered the sole beneficiary of any insurance benefits and can claim them accordingly. Any commitments the policyholder may have made to a third party have no effect on the parties of this contract, even in such cases as these commitments have influenced its signing. Contractual exceptions specifically expressed are reserved.

4.7. Age limitations

1. Individuals can only apply and conclude an insurance contract after having reached the age of 18 years old.

2. Children under the age of 18 years old can only obtain coverage together with their parents or legal guardians as dependents.

3. Applications and conclusions are only accepted until the age of 69 years old.

4. After the age of 70 years old, the coverage from the health insurance plan is limited to emergency medical care. Long-term medical care is not included in the coverage.

4.8. Dependent

A dependent is a spouse or partner and/or unmarried children, (including any step, foster or adopted child) which is financially dependent on the policyholder. A dependent is considered as such up to the day before their 18th birthday or up to the day before their 24th birthday if enrolled in full time education. Every dependent must be named in the insurance contract and defined as a dependent.

4.9. Next of kin

A next of kin is a person who has a close relationship with the insured, whilst not necessarily being related.

4.10. Third party

A person who is not in any way related to the insured, nor a spouse or a flat mate, nor in a work relationship nor an organ of a relevant legal entity.

4.11. Home country and host country

1 Home Country: The country where the insured normally resides or used to reside and out of which he/she is expatriated to another country (as declared in the application form) and to which he/she intends to return to after the expatriation period. If the home country cannot be named according to this definition, it is the country of which the insured has the nationality and is holding a passport from.

2 Host Country: The country where the Insured is expatriated to, as declared in the application form.

5. Insurance contract

5.1. Key points

1 The insurance contract is a mutual agreement in writing, between the applicant and the insurer, covering all the key points of their relationship. The basis of this contract consists of the sum of declarations made by the policyholder, the insured person or a legal representative, and laid down in the policy or in further written agreements as well as the medical history.

2 The key points and criteria of the contract are the following:

a) The General Insurance Conditions must be taken into account and approved;

b) Completed application forms, including the general health/medical questionnaire and any other enclosed forms;

c) The insurer must explicitly accept the application for the contract to be concluded;

d) The insurer must have received the payment of the premium in its entirety - costs for the transfer of the fees are at the expense of the insurance taker/policyholder/insured;

3 The insurer can, for instance, because of certain elements in the medical history decline an application and consequently refuse the issuing of a policy. The insurer is not obliged to give any explanations.

5.2 Insurance policy

1 The document that confirms the existence of an insurance contract and records the rights and obligations of the involved parties.

2 Should the contents of the policy or its annexes not be in accordance with what has been agreed on previously by the relevant parties, the policyholder can insist on amendments within four weeks after reception of the policy. Once the delay of four weeks has passed, the terms of the insurance policy are considered as approved by the policyholder and are valid and effective.

5.3. Insurance certificate

1 An insurance certificate is a statement provided by the insurer to the insured, by request so that the insured can approach third parties (embassies, etc.) in view of completing any administrative procedures necessary such as receiving an authorization to stay in a geographical area for a limited time or for school attendance.

2 With this document, the insurer confirms his willingness to enter into an agreement with the insured provided that all the key points of the contract are fulfilled, particularly only after the insurance premium has been paid.

3 An insurance certificate cannot replace an insurance contract. In case of reimbursement of the premium or cancellation of the contract the insurer has the right to inform the concerned authorities and other third party parties.

5.4. Benefits list

The benefits list outlines the insured sums and the coverage for the three levels of insurance plans available as listed below. The conversion rates of the different currencies (USD, EUR & CHF) will be done 1 to 1. Meaning, that for example if the overall insurance sum is indicated in USD all the amounts stated in the list of benefits as well as the respective premium will be in USD. The maximum annual plan benefits mentioned in the benefits list under each specific plan is the total amount guaranteed for the entire year the insurance policy is valid.

Standard | Comfort | Premium

The benefits list is an integral part of the GIC's, and thus also of the insurance contract.

5.5. Membership card

The insurance membership card provides the name of the insured, the start date of the insurance plan, the plan name, the policy number and instructions with telephone numbers for the 24/7 alarm center.

The insurance membership card is not a medical card that allows the customer to access a specific medical network and/or their direct billing services nor does it provide any guarantee of payment to any medical providers (hospitals, general practitioners, specialists, pharmacies etc.)

5.6. Contract modification by the insured

Changes in the insurance contract by the insured will require a new application that will have to be sent to the insurer for a new risk evaluation.

5.7. Change of name/address

Any changes of name or address (es) of the policyholder and insured have to be notified in writing within 30 days to the insurer. In the meantime the last known (contact) address will remain valid.

5.8. Transition from a group insurance to an individual insurance

The insured wishing to leave a collective insurance or having to leave it due to cancellation by the policyholder can enter an individual contract provided the insured remains within the same territory as contractually agreed upon in the group insurance policy.

The insured must make this request in writing within 30 days before the end of the group insurance policy. The insured will be transferred under similar conditions as previously with the group insurance.

Any claims that may have occurred during the period with the group insurance will be taken into account for the individual insurance. Any pre-existing exclusions or addendums will also remain and be transferred.

5.9. Right of withdrawal

The policyholder/insured shall have a period of fourteen (14) calendar days to withdraw from the contract without penalty and without giving any reason. The period of withdrawal shall begin either from the day of the conclusion of the online contract or from the day on which the consumer receives the contractual terms and conditions if that is later. The policyholder/insured will be entitled to the return of the full premium paid, on the condition that not one claim has been submitted yet.

For compliance with this deadline it is sufficient for the policyholder/insured to send his/her notice of withdrawal by post, e-mail or fax to the Swisscare Customer Care Unit.

6. Beginning, end, duration and renewal

6.1. Start date of insurance coverage

1 The insurance coverage commences on the date and under the conditions defined in the insurance policy.

2 Addition of a newborn as a dependent is possible, provided that the insurance application is made within two (2) months following the date of birth. Automatic affiliation is only possible if at the time of the application there be no indication of congenital defects or diseases.

In case the declaration of a newborn has not been made within two (2) month, a medical questionnaire has to be completed and sent to the medical consultant of the Claims Department. The medical consultant can propose an additional premium to waive exclusions.

Premiums for the newborn baby are due as from the first (1st) day of enrolment.

3 The same is applicable in a case of child adoption provided the child is still underage at the date of adoption. There may, however, be a request for an additional premium under consideration of a risk increase accompanying an adoption.

6.2. Duration of insurance coverage

1 The duration of coverage is stated in the insurance policy, the minimum duration is 1 year.

2 The insurance year begins on the effective date of the insurance, as indicated on the insurance policy and ends one year later.

6.3 Insurance renewal

As long as no party wishes to terminate the contract, it will be automatically renewed from year to year (tacit renewal). The contract commences at 0h00 on the day following the date given on the contract and will end 12 months thereafter.

6.4. End of insurance coverage

1 The coverage expires on the same day that the insurance policy expires. It also expires for additional new claims, which would be made with respect to an incident already declared within the period of coverage.

2 In the event the insured has to remain at his place of destination because of a medical emergency a month after termination of the period of coverage, this coverage may be prolonged by written request of the insured until he/she can safely return to the host country without endangering his/her life. The insurer will, however, request a medical report from an independent certified medical practitioner mandated by the insurer. In any case, the prolongation may not exceed a period of another two months and an additional premium will have to be paid.

3 For the Insured, the insurance under this policy shall automatically terminate:

- if any premium on this policy is not paid on the due date or within the grace period;
- if the insured is a dependent child, on the thirty-first (31st) of December of the year during which the dependent child becomes twenty-four (24) years old or when he/she is no longer considered to be a dependent child or upon the date of marriage;
- if the dependent is the spouse or legal partner, upon the date of divorce or legal separation from the insured, or as from the end of the legal partnership;
- if it becomes unlawful for the insurer to provide any of the coverage available under this policy;
- if the insurer has been provided with misleading information or if information has been withheld that should have been provided and could have affected the Insurer's assessment of the risks to be insured under this policy;
- upon the death of the insured.

6.5. Change of geographical scope, level of coverage or deductible

For individual policies
If the host country of the insured is the USA, it is compulsory for the insured to choose worldwide coverage including the USA.

If the insured's host country becomes the USA, the insured must notify the insurer immediately upon finding out about the change of host country, so that the policy can be changed to include the USA.

Should the insured's home country be the USA, coverage including the USA is not possible and voluntary treatment can not be covered. .

Should the insured wish to change the level of coverage, in every case a new medical questionnaire will have to be completed and signed.
Waiting periods will apply to the new level of coverage beginning on the effective start date of the new level of coverage.

Should the insured wish to change the deductible, the new deductible will be valid for any claims arising from the effective start date of the new insurance contract, regardless of the deductible that has been paid up to that date. The entire deductible amount will be applicable to the new insurance contract.

Any change of coverage or deductible hast to be requested in writing at least one (1) month before the policy renewal date. Please submit this request by email, fax or post to the Swisscare Customer Care Unit.

7. Obligations of the insured

7.1 Non-disclosure

1 If the person submitting the insurance application has, in the process of concluding an insurance policy, omitted or stated imprecise information about relevant facts known to the insured or that the insured could have assumed would be relevant, the insurer has the right to terminate the insurance policy by written notification within four weeks of discovering the non-disclosure.

2 In such a case, coverage also ends with regard to incidents that have already taken place in the cases that the undisclosed information has influenced the occurrence or the scope of the incident.

