RE-INSURED BY

GENERAL TERMS AND CONDITIONS

Welcome and thank You for choosing MEDIHELP INTERNATIONAL PLANS.

When joining our plans, please check Your Insurance / membership certificate and ensure all details are correct. If any changes need to be made, please let Us know immediately.

Please read, familiarise yourself with this Policy and Insurance / membership certificate.

This document explains:

- The coverage (both benefits and limitations),
- How the Policy works and is administered,
- What is and is not covered,
- How to use the Policy, including receiving Treatment and submitting Claims,
- If in the unlikely event You are unsatisfied, how to make a complaint,
- Definitions and what we mean by the words throughtout this document. Where the context permits, words in this Policy denoting the singular shall include the plural and vice versa. Words denoting any gender shall include a reference to each other gender.

Your Membership Pack is formed of the following documents:

- The Application form and declarations completed by You, Your employer (if this is a Company policy),
- Insurance / membership certificate – showing the details of Your Insurance Plan,
- Payment Notification – showing the insurance premium and payment frequency,
- General Terms and Conditions (Policy Wording) – current document including all policy details,
- Electronic Membership Card.

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1. CONTRACT OBJECTIVES

Your MediHelp International Plan is an International Private Medical Insurance, insured by Inter Partner Assistance S.A., member of AXA Group, hereafter referred to as the Insurer and reinsured by AXA PPP healthcare Limited. There are also some aspects of the administration of Your Policy that is undertaken by different AXA Group entities.

The Policy is subject to the Romanian law.

The General Terms and Conditions describe all benefits which are available in the frame of the 5 (five) plans, but the cover which will be provided to the Insured Person or Policyholder in relation to the Insured Event will be in accordance with the selected programme as shown in the Policy or Insurance /membership certificate issued to the Insured Persons and in the Table of Benefits. Any benefit which is not provided by a selected programme cannot be granted.

We will pay charges for Pre-authorised, appropriate, Medically Necessary Conventional Treatment for eligible medical conditions subject to Reasonable and Customary charges authorised during the Period of Insurance.

Your Insurance Plan can be at any of the 5 (five) chosen levels of annual coverage, where some parts of the coverage have their own separate limits as listed in the Table of Benefits less any Co-pay and/or chosen Deductible:

1. BLUE PLAN → € 500 000
2. AZURE PLAN → € 1 200 000
3. COBALT PLAN → € 1 500 000
4. ADMIRAL PLAN → € 2 000 000
5. ROYAL PLAN → € 3 000 000

1.1. UNDERWRITING

Your Policy is designed to cover Conventional Treatment of new medical conditions that begin after You and Your Dependents join the Insurance Plan.

Your underwriting terms are subject to the different types of underwriting options You joined the Policy on and this is explained in the following section.

1.1.1. Individual Plans

Full Medical Underwriting (FMU)

Under this underwriting option, You will be required to complete an Application form and health declaration statement(s), declaring the medical history for all Insured Person(s), which will be assessed by Us. All Pre-Existing Conditions or Treatment the Insured Person(s) have received or suffered from, or any signs and Symptoms before the Insurance with Us started, will not be covered, unless the Insured Person(s) had declared this in the Application form and health declaration statement(s) and We have agreed in writing to provide cover. The Insurance /membership certificate issued to the Insured Person(s) will detail any medical exclusions and/or limitations endorsed on this Policy.

Continued Personal Medical Exclusions (CPME) underwriting

If You or any Insured Person(s) have an existing Policy, You can use CPME underwriting to transfer Your private medical insurance cover over to Us on the same individual underwriting terms that were applied by the previous insurer, providing that continuous cover is maintained. If any medical exclusions or restrictions were imposed on Your and/or any of the Insured Person(s) private medical insurance cover by the previous insurer, this will also continue under Your and/or the Insured Person(s) cover with Us.

Please take note: For all individual Plans, the minimum attained age at entry for a Policyholder is 18 years old. In the case of an applicant being under the attained age of 18 years, a parent or guardian is required to sign the Application form and the parent or guardian shall be the Policyholder.

1.1.2. Group Plans

There is a possibility for group Insurance Plan to be concluded for the Employees by the Employer/company. Under such circumstances, the insurance contract and the policy will be concluded for the Employer/company, whereas the Insured Person receives an Insurance/membership certificate. This depends on Us accepting the Group Application form, Individual Group member Application form and health declaration statement(s) completed by the Employees, if the underwriting terms are on FMU or CPME. FMU or CPME underwriting is applicable for groups starting from 3 to 19 Employees.

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If the underwriting terms is on Medical History Disregarded (MHD), We require a Group Application form and Group membership census. This applies if the Insured Person has joined the Insurance Plan as a member of a group or company scheme with 20 or more