7.2 Double insurance

1 If the same risk is covered for the same period of time by more than one insurer to the extent that the combined sums insured exceed the insurance value, the policyholder and/or the insured are obliged to inform all insurers by written notification immediately.

2 If the policyholder has intentionally omitted to notify the insurer of these facts or taken out a double insurance in view of obtaining an illicit profit, the insurer shall henceforth automatically be relieved of any contractual obligations.

7.3 Increase of risk / aggravation of risk

1 An increase of risk is of significance if it affects the risk evaluation that has been established during the drafting of the insurance contract. All factors that might influence the decision of the insurer to accept the policy or to accept it under the agreed conditions are important (especially important is the insured's state of health, illnesses can be considered a risk increase, or if he/she undertakes dangerous activities, etc.).

2 If the insured causes a significant increase of risk during the duration of the insurance, the insurer will cease to be bound by the insurance policy. The insured has the obligation to inform the alarm center immediately followed by a letter or an e-mail to the alarm center of the Claims Department.

3 If the increase of risk is not caused by the insured this will only lead to an automatic cancellation of the policy if the insured has neglected to notify the insurer as stated above. If the insured provides such a notification the insurer reserves the right to terminate the policy within the 14 days following the notification.

4 Obesity is an increase of risk and is diagnosed when a person has a Body Mass Index (BMI) of over 30. If significant weight gain leads to obesity during the insurance period it is considered to be a significant increase of risk.

5 Aggravation of the risk
Except for changes in the state of health of the insured incurred after acceptance into the insurance, the insured is obliged to inform the insurer of any change in circumstances or conditions that may increase the risk of illness or accidents (e.g. dangerous professional activity). The insurer may then propose new insurance conditions (within a period of one (1) month after having received notification of the aggravation of the risk) or cancel the insurance coverage, within one (1) month, retroactively as from the moment of the start of the aggravation of the risk.

7.4. Immediate notice/communication of a claim

In case of any imminent or declared incident all insured have the obligation to contact the alarm center immediately in order to notify the insurer. Should verification of a claim no longer be possible due to the failure of the insured to notify the Alarm center in a timely way, and due to this late notification a claim can no longer be identified or verified, the Insurer will not indemnify the claim that can not be identified or verified.

1 In case of a claim, it is imperative to contact the 24/7 alarm center number as soon as possible after the incident has occurred.

Tel : +41 22 929 52 52
Fax: +41 22 929 52 55

2 If the insured is entirely unable to notify the insurer immediately and it can be proven that a personal or indirect contact with the alarm center prior to consulting a certified medical practitioner at the moment of the event was impossible because of the patient's life threatening situation, a reasonably speedy notification by the insured, the policyholder, the police, the hospital or any party to the incident, will be considered a valid notification.

All inpatient treatment (except emergency hospital admissions), are subject to pre-certification. This means that in case of non-emergency hospitalization (planned) for which the diagnosis of the medical condition has been established more than five (5) days before actual admission into a hospital the Claims Department has to be informed - by postal mail, fax or email - at the latest five (5) days before the hospitalization will take place - in the case of childbirth five (5) days before the planned due date.

The following information is required:

- diagnosis;
- description of the required treatment;
- name and address of the facility where the inpatient treatment and stay will take place;
- expected length of stay;
- estimated costs ;

In case of an emergency hospitalization, the Claims Department has to be informed as soon as possible (normally within forty- eight (48) hours) and at the latest before discharge from the hospital. In case of failure to comply with the pre-certification requirement, a penalty of twenty-five (25)% will be applied by the Insurer, meaning that the reimbursement of the eligible expenses will be reduced to seventy-five (75)% of the amount the Insured would normally be entitled to if he/she had duly fulfilled the said requirements.

3 Especially in cases of dental prosthesis or maxillofacial reconstruction, the insured must, prior to starting the treatment, present the insurer with a detailed description as well as a cost estimate of the dentist or certified medical practitioner. These documents will be given to the medical service of the insurance for the purpose of examination and acceptance.

4 In the event of a prescribed psychotherapy it is **mandatory** that acceptance has to be granted by the insurer prior to the treatment.

7.5. Calculation of deadlines and terms

1 The fixed delay set in days does not take into account the first day on which it starts to run.

2 The fixed delay set in months and years always ends on midnight of the last day that corresponds, by its

number.

7.6. Obligation to minimize claims

The insured is obliged to take all reasonable steps to avoid or minimize any claims.

7.7. Consequences of the violation of the obligations

1 Besides the consequences of disregarding articles already mentioned above, upon infringement of the contractual obligations the following consequence can be applied to the insured:

a) Should the disregard of the obligations happen with the intention of defraud, the contract with the insured will automatically be null and void. The insurer will no longer be bound to provide services and benefits and can ask for a refund of the indemnification already received by the insured. The insurer will not refund any premiums paid by the insured.

b) Should a disregard of the obligations happen willfully or out of culpable negligence, the insurer is no longer bound to the contract and therefore no longer obliged to offer coverage if the notification has been made to the insured within 4 weeks from the moment of becoming aware of the violation.

c) In the event of other violations or any disregard to the insured's obligations, the insurer has the right to reduce coverage proportionally to arising damages.

2 The policyholder and/or the insured are solely responsible for the execution of the contractual obligations.

8. General provisions concerning coverage

8.1. Recognition of medical service providers

Only invoices issued by qualified medical service providers, possessing recognized and valid diplomas of the country in which the insured is being treated and where they are authorized to practice will be taken into consideration.

8.2. Extent of expenses covered in general

1 The services provided in the context of the insurance conditions should be effective, appropriate and economical. Effectiveness, adequacy and cost effectiveness have to be scientifically proven. If this is not the case the insurer reserves the right to reasonably reduce the benefits accordingly.

In- and outpatient treatment must be received in the appropriate medical facility, and **experimental treatment is excluded**.

2 Medical expenses must be reasonable and customary. This means that the expenses must correspond to the expenses usually incurred by a similar service or supply and do not exceed the normal charges incurred under the best prevailing conditions for such a service or supply in the locality where the service or supply is received. If usual and prevailing expenses charged can not be determined due to the unusual nature of the service or supply, the insurer will determine to what extent the charge is reasonable, taking into account:

- The complexity involved
- The degree of professional skill required
- All other relevant factors

3 The usual tariffs in the territory of the treatment define the amount and the duration of the insurance benefits.

4 If no special conditions have been negotiated such as the compulsory consultation of a predefined medical network, the insured can be treated by a certified medical practitioner of choice. Should a recognized medical service provider be established in another area than the insured and the travel to and from the medical office (kilometric or travel indemnity) is invoiced, the insurer is entitled to indemnify the travel costs that would have incurred if the nearest possible certified medical practitioner had been chosen.

8.3. Extent of coverage for medical expenses

1 Necessary and reasonable medical care or treatment due to an involuntary illness or injury is covered.

2 The coverage comes into effect when the medical treatment commences and coverage ends as soon as the medical results indicate that further treatment is no longer necessary.

3 Should the treatment be extended to an illness or the consequences of an accident without causal connection to the original incident any claims arising out of those treatments will be treated as caused by a new incident.

8.4. Partial benefits

If the insured does not benefit at all or only partially from the insurance policy, the insurer cannot be obliged to refund the benefits covered in kind. If the costs entailed by an occurrence are less than those set out in the insurance policy, the insured is not entitled to claim the difference.

8.5. Deductible

1 A deductible is an amount stated in the insurance policy, which is at the expense of the insured, before the insurer covers the remaining costs.

2 A copayment means that a certain percentage of the coverage will be at the expense of the insured.

The benefits list states how much is covered by the insurer. The part that is not covered is at the expense of the insured.

8.6. Maximum sum insured per year

A maximum sum insured per year is the maximum amount that is covered during a contract year.

The maximum sum insured per year is used for a global plan limitation and / or for benefits coverage limitation. The benefits list states the different maximum sums insured.

8.7. Total sum insured and lifetime maximum sum insured

Payment of benefits is subject to the annual total sum insured per beneficiary or insured. The annual total sum insured includes all maximum sums insured as specified in the insurance contract including any additional written agreement part thereof.

Benefits can be subjected to a lifetime maximum, meaning that the total sum insured is once during the entire lifetime of the beneficiary or the insured.

8.8. Subsidiarity

Coverage is subsidiary to any benefits that are provided by the compulsory social insurances, other insurance branches (e.g. accident insurance, health insurance of the home country), service agreements or associations to which the insured is a party or pays a contribution, whenever the latter do not offer the insured person sufficient protection.

9. Claims

The unintentional event that occurs within the period of coverage and under the conditions specified in the insurance contract and which causes the insurer to fulfill the obligation to provide benefits to the insured within the legal and contractual constraints.

The insurer shall effect reimbursement of the covered reasonable and customary medical expenses (up to the limits defined in these GIC's) following the receipt of the claim form and the relevant and complete written evidence of the medical expenses.

Reimbursements shall be made to the insured, but if the insured has deceased, payment shall be made at the sole discretion of the insurer, or to any person submitting satisfactory evidence that he/she is entitled to such payment. Benefits may be directly assigned to hospitals.

9.1 How to submit a claim

1 The insurer will only consider reimbursement or payment if all requested documents concerning the incident have been submitted. Each claim has to be submitted to the Claims Department, in writing - using the special claim forms made available by the Claims Department - as soon as possible after the event giving rise to the claim has occurred.

2 The submitted documents, invoices, expenditures, medical reports, prescriptions lab results etc. can be scanned and sent by email, fax, postal mail or brought by personally. The insurer has the right to request the original ones if necessary. The insurer has the right to ask for evidence that the bills the reimbursement of which is being requested have already been paid. In the event of another insurance company participating in the reimbursement of the expenditures, copies of the invoices will suffice, provided a receipt issued by the other insurance company is submitted.

3 All invoices and honorary notes have to include the name and address of the treating certified medical practitioner, the insured, the date of treatment, details of the different medical services as well as the diagnosis (name of the affliction, DRG number, ICD 10 code etc.). The prescriptions have to be sent to the insurer and have to be accompanied by the honorary fees of the certified medical practitioner, bills for medication, equipment etc.

4 The submission of a medical center's document certifying the inpatient care in a hospital together with admission and discharge always stating the treated affliction is compulsory.

5 All bills and honorary fees have to be submitted to the insurer immediately upon receipt.

6 Inpatient cash benefits are payable when treatment and accommodation for a medical condition, that would otherwise be covered under the insured's plan, is provided in a hospital where no charges are billed. Coverage is limited to the amount specified in the table of benefits and is payable upon discharge from the hospital.

7 The insurer has the right to reimburse the authorized bearer or sender of the correct and complete documents.

8 Costs of treatments in a foreign currency will be converted at day's value (date of receipt) in USD, EUR or CHF depending on the currency of the insurance policy.

9 Expenses such as inherent costs of transmissions and translations will be deducted from the benefits.

10 Money transfer fees or taxes are not covered by the insurer.

9.2. Documentation

1 Any documents have to be submitted to the Insurer or Swisscare as soon as possible, however at the latest 365 days after the **occurrence of the incident**, proven by postal stamp or official certification, the insured must spontaneously and at his/her own expense, provide the insurer with the requested documents listed below. Beyond the delay of one (1) year, no claim shall qualify for reimbursement and consequently the insured forfeits the right for reimbursement.

a) In case of an accident the insured must provide an accident report and/or statements drawn up by the police authorities, fire department or any other emergency service as well as:

- date and detailed description of circumstances and place of the accident;
- identity of persons involved, as well as of witnesses and persons possibly liable;
- official report from local authorities (police or other).

b) The complete medical report written by the certified medical practitioner consulted or provided by the hospital the insured was admitted to or treated in, in relation with the claim;

c) Medication and other prescriptions for the apothecary, or pharmacy;

d) Invoices for the medical treatments undergone by the insured, any stay in a hospital and purchases of medication;

2 Furthermore, the insured and the policyholder have to provide the insurer with any other information and proof relating to the incident, which might help to clarify the circumstances of the incident/claim and allow an estimate of the extent of its consequences, provided they ought to know of this information.

3 In view of clarifying the circumstances of the announced incident, and in order to estimate the extent of its consequences and verify its veracity the insurer reserves the right to request, from the insured and at the latter's expense, supplementary information, facts and proof. If the insurer formulates this request in writing a delay of at least ten days can be granted (formal notice) in order to receive these documents. If the insured lets the time elapse, all rights to the claim will have been forfeited.

4 On the insurer's request, the insured has to undergo a medical check-up done by a certified medical practitioner appointed and paid for by the insurer.

9.3. Non transferability of claims

Claims of the insured arising or likely to arise from the insurance policy can neither be transferred nor held as a deposit. Especially rights to benefits stemming from the insurance policy cannot be transferred to a next of kin, a hospital, debt collecting agency, a company, an insurance taker, a work colleague or an authority, etc.

9.4. Subrogation

1 The Insurer has full rights of subrogation for any benefits paid within the framework of this insurance policy. The rights and claims of any natural person or legal entity that benefits in whole or in part from the coverage provided in the insurance policy as stated in the conditions of insurance against the third party responsible for the event shall pass to the insurer up to the level of compensation and costs paid by the insurer in view of fulfilling this insurance contract.

2 Should the insured have a right to compensation by a third party and notwithstanding the contractual subrogation, this right has to be passed on in written form to the insurer up to the level of the amount of the benefits the insured is likely to receive from the third party. Thus, this right will pass to the insurer. If the insured waives the right to compensation or its relative security, without prior agreement of the insurer, the latter will be released from all obligations up to the sum the insured would have received or could have been entitled to by the third party.

Therefore, when asked to confirm this right to the Insurer in order to assist the Insurer in recovering from a third party any amount paid or which will be paid by the Insurer to the Insured or expenses made on behalf of the Insured, the Insured shall be obliged to provide this confirmation in writing to the Insurer.

3 Any defense inherent in the insurance contract, which the Insurer may raise against the Policyholder may also be raised against the Insured, whoever he/she may be.

9.5. Coordination of benefits - other insurances

If the insured is entitled to a reimbursement by another insurer or social security system, the coverage will be applied on the difference between the eligible medical expenses and the reimbursement made by the other insurer. However, in case Swisscare Expatline is offered as a supplementary insurance, the amount reimbursed by the other insurance will be deducted from the amount of reimbursement. In any case, the insured has to attach copies of the pertaining medical bills and the settlement notes (with details of the amount reimbursed) provided by the other insurer or the social security system concerned. Total reimbursement for any given claim will never exceed the total amount of expenses actually incurred by the insured.

10. Core plan and additional options, definitions and coverage

The insurance policy Core plan includes inpatient treatments and assistance benefits. The additional options can only be chosen together with the core plan, they are not individual independent insurance products that can be taken out on their own.

The three additional options available are:

- Outpatient coverage
- Maternity coverage
- Dental treatment coverage

The core plan and the selected options are stated in the insurance contract.

10.1. Definitions that are applicable to all plans and levels of coverage

10.1.1. Medical necessity

Medical necessity refers to those medical services or supplies that are determined to be medically necessary and appropriate. They must be:

Essential to identifying or treating a patient's condition, illness or injury.

Consistent with the patient's symptoms, diagnosis or treatments of the underlying condition.

Consistent with the diagnosis and customary medical treatment for a covered illness or injury

In accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time.

Required for reasons other than the comfort or convenience of the patient or his/her physician.

Proven and demonstrated to have medical value.

Considered to be the most appropriate type and level of service.

Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of a patient's medical condition.

Provided only for an appropriate duration of time.

The charges are fair and reasonable for the treatment.

The treatment may not be of experimental, investigational or research nature.

As used in this definition, the term "appropriate" shall mean taking patient safety and cost effectiveness into consideration. When specifically applied to inpatient treatment, medical necessity also means that a diagnosis cannot be made, or treatment cannot be safely and effectively provided on an outpatient basis.

10.1.2. Accident

An accident is an injury which is the result of an unexpected event, independent of the will of the insured and which arises from a cause outside of the insured's control. The cause and symptoms must be medically and objectively definable, allowing for a diagnosis and require therapy.

10.1.3. Sudden illness

Any unintended negative change in health that requires professional examination, treatment or medical care and which is not due to an accident or a pre-existing condition.

10.1.4. Emergency

An emergency constitutes the onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment occurring within 24 hours of the emergency event will be covered. Once the emergency condition is stabilized, the claim department of the insurer will coordinate the post stabilization care as foreseen in the GIC's.

If the insured reaches the age of 70 years old coverage is limited to emergency treatment until the insured is stabilized. The post stabilization care is not covered. That includes hospitalization fees, all medical treatments, drugs, medicine and all costs that occur after the insured is stabilized. A relapse for the same illness or injury is not covered.

10.1.5. Chronic condition

A chronic condition is defined as a sickness, illness, disease or injury, which has one or more of the following characteristics:

- Is recurrent
- Is without a known, generally recognized cure
- Is not generally deemed to respond well to treatment
- Requires palliative treatment
- Requires prolonged supervision or monitoring
- Leads to permanent disability

Chronic conditions are only covered if accepted in the process of full medical underwriting of the insurance policy, or if it is not a pre-existing condition and all chronic conditions are subjected to the limitations of the insurance contract.

10.1.6. Acute medical condition

A medical condition that is likely to respond quickly to treatment which aims to return the insured to the state of health he/she was in immediately before suffering from the disease, illness or injury, or which leads to full recovery.

10.1.7. Consult

A consult is any consultation or discussion with a certified medical practitioner or specialist, including check-ups and the issue of any prescriptions.

10.1.8. Certified medical practitioner

1 A medical practitioner who holds primary degrees in medicine or surgery as recognized by the World Health Organization and who is legally licensed to practice in the country where treatment is provided.

2 Certified medical practitioner fees refer to non-surgical treatment performed or administered by a certified medical practitioner.

10.1.9. Specialist

A certified medical practitioner qualified to consult in a specialty at a National Health Service hospital or is appointed by an institution we recognize as having equivalent professional status, or is recognized as such by the relevant officials of the country in which the treatment is being given.

10.1.10. Anesthetist

An anesthetist is a certified medical practitioner or a technician trained to administer anesthetics.

10.1.11. Medication

Drugs, medicine and corrective devices (including prosthesis when used as an integral part of a surgical procedure) prescribed by a certified medical practitioner or specialist.

10.1.12. Outpatient treatment

1 Outpatient treatment refers to treatment provided in the practice or surgery of a certified medical practitioner, therapist or specialist that does not require the patient to be admitted to a hospital.

2 Outpatient surgery is a surgical procedure performed in a surgery, hospital, day-care facility or outpatient department that does not require the patient to stay overnight out of medical necessity.

10.1.13. Day-care

Day-care treatments are planned treatments received in a hospital or day-care facility during the day, including a hospital room and nursing that does not medically require the patient to stay overnight.

10.1.14. Emergency outpatient treatment

Emergency outpatient treatment is treatment received in a casualty ward/emergency room following an accident or sudden illness, where the insured does not, out of medical necessity, occupy a hospital bed. The treatment must be received within 24 hours of the emergency event.

10.1.15. Palliative care

1 Palliative care refers to inpatient, day-care or outpatient treatment, following the diagnosis that the condition is terminal and treatment can no longer be expected to cure the condition.

2 Treatment given to an insured for the primary purpose of temporary relief of symptoms, as curing the medical condition is no longer an option.

10.1.16. Pathology

Tests carried out to help determine or assess the nature of disease and the changes in structure and functions brought about by disease.

10.1.17. Psychiatric illness

1 Treatment of a mental disorder carried out by a clinical psychologist. The disorder must be associated with present distress, or substantial impairment of the individual's ability to function in a major life activity (eg. employment).

2 The aforementioned condition must be clinically significant and not merely an expected response to a particular event such as bereavement, relationship or academic problems and acculturation.

3 The disorder must meet the criteria for classification under an international classification system such as Diagnostic and Statistical Manual (DSM-IV) or the International Classification of Diseases (ICD-10).

10.1.18. Treatment

1 Any medically necessary surgical procedure or medical intervention required to cure or provide relief of an acute medical condition.

2 Complementary treatment means therapeutic and diagnostic treatments that exist outside the institutions where conventional western medicine is taught. Such medicine includes chiropractic treatment, osteopathy, homeopathy and acupuncture as practiced by approved therapists.

3 Oncology treatment refers to specialist fees, diagnostic tests, radiotherapy, chemotherapy and hospital charges incurred in relation to the planning and carrying out of treatment for cancer, from the point of diagnosis on.

4 Long-term care refers to care over an extended period of time after the acute or emergency treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long-term care can be provided at home, in the community, in a hospital or in a nursing home

10.1.19. Infertility treatment

Infertility treatment refers to treatment for both sexes including all invasive investigative procedures necessary to establish the cause for infertility such as hysterosalpingogram, laparoscopy or hysteroscopy.

10.1.20. Rehabilitation

Rehabilitation is treatment aimed at the restoration of a normal form and/or function after an acute illness or injury. Rehabilitation is only covered if the treatment begins immediately after the acute medical treatment ceases.

10.1.21. Hospitalization or inpatient treatment

1 Admission to a hospital establishment for medical intervention for a period of at least 24 hours.

2 Hospital accommodation refers to general ward, semi-private room or private room.

Deluxe, executive rooms and suites are not covered. Accommodation includes charges for services, such as general nursing care, that occur in connection with the hospital stay.

3 Hospital also includes clinics and medical units that are managed by certified medical practitioners and medical staff who treat ill or injured patients.

4 Not included are wellness hotels and thermal baths, establishments for elderly and chronically ill individuals as well as socio-medical and similar establishments that are not suited for the treatment of acute illness.

10.1.22. Stabilization center

The place where the insured is taken to following an incident in order to prepare for transfer or repatriation.

10.1.23 War and Terrorism

1 War

- armed conflict, declared or undeclared, between one State and another, an invasion or a state of siege.
- also considered as acts of war are: all similar actions, the use of military force by a sovereign nation to achieve certain economic, geographic, nationalistic, political, racial, religious or other ends.
- civil war: armed conflict between two (2) or several parties belonging to one and the same state, the members of which are of different ethnic origin, religion or ideology.
- also considered as acts of civil War are: an armed rebellion, revolution, sedition, insurrection, a coup d'état, the consequences of martial law and border closings ordered by government or by local authorities.

2 Terrorism

- any actual or threatened use of force or violence directed at or causing damage, injury, harm or disruption;
- commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not;
- robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorists acts.

Terrorism shall include any act that is verified or recognized by the (relevant) government as an act of terrorism.

3 Description of benefits

With respect to the risks and consequences of War and Terrorism, all consequences of active participation of the insured (and/or his/her covered dependents) in operations of war and terrorism are explicitly excluded from all coverage. In case the insured is victim of acts of war and terrorism without any active involvement on behalf of the insured or his/her beneficiaries in these acts, the insured is covered within the limits and the ceilings of the cover. The optional insurance covers (accidental death and disability) are not valid when the insured (or covered dependent) is travelling to or from or is residing in a country or a part of a country publicly known to be in state of war or civil war at the time damages (bodily injury, or death) to the insured or his/her covered dependents happen. In the event the insured, whilst abroad, is faced with the sudden, unanticipated occurrence of a new (outbreak of) war or warlike situations and acts, the insurance coverage remains valid for fourteen (14) days starting from the beginning of the hostilities.

11 Core plan health and accident coverage

11.1. Object of this coverage

1 The insurer provides coverage according to the scope of the insurance contract.

During the insured's stay inside the contractually defined territory according to scope of the insurance contract, illnesses and accidents are covered.

11.2. Hospital admission

1 The following costs for inpatient care in a hospital and in the contractual territory, are covered:

a) Inpatient treatment in a public or private medical establishment;

b) Admission to a hospital or surgical establishment;

c) Medical costs arising during the hospital stay as an inpatient;

d) Intensive care in a public or private medical establishment

e) Accommodation, operating theatre & recovery room in a public or private medical establishment.

2 If no special conditions have been negotiated such as the compulsory consultation of a predefined medical network, the insured may chose between the public or private clinics, which are permanently staffed with qualified medical personnel, who can make a diagnosis and who have the necessary diagnostic and therapeutic means at their disposal and work with scientifically recognized methods.

3 Reimbursement of costs depends on the coverage and what has been agreed on in writing when the insured informed the insurer about the intention of inpatient treatment.

4 The insurer provides coverage for services for medical examinations, healing methods and medication generally accepted by conventional medicine. Coverage will also be provided for methods and medication that have proven to be effective in practice when conventional methods or conventional medication do not exist or cannot be applied. The insurer can, however, reduce coverage by adapting the coverage to the amount that would have had to be paid if conventional methods and medication were applied.

5 Accommodation costs for one parent staying in a hospital with an insured child refers to the hospital accommodation costs of one parent for the duration of the insured child's admission to hospital for eligible treatment. If a suitable bed is not available in the hospital, the insurer will contribute the equivalent of a three star hotel daily room rate towards any hotel costs incurred. The insurer will not, however, cover sundry expenses including, but not limited to meals, telephone calls or newspapers.

6 The insurer will pay up to the policy limits in the benefits list for charges incurred in a hospice facility, hospital or convalescent facility for accommodation and other services and supplies given to an the insured while a full-time inpatient for pain control and other acute and chronic symptom management when given as a part of a hospice care program. The hospice care program must be approved by the insurer in advance and must provide a centrally administered program of palliative and support services to terminally ill insured and their families. Terminally ill means the patient has a prognosis of eight months or less. A medically supervised interdisciplinary team of professionals and volunteers will provide these services.

7. If it is considered a legal abortion according to the Criminal Code of the country in question and if the abortion is medically necessary because of imminent danger to body and soul (profound distress) of the pregnant mother, the insurer will pay for the abortion and it will be considered an illness.

11.3. Psychotherapy and similar treatments when necessary during a hospitalization

1 The insurer will only reimburse the costs for inpatient psychotherapy if approval has been given in advance in writing after have received an assessment by the insurers own expert. With the Core plan, only treatment that is directly in connection with inpatient treatment is covered.

2 Psychiatry and psychotherapy refer to treatment of mental or nervous disorders, carried out by a psychiatrist or clinical psychologist. The disorder must be associated with present distress or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The aforementioned condition must be clinically significant and not triggered by a particular event such as bereavement, relationship or academic problems or acculturation.

The disorder must meet the criteria for classification under an international classification system such as the Diagnostic and Statistical Manual (DSM-IV) or the current International Classification of Diseases (ICD).

Psychotherapy is covered according to the insurance policy, insurance contract provided the treatment is prescribed and performed by a certified medical practitioner.

11.4. Laboratory and x-ray expenses

With the Core plan, only treatment that is directly in connection with inpatient treatment is covered.

1 Diagnostic tests are investigations such as x-rays or blood tests, undertaken in order to determine the cause of the presented symptoms.

2 The costs for lab examinations, x-rays, scanner and MRI's, if prescribed by a certified medical practitioner for valid reasons are covered.

11.5. Inpatient treatment for mental illness

1 The costs for psychiatric inpatient care are covered according the amount stated in the benefits list.

2 Allowable charges in respect of psychotherapeutic treatment and psychiatric counseling and treatment for approved psychiatric diagnosis are covered. The relevant annual limits will be applied to each insured for inpatient mental health treatment in a hospital or approved facility.

3 A physician or a licensed clinical psychologist must provide all mental health care services. Services of a clinical psychologist must be rendered in the provider's office or in the outpatient department of a hospital. The disorder must meet the criteria for classification under an international classification system such as the Diagnostic and Statistical Manual (DSM-IV) or the current International Classification of Diseases (ICD).

11.6. Organ transplant

1 The inevitable transplant of an organ is covered. However, the costs related to finding matching donor organs (organ bank) are not included in this coverage.

2 An organ transplant is the surgical procedure concerning the following organ and/or tissue transplants: heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, muscular/skeletal and cornea transplants.

3 Expenses incurred for the acquisition of organs are not covered.

11.7. Medication

1 Medication approved of by the state's authorities is covered according to the benefits list. Homeopathic treatments are also covered. Under the Core plan, only treatment that is directly in connection with inpatient treatment is covered.

2 Medication, wound dressings and medical equipment have to be prescribed by a certified medical practitioner or another agreed specialist. Certified medical practitioners who are next of kin of the insured or the policyholder will not be taken into consideration.

3 The prescribed medication has to be bought at the chemist's and not at a drugstore since the latter are not subject to the same severe controls. The purchase of more than one package of the same medication has to be written on the certified medical practitioners prescription.

4 Products such as pure alcohol for medical use, cotton, sun protection, products for dental care, shampoo, food for special diets, mineral water, special sorts of wine, fresh or dried glands, contraceptives, cosmetics, sanitary products, anti-alopecia, insect repellent spray, etc. are non medical substances and therefore not covered.

11.8. Nursing at home

1 Nursing at home or in a convalescent home refers to nursing received immediately after or instead of eligible inpatient or day-care treatment. The insurer will only pay the benefit where the treating certified medical practitioner decides (and the insurer agrees) that it is medically necessary for the member to stay in a convalescent home or have a nurse in attendance at home. Coverage is not provided for spas, cure centers and health resorts or in relation to palliative care or long term care.

2 Following a stay in a hospital or in replacement of an inpatient treatment in a hospital, a daily amount will be covered for each contractual year.

11.9. Physiotherapy and medical gymnastics

With the Core plan, only treatment that is directly in connection with inpatient treatment is covered.

1 Prescribed physiotherapy refers to treatment by a registered physiotherapist following referral by a certified medical practitioner. Physiotherapy is initially restricted to 6 sessions per condition, after which the referring medical practitioner must review the treatment.

Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as rolfing, massage, pilates, fango and milta therapy.

2 A daily amount fixed by the insurer will be granted following a hospitalization.

11.10. Vaccinations

1 Vaccinations refer to all basic immunizations and booster injections required under regulation of the country in which treatment is being given, any medically necessary travel vaccinations and malaria prophylaxis. The vaccine and its administration are both covered.

2 A maximum sum insured for vaccinations on prescription will be granted to the insured party for every insurance period.

11.11. STDs Screening (Sexually Transmitted Diseases)

Subject to the limitations of the insurance contract STD screening is covered. HIV tests are excluded.

11.12. Preventive care

1 Preventive care refers to treatment that is undertaken without any clinical symptoms being present at the time of treatment. Children are only covered if they have their own insurance policy.

2 The costs for the preventive treatment mentioned below are covered:

General tests;

- Ultrasound for Abdominal Aortic Aneurysm check up once a year if presenting a high risk
- Cholesterol blood test once every five years after the age of 35 years.
- Colonoscopy once every five years without medical indication after the age of 50 years.
- Yearly skin exam by a dermatologist
- Eye exams are only covered once a year if done by an ophthalmologist. Exams done by an optician are not covered. Tests in connection with obtaining or renewing a driver's license or any other kind of license or permit are not covered.
- Diabetes screening once every three years after the age of 44 years.

Yearly physical exam;

- Blood pressure
- Heart rate
- Respiration rate
- Temperature
- Heart and lung exam with a stethoscope
- Blood count
- Chemistry panel

MRI's, X-Rays or other specialized analysis, laboratory tests etc. are only covered if medically indicated and thus are not part of the preventive care coverage.

Immunizations;

- HPV, Tetanus booster shots and other medically necessary vaccines and immunizations including the flu vaccine are covered**.**

Preventive gynecological tests;

Screening of STDs (excluding HIV) and the costs for preventive treatment are covered up to the maximum sum insured.
Preventive treatment:

- Check-ups;
- Preventive, gynecological tests;
- Annual pap smear.
- Mammogram (for women aged 50+, or earlier where a family history exists).

3 Routine health checks including screening for early detection of illness or disease are health checks, tests and examinations, performed at an appropriate age interval, that are undertaken without any clinical symptoms being present. Such tests include:

- Cardiovascular exam.
- Neurological exam.
- Prostate screening (for men aged 50+, or earlier
- Where a family history exists).

All preventive care that is not explicitly mentioned requires prior approval by the insurer.

11.13. Accepted medical aids/equipment

1 Prescribed medical aid refers to any instrument, apparatus or device which is medically prescribed as an aid to the function or capacity of the insured person, such as hearing aids, speaking aids (electronic larynx), crutches or wheelchairs, orthopedic supports/braces, artificial limbs, stoma supplies, graduated compression stockings as well as orthopedic arch-supports. Medical aids that form part of palliative care or long term care are not covered.

2 Prescribed aids such as glasses, spectacle frames of which the tariff is contractually fixed (every fourth year after the last acquired glasses), contact lenses, bandages and supporting bandages, support stockings, orthopedic insoles, support plasters, correcting tapes, orthopedic equipment to support the upper body, the arms, the legs, hearing aids, electronic larynx, artificial arms, legs or feet are covered according to the insurance policy.

3 Prescribed glasses and contact lenses refer to coverage for an eye examination carried out by an optometrist or ophthalmologist (one per insurance year is covered).

4 The costs for medical aids and equipment are covered according to the insurance contract.

5 The waiting period for coverage for visual aids is 6 months after the insurance policy comes into effect.

6 The maximum sum insured for glasses, frames and medically prescribed contact lenses is defined in the benefits list.

7 Costs for other prescribed medical aids and sanitary devices, such as any other equipment, orthopedic shoes, appliance for massage, inhalators, infrared and blue-light lamps for therapy as well as heating pads, their installation, use and maintenance, are covered according to the insurance contract.

8 Surgical appliances and prostheses refer to artificial body parts or devices, which are an integral part of a surgical procedure or part of any medically necessary treatment following surgery.

11.14. Costs for medical transportation / voluntary treatment abroad

1 Medical transportation means that if the emergency treatment for which the insured is covered is not available locally, the insured may be transported to the closest appropriate facility. Only the reasonable and customary costs of treatment and transport that have to be pre-approved by the insurer are covered. Should it not be a

medical emergency, the travel to and from the medical facility is not covered. In every case pre-approval from the insurer is mandatory.

If the necessary medical treatment for which you are covered is available locally, but you choose to travel to another country within your geographical area of coverage for treatment, we will reimburse all eligible (meaning reasonable and customary) medical costs incurred within the terms of your policy, however travel expenses are not covered. In any case coverage in such situations is subjected to mandatory pre-approval of the insurer.

2 The insurer covers the costs per contractual year for urgent medically indicated transportation so as to provide the insured with appropriate treatment at the nearest possible hospital or an approved medical service.

3 Medical transportation related costs will only be reimbursed if the insured's state of health does not allow for use public or private transportation.

4 Costs related to transportation per contractual year are not covered, in the event of:

a) An illness or accident intentionally provoked by the insured, self-mutilation or attempted suicide;

b) Addiction or alcoholism;

c) Ethylic state, open drunkenness or if proven that the insured party while being involved in an accident had alcohol in his blood of more than 0,8 g/lt.

5 The insurer covers the transportation costs, the insurer's coverage is subsidiary to any other provider and contractual as well as insurance policy limitations apply.

11.15. Convalescent and rehabilitation expenses

1 Costs incurred by a stay at a convalescent facility with the following services and supplies are covered if the insured is recovering from illness or injury.

Rehabilitation is treatment aimed at the restoration of a normal form and/or function after an acute illness or injury. Rehabilitation is only covered if the treatment begins immediately after the acute medical treatment ceases.

2 Coverage for accommodation includes service charges, such as general nursing care, made in connection with room occupancy. Benefits will be covered according to the benefits list.

3 Charges incurred in a hospice facility, hospital or convalescent facility for accommodation and other services and supplies are covered while the insured is a full time inpatient for pain control and other acute and chronic symptom management when given as a part of a hospice care program. Hospice care program to provide an administered program of palliative and support services to terminally ill persons must be approved by the insurer. Terminally ill means the patient has a prognosis of eight months or less.

12. Core plan assistance coverage

12.1. Object of coverage

1 The insurer provides assistance, within the legal and contractual scope to insured that are in difficulty or in emergency situations while on a journey or a visit within the territory laid down in the policy, provided that these insured simultaneously possess a Expatline health insurance.

2 According to the assistance coverage, the insurer will provide immediate help, be it in cash or in kind, to the insured encountering difficulties as a result of a chance event, in the cases and conditions specified in the contract.

3 Providing emergency assistance does not exclude the possibility of receiving aid according to the conditions of insurance. However the insurer will only decide after having received all the relevant documentation and information.

12.2. Periods of coverage

1 Definition

The period of coverage must commence and end during the period stipulated in the insurance contract. The start date has to be indicated in the policy.

12.3. General exclusions assistance

The following situations and their consequences are excluded from the insurance coverage:

If damage is caused by force majeure or other exceptional situations, such as a war or a warlike conditions, a revolution, nuclear radiation or any natural catastrophe (i.e. volcanic eruptions, meteorites, tidal waves/tsunamis, earthquakes);

If the insured party takes part in high-risk endeavors and thus substantially aggravates the risk stipulated in the contract;

If the insured behaves abusively by requesting the organization of evacuation or repatriation although only suffering from a minor affliction or injury which could be treated in the area and would not prevent continuation of travel or stay;

Accidents caused by the symptoms of epilepsy and malaria;

Running away or kidnapping;

Ignoring official prohibitions and not respecting the rules and safety measures in for sport or leisure activities:

If the insured participates, at any level, in high risk sports (parachuting, car racing and motorcycle racing of 125 cm3 or more, any kind of hunting, etc.);

Costs related to excess baggage and customs in the case of repatriation by means of a normal flight;

Exclusions from the policy or incidents that occur outside the effective period of coverage.

12.4. Assistance benefits

12.4.1. Search and rescue

When an incident occurs the insurer will participate in the search and rescue costs incurred by the competent authorities.

12.4.2. Evacuation and repatriation

1 As soon as the condition of the insured, who has experienced a sudden illness or an accident, allows it and provided that the certified medical practitioners treating the insured give their consent, the insurer will arrange and pay for a transfer of the insured to the nearest appropriate hospital.

2 As soon as the condition of the insured, who has experienced a sudden illness or an accident, allows it and provided that the certified medical practitioner treating the insured give their consent, the insurer will arrange and pay for repatriation of the insured party to his home country or host country according to the insured's wishes. Where no choice is or can be made, the insurer will arrange repatriation to the host country.

3 The choice and the organization of the appropriate means of transport (air, land or sea) will remain with the insurer.

4 The insurer will only pay for the costs of repatriation that are considered to be reasonable.

5 The benefits of a medical evacuation and/or if needed a repatriation can only be provided if approved by the insurer's medical team working closely with the certified medical practitioner treating the patient or the certified medical practitioner in the emergency stabilization center.

12.4.3. Repatriation of mortal remains

1 In the event of the death of the insured during a journey or a visit abroad, the insurer will arrange for the repatriation of the mortal remains from the place of death to the funeral site within the home country or permanent residence. Repatriation, if possible, will be carried out in accordance with the appropriate national laws and international conventions in force.

2 The insurer will cover the transfer costs of the mortal remains.

3 The insurer will take care of all the formalities required for the transportation of the mortal remains.

4 If it is objectively necessary to make transportation possible, the insurer will cover the expenses related to initial preservation, maintenance, laying in coffin, arrangements specifically related to transportation, preservation services required by law, preparation and coffin costs for the simplest model required for transport and in accordance with local and international laws.

Not covered are expenses related to embalming, burial, the funeral ceremony or other costs. Cremation costs will only be covered if required by legal provisions in force.

Costs incurred by any accompanying persons are not covered, unless this is specifically mentioned in the insurance contract. All covered expenses in connection with the repatriation of mortal remains must be pre-approved by the insurer.

5 Travel costs of insured family members in the event of the repatriation of mortal remains refer to the reasonable transportation costs of any insured family members who had been residing abroad with the deceased insured member, to return to the home country/chosen country of burial of the deceased. Coverage does not extend to hotel accommodation or other related expenses.

12.4.4. Medical accompaniment

1 During transfer or, when necessary, repatriation, the insured is accompanied and assisted by medical and/or paramedical staff with the required expertise to care for the patient's condition as requested by the insurer's team of certified medical practitioners.

2 Expenses for one person accompanying an evacuated/repatriated person refer to the cost of one person travelling with the evacuated/repatriated person. If this cannot take place in the same transportation vehicle, transport at economy rates will be paid for. Following completion of treatment, the insurer will also cover the cost of the return trip, at economy rates, for the accompanying person to return to the country from where the evacuation/repatriation originated. Coverage does not extend to hotel accommodation or other related expenses.

3 In case of inpatient treatment of a child under 18 years old, the insurer covers the expenses for one accompanying family member or dependent. This includes hotel accommodation or other related expenses including an airplane ticket in economy class for one trip.

12.4.5. Compassionate travel / family emergency travel

1 A compassionate travel ticket in economy class is covered for those times when travel is a necessity due to a family member in a life-threatening situation.

2 A travel ticket in economy class is covered for one family member when travel is a necessity if the insured is in a life-threatening situation.

12.4.6. Long-distance medical advice

When the insured requires long-distance medical advice the insurer organizes contact with an independent certified medical practitioner who is qualified to answer the questions pertaining to the state of health. The insurer cannot be made liable for the opinion provided by that certified medical practitioner and any consequences that it may entail.

12.4.7. Recommendation of local specialized certified medical practitioner

If the initial examination reveals that the insured is in critical condition and requires a specialist's intervention, the insurer will supply the insured by request or at the request of the certified medical practitioner treating the insured at the place where the incident occurred, with the name of a certified medical practitioner specialized in the relevant field provided that such a specialist exists in the region in which the insured is located. The insurer cannot be made liable for the medical treatment in question or any possible consequences that this treatment might entail.

12.4.8. Emergency dispatch of medication

The insurer will arrange and pay for the dispatch of medication required in order to treat the insured if the medication in questions is not available in the country in which the incident has occurred and that the use of it is not prohibited in the contractual territory where it is to be used. The costs for the dispatch are covered.

12.4.9. Transmission of urgent messages

The insurer undertakes the transmission of urgent messages on behalf of the insured to any person in the home country of the insured and nominated by the latter if the insured is not capable of communicating with the nominated person. The insurer covers the costs that arise for the transmission.

12.4.10. Repatriation of other insured parties involved in the same incident

The insurer will arrange and pay for the repatriation costs of any insured parties involved in the same incident if they are unable to return by their intended means of transport as long as they are insured with the same insurer and have the same coverage.

12.4.11. Limitations of coverage

1 In addition to the general contractual exclusions and limitations, the insurer is not obliged to provide coverage in the following events or has the right, if necessary, to terminate the contract:

If the incident has not been immediately notified to the alarm center by the insured or a third person involved;

If medical examinations, medical investigations or hospital treatment have been undertaken/organized by the insured without having received the insurer's compulsory prior approval;

If the communication by the insured of important documents and information needed for the control or treatment of the case are still missing or have reached the insurer with delay;

If the diagnosis reveals that the present health condition had been a pre-existing condition. Furthermore, the insurer reserves the right to reduce benefits if, although the present health condition was not a pre-existing one, its onset has revealed important factors of risk such as diabetes, high blood pressure and hypercholesterolemia, etc.;

If incidents, discomfort and complications occur in relation with pregnancy which the risk was known or foreseeable before travelling.

If the insured has involuntarily or voluntarily omitted to inform the insurer of the existence of another insurance covering the same risk or in case of non-disclosure;

If the insured did not take the necessary precautions which would or could have avoided a substantial aggravation of the risk leading to a claim;

If the insured refuses cooperation with the insurer.

2 Any refusal on the part of the insured or the person deciding on his or her behalf regarding the benefits (such as repatriation) provided in a case of a claim and according to the policy will entail an immediate suspension of the assistance coverage and the benefits. Costs and expenditures will have to be borne by the insured. If the insured changes his/her mind before the end of the coverage period, he/she will have to bear the costs stemming from the refusal to accept the initial benefits (e.g. costs relating to prolonged hospitalization etc.) and from a change of mind.

3 The insured and the policyholder will lose their rights to benefits if they do not restrain from any form of intervention in the administration of the claim by the insurer without the latter's prior consent.

13. General benefits accidental death or disability

13.1 Benefits

In the event of an accidental death or disability the insurer pays a lump sum to the insured that is stated in the benefits list.

13.2 Object of this coverage

In case of a permanent disability the insurer pays a percentage of the lump sum as mentioned below:

Loss of life	**100%**
Loss of one hand	**50%**
Loss of one foot	**50%**
Loss of sight in one eye	**50%**

If two or more losses from above have affected the insured, the insurer pays 100% of the lump sum. In no case will the insurer pay more than the sum insured according to the insurance contract.

If any lump sum has already been paid in case of disability this amount will be deducted from the total amount insured in the policy.

The coverage is reduced to 50% after an insured has reached 70 years of age.

14. Option Outpatient

14.1. Object of this coverage

1 The insurer provides coverage according to the scope of the insurance contract. This option is an addition to the Core plan and can't be taken out individually. All benefits are subjected to the limitations and coverage of the insurance contract and the benefits list.

During the insured's stay inside the contractually defined territory according to scope of the insurance contract, the benefits mentioned below are covered:

14.2.1. Emergency outpatient treatment

Emergency outpatient treatment is treatment received in a casualty ward/emergency room following an accident or sudden illness, where the insured does not, out of medical necessity, occupy a hospital bed. The treatment must be received within 24 hours of the emergency event.

14.2.2. Psychotherapy and similar treatments

All benefits are subjected to the limitations and coverage of the insurance contract and the benefits list.

1 The insurer will only reimburse the costs for psychotherapy if approval has been given in advance in writing after have received an assessment by the insurers own expert.

2 Psychiatry and psychotherapy refer to treatment of mental or nervous disorders, carried out by a psychiatrist or clinical psychologist. The disorder must be associated with present distress or substantial impairment of the individual's ability to function in a major life activity (e.g. employment). The aforementioned condition must be clinically significant and not triggered by a particular event such as bereavement, relationship or academic problems or acculturation.

The disorder must meet the criteria for classification under an international classification system such as the Diagnostic and Statistical Manual (DSM-IV) or the current International Classification of Diseases (ICD).

Psychotherapy is covered according to the insurance policy, insurance contract provided the treatment is

prescribed and performed by a certified medical practitioner.

14.2.3. Laboratory and x-ray expenses

1 Diagnostic tests are investigations such as x-rays or blood tests, undertaken in order to determine the cause of the presented symptoms.

2 The costs for lab examinations, x-rays, scanner and MRI's, if prescribed by a certified medical practitioner for valid reasons are covered.

14.2.4. Alternative medicine

All benefits are subjected to the limitations and coverage of the insurance contract and the benefits list.

1 Following therapies are covered:

Services of officially licensed masseur or those of kinesitherapy (thermo therapy, electrotherapy, physiotherapy) if they are authorized and licensed in within the contractual territory.

Services of officially licensed chiropractors and osteopaths are only covered if they are authorized and licensed within the relevant contractual territory.

2 The costs for alternative medical treatment will be reimbursed (medical physicals and tests, therapy, medication) provided that a therapy will only be granted on medical prescription and can only be performed by physician, an official herbalist (recognized by the authorities) or by an official therapist for alternative medicine. The coverage of costs for medication/remedies is always linked to the prescription of the treatment by a certified medical practitioner and if the insurer deems it necessary a second opinion will be obtained through a private medical expert.

14.2.5. Physiotherapy, logopedics and orthopedics

All benefits are subjected to the limitations and coverage of the insurance contract and the benefits list.

1 Physiotherapy, logopedics and orthoptics are only covered if prescribed by a certified medical practitioner. The therapist must be licensed and authorized within the relevant contractual territory.

2 Logopedics refers to treatment carried out by a qualified speech therapist to treat diagnosed physical impairments, including, but not limited to, nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

14.2.6. Medication

1 Prescribed medication approved of by the state's authorities is covered. Homeopathic treatments are also covered.

2 Medication, wound dressings and medical equipment have to be prescribed by a certified medical practitioner or another agreed specialist.

3 The prescribed medication has to be bought at the chemist's and not in a drugstore since the latter are not subject to the same severe controls. The purchase of more than one package of the same medication has to be written on the certified medical practitioner's prescription.

4 Products such as pure alcohol for medical use, cotton, sun protection, products for dental care, shampoo, food for special diets, mineral water, special sorts of wine, fresh or dried glands, contraceptives, cosmetics, sanitary products, anti-alopecia, insect repellent spray, etc. are non medical substances and therefore not covered.

14.2.7. HIV

The insurer will cover, after 24 months from the start date of the insurance policy, treatment and medication arising from or related to HIV/AIDS/ARC according to the selected insurance plan for a maximum period of 5 years.

Treatment is only covered if HIV was first contracted after the start date of the insurance policy. HIV tests are not covered.

15. Option Maternity and Childbirth

15.1. Object of this coverage

Maternity and childbirth are only covered if the option has been included in the insurance contract. This is only possible with the Core plan on the level of comfort and premium. The limitations according to the benefits list and the insurance conditions are applicable. All other conditions and obligations are also applicable to this option. All benefits concerning pregnancy and maternity are subjected to a waiting period of 12 months after the insurance comes into effect.

15.2. Maternity, newborn, premature birth, congenital conditions, birth anomalies

Maternity care includes consultations, treatment and medical examinations that are directly related to the pregnancy as well as those related to the birth. Outpatient medical exams that are required by law for targeted diagnostic purposes are also covered.

15.3. Complicated delivery

1 A complication of childbirth refers only to conditions that arise during childbirth and that require a recognized obstetric procedure (postpartum hemorrhage and retained placental membrane).

2 Complications of childbirth are only covered if the policy also includes maternity benefits. Where the policy includes maternity benefits complications of childbirth shall also include medically necessary caesarean sections.

15.4. Complicated pregnancy

Complications of pregnancy are related to the health of the mother. Only the following complications that arise during pregnancy are covered:

- Ectopic pregnancy,
- Gestational diabetes,
- Pre-eclampsia,
- Miscarriage,
- Threatened miscarriage,
- Stillbirth and hydatidiform mole,
- Premature birth.

1 The expenses arising from pregnancy and from birth, and especially from pregnancy management (medical check-ups), lying-in clinic, necessary lactation counseling, mother and baby care in the clinic (when the child is healthy) are covered up to the standard tariffs in the contractually specified territory.

2 Pregnancy refers to the period of time, from the date of the first diagnosis, until delivery.

3 Prenatal care includes common screening and follow-up tests as required during a pregnancy. For women aged 35 and over, this includes Triple/Bart's, Quadruple or Spina Bifida tests, amniocentesis and DNA-analysis, if directly linked to an eligible amniocentesis.

4 Routine maternity refers to any medically necessary costs incurred during pregnancy and childbirth, including hospital charges, specialist fees, the mother's prenatal and postnatal care, midwife fees and newborn care.

5 Costs related to complications of pregnancy or complications of childbirth are not payable under routine maternity. In addition, any non-medically necessary caesarean sections will be covered up to the cost of a routine delivery in the same hospital, subject to any contractual limitation of coverage in place.

6 Postnatal care refers to the routine postpartum medical care received by the mother, up to six weeks after delivery.

7 Newborn care includes customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures. These essential examinations are carried out immediately following birth.

Further preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests, are not covered under the mother's insurance policy because any medically necessary follow-up investigations and treatments are covered under the newborns own policy.

8 Charges for hospital nursery services and professional services for the newborn infant are covered separately from the mother's' maternity benefits.

9 Coverage for congenital conditions is only available to infants born of a covered pregnancy and having continuous coverage effective from the date of birth.

When coverage is available, benefits are provided for medically necessary inpatient and outpatient treatment, services and supplies for congenital conditions as those conditions are defined.

10 The travel ticket for childbirth in the home country or host country is covered in economy class.

16. Option dental care

16.1. Object of this coverage

1 Dental is only covered if the option has been included in the insurance contract. This option is available for all levels of the Core plan. The limitations according to the benefits list and the insurance conditions are applicable. All other conditions and obligations are also applicable to this option. All services must be carried out by a dentist certified and authorized in the country the treatment is performed. All benefits concerning dental care are subjected to a waiting period of 6 months after the insurance comes into effect.

16.2. Simple filling

Simple fillings refer fillings that are medically necessary due to cavities or decay.

16.3 Check up

One annual check up by a dentist is covered.

16.4 Tooth extraction and root canal treatment

Medically necessary tooth extractions and root canal treatments are covered according to the limitations of the insurance contract and benefits list.

16.5. Periodontics

Treatment for periodontitis is covered if it is medically indicated and subjected to a 6-month waiting period.

16.6. Orthodontic treatment and dental prosthesis

This coverage is only available to the levels comfort and premium and coverage is according to the limitations of the insurance contract and benefits list and subjected to a 6-month waiting period.

Dental prosthesis includes crowns, inlays, on lays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.

17. Exclusions and limitations of coverage applicable to all options and levels of coverage

17.1. General exclusions

The following situations and their consequences are excluded from the insurance coverage

a) If the insured commits a crime, an offence or acts in a rash way that leads to the claim;

b) If the insured takes drugs and/or alcohol and/or hallucinogenic products and toxic substances which lead or contribute to the incident

c) If there are harmful effects to the insured's health that resulted from the production and the use, intentionally

or unintentionally, of chemical, biological, bio-chemical, electro-magnetically substances meant to be used as a weapon (independently from any possible concurring causes), as well as damages due to nuclear or any other form of radiation.

d) If the incident occurred outside the territory fixed in the insurance contract or insurance policy or outside the effective period of coverage.

c) Illnesses and injuries that arise out of the participation in extreme sports including but not limited to the activities mentioned below are not covered.

1 In addition to the general contractual exclusions and limitations, the insurer is not obliged to provide coverage in the following events:

Afflictions including their consequences from an accident due to war or warlike conditions or those stemming from military service in a country not specifically listed;

Illnesses or accidents and their consequences intentionally provoked;

Treatments by certified medical practitioners, dentists and hospitals that have been explicitly excluded from the service package that are notified to the insured or to the person taking decisions on his behalf.

Outpatient treatment in a spa or hot spring resort.

Care and treatment provided by the spouse, by in-laws or by offspring, or by a next of kin;

Any cosmetic surgeries, the consequences or complications thereof;

Expertise, certificates, written evidence, opinions, instructions or estimates issued by the provider to the extent that they have to be submitted by the insured to the insurer;

In the event that the services provided are deemed not efficient, appropriate, and economic by an independent medical expertise sought by the insurer.

Any fertility/infertility services, tests, treatments, drugs and/or procedures

Aptitude testing, educational testing and services.

Services for mental disorders or illnesses that are not medically necessary.

Services related to drug and alcohol abuse, including private or special nursing, or services rendered by a physician.

Chronic brain syndrome, senility, mental retardation.

2 In the event that the provided services for treatment or any other care exceed the real necessary medical costs, the insurer may reduce the benefits in such a way as to reach an acceptable amount. The insurer has also the right to reduce the benefits if other types of medical care, less expensive, would have been just as appropriate.

18. Various contractual provisions

18.1. Communication and notifications

1 Declarations of intent and notifications to the insurer have to be submitted in writing.

2 Agents, brokers and other insurance intermediaries are not empowered to receive such communications, which are therefore considered by the insurer as not received.

3 If the policyholder or the insured omits to inform the insurer of a change in his address, the insurer will send any declaration of intent to the insured's last known address to make his notification legally valid.

This declaration shall be effective on the day it would have reached the insured or the policyholder by regular post at his last known address if there had not been a change in the address.

18.2. Payment of the insurance premiums

1 Receiving premium payment is an essential part of the insurance contract whatever which mode of payment has been agreed upon. The premium is to be paid in advance on a quarterly, half-yearly or yearly basis unless otherwise agreed upon in writing by both the policyholder/insured and the insurer.

2 Premiums have to be paid before the chosen start date of the insurance in their entirety - fees that arise due to the payment are entirely at the expense of the policyholder / insured, before the start date of the rates and before the annual renewal date of the insurance. Taxes and charges as established by the applicable laws will be added to the amount of the premium, and have to be paid in full by the policyholder/insured.

If the payment is credited after 30 days from the chosen start date of the insurance, a new confirmation of medical statement must be filled out and the insurer will propose a new start date.

3 The premium payment frequency can be altered:

- from quarterly to half-yearly or to yearly (frequency decrease), if requested at least one (1) month before the policy renewal date;
- from yearly to half-yearly or to quarterly (frequency increase), if requested at least one (1) month before the annual renewal date.

The policyholder can, upon request and for an additional surcharge of 5%, pay the premium in quarterly or semester rates.

4 In any case, the insurance policy and membership card will be only issued after the payment is credited on the bank account of the insurer.

5 Withholding the payment of a premium in order to compensate some outstanding benefit is not permitted.

6 The premium is calculated always for an entire year. The payments rates must fulfill a complete year. No premiums will be refunded.

7 The non-payment of the premium on the day it is due will automatically be considered an enforceable delay without necessity of sending a prior notice to the insured. Should the amount be still outstanding after the day the premium was due, the insurer can suspend all benefits and claims payment without making any notification. After 45 days from the day the premium was due, the contract is automatically cancelled.

18.2.1. Suspension of coverage and cancellation of the insurance because of non-payment of premium

In case of failure by the policyholder/insured to pay the premium on the due date, the insurer has the right to suspend or cancel the insurance policy.
The insurer will first notify the policyholder/insured by means of a registered letter, reminding the policyholder/insured of the amount of the premium that has to be paid, and informing him/her of the consequences of non-payment. If the premium has not been paid within fifteen (15) days following service or posting of the registered letter, the insurance coverage will be automatically suspended. Payment if the premiums due by the policyholder/insured of shall terminate suspension.
The insurer may cancel the policy during the period of suspension. In this case, cancellation shall take effect on the expiration of the period of fifteen (15) days, starting from the first day of suspension.
Claims incurred during the period of suspension are not covered.

18.3. Adjustment of the premiums

Premium increase
In case the insurer increases the premium rate, he will notify the policyholder/insured, in writing, of said increase and of the date as from which the new premium will become effective. This notification will be sent to the policyholder/insured, in writing, at the latest on:

- for individual policies, the fifteenth (15th) of November of the expiring calendar year;
- for group policies, two (2) months prior to the Annual Renewal Date, unless otherwise agreed upon between the policyholder and the insurer.
- The new premium rates will become effective as from:

  - for individual policies, first (1st) of January of the next calendar year;
  - for group policies, the next annual renewal date (on or after first (1st) of January of the next

calendar year).

If the policyholder does not agree with the new premium conditions, he/she can terminate the policy through notification of cancellation to the insurer by registered letter, e-mail or fax delivered to the insurer or the Swisscare Customer Care Unit:

- for individual policies before fifteenth (15th) of December;
- for group policies at least one (1) month before the annual renewal date of the policy.

Alternatively and exceptionally for individual contracts, the insurer accepts an upgrade or a downgrade of coverage level on1st January. This exceptional change has to be requested the thirtieth (30th) of November at the latest through notification to the insurer by registered letter, e-mail or fax delivered to the insurer or Swisscare Customer Care Unit..
The premiums are age related and there will be no notification in the event of a premium increase due to a change of age band. The new premium rates will become effective as from the next policy renewal date after the insured's birthday. There is no possibility to terminate the contract due to an age band-related premium increase.

The premiums are age-related and will therefore also be adjusted on the first due date after the insured's birthday

18.4. Modification of insurance conditions

1 The insurer has the right to modify the insurance conditions including those relative to an already existing contract.

2 The new conditions will be notified to the insured no later than 2 months prior to their becoming effective, unless there is a case of emergency, force majeure or a legal, administrative or judicial obligation that bears no delay.

3 In the absence of a termination of the existing insurance contract in writing by the insured or the policyholder, the new insurance conditions will come into effect and be viewed as accepted.

4 The insurer may at any time modify the wording of the terms and conditions, however only to exclude typing errors or obvious inaccuracies, to get rid of uncertainties in the interpretation, to explain a certain passage in the text or to change the conditions in favor of the insured.

18.5. Salvatory clause

1 The present invalidity or the future invalidation of one of the provisions to be found in the insurance conditions and the appearance of a legal gap (lacuna) do not have any effect on the validity of the other clauses.

2 In order to replace or add to the invalid or missing clause, the insurer will add a clause that makes sense and which will be within the realms of possibility and tolerance and the closest it can get to the original contents of the contract of the parties.

18.6. Data processing and data protection – inquiries

1 The insured entitles the insurer to process all necessary data for his database and the data required for claim handling. The insurance policy is subject to compliance with the Swiss Data Protection Act. This Act applies in relation to any personal data processed in connection with this insurance policy. All involved parties will provide sufficient guarantees in respect of the technical and organizational measures governing the data processing to be carried out, and will therefore operate technical and organizational measures to protect against unauthorized or unlawful processing of such data and against accidental loss or destruction of or damage to such data.

2 The insured benefits from the Swiss data protection laws and regulations concerning data protection, data processing and confidentiality.

3 The insurer collects and maintains personal information in order to underwrite and administer the insurance policies. All personal information is treated with the utmost confidentiality and with appropriate levels of security. The information will be protected from accidental or unauthorized disclosure. The insurer will only reveal the information if it the law allows it, if it is authorized by the insured, or in order to prevent fraud.

Any inaccurate or misleading data will be corrected as soon as possible. The above principles apply regardless

of if the information is digital or analog.

18.7. Medical confidentiality

By accepting this document and the conditions herein, the insured releases all certified medical practitioners and paramedical staff who have examined or treated him both before and after the incident from their obligation to maintain medical confidentiality with respect to the insurer. The insured commits to reiterating consent after the claim and/or to signing an ad hoc form for the insurer. A refusal will mean the loss of all contractual rights to the claim.

18.8 Termination of the contract

1 The policyholder has the right to terminate the contract and/or interrupt the tacit renewal of the contract by notifying the other party per scan by email or by postal mail at the latest one month before the end of the current contractual year.

2 In the event of an adjustment of the premium or any other modification of the insurance conditions that expressly allow for the termination of the contract, the insured has the right to terminate the contract per scan or postal mail sent to Swisscare Customer Care Unit services within 1 month after reception of the notification related to these modifications. In this case the termination will come into force on the date when the foreseen modifications will take place.

3 Besides the legal and contractual clauses that make it possible to declare/render the contract invalid, to terminate it retroactively, to terminate it with immediate effect and to terminate it within a certain different delay, an unintentional culpable attitude of the policyholder or the insured will entitle the insurer to do the following:

a) The contract will be terminated within one month from the moment of the insurer's becoming aware of the irregularity;

b) The insurer may propose to modify the contract within a month after his becoming aware of the irregularity. If the other party refuses the proposed modifications or does not accept them within a delay of a fortnight after receipt of the proposal, the insurer may terminate the contract within a delay of the following fortnight.

4 If in the frame of an insurance contract covering several insured parties, the conditions for termination for only a few insured persons are met, the right to termination can only be valid for those concerned.

5 If the policyholder terminates the contract for all of the insured or only for a few of them, the policyholder will have to prove, if he wishes to validate this termination, that these insured persons have been duly informed of his intention and have accepted. If these or some of them wish to continue their insurance, they may do so by registered post to Swisscare Customer Care Unit services within a delay of 1 month after the termination of the contract by the policyholder.

6 The insurance contract automatically terminates with the death, the bankruptcy, or the official insolvency of the policyholder.

7 Return to the Home Country

When the insured returns to live and/or to work in his/her home country, thereby ending the period of expatriation abroad, the insured or the policyholder have to notify the insurer (through the Swisscare Customer Care Unit) by postal mail, email or fax, of the exact date of relocation to the home country, at least one (1) month prior to the policy renewal date. The insurance will remain in force until the exact date of return to the home country, at which date it will be automatically terminated.

The policyholder can nevertheless request - in writing and at least one (1) month before the policy renewal date - cover for one additional three (3)-month period (without interruption of cover), at the conditions prevailing on the first day of this additional three (3)-month period. During this period the insured (or the policyholder) can apply for affiliation to a local social security scheme or look for another private insurance.

Failure to notify the insurer of the relocation to the home country, shall result in the insurer not providing cover for the duration of the insured's return to the Home Country.

18.9. Applicable law

1 Swiss law is applicable.

2 The benefits of this insurance do not hinder the applicability of legal statutes and of the compulsory basic health care legislation pertaining to the host country to which the present conditions of insurance refer and which are thus part and parcel of the insurance contract within the limits of these references.

18.10. Conciliation, complaints procedure and place of jurisdiction

1 Before taking any judicial or arbitral action, each party agrees to contact the other party, in writing, within 10 days of the beginning of the dispute, in order to find an amicable settlement.

2 In the event that the conciliation was unsuccessful, the insurer undertakes to put a free internal opposition proceeding at the insured's disposal. The commencement of this proceeding does however not suspend the course of any legal or contractual delays or deadlines.

3 Complaints procedure

If an Insured has any complaint regarding the standard of service received under this insurance policy, the following procedure is available to restore the situation:

- in first instance, the Insured should write to the:
  - Head of the Evasan Expatline Claims Unit, SOS Evasan S.A. Route de L' Etraz 12c CP 5, CH-1267 Vich, Switzerland
- if still not satisfied, the Insured can write to the:
  - Chief Executive Officer SOS Evasan S.A. Route de L' Etraz 12c CP 5, CH-1267 Vich, Switzerland

4 In case of a judicial procedure, the dispute regarding the interpretation and implementation of this contract falls under the exclusive jurisdiction of the courts of Switzerland, at the seat of Evasan.

5 Paragraph 3 does not impair the application of mandatory, conventional or legal, provisions concerning the place of jurisdiction.

6 Moreover, the parties remain free to use, by means of an agreement in writing, the possibility of arbitration of one or three arbitrators.

19. Validity

The present insurance conditions are valid from 01.11.2015 and replace all previous conditions governing the same product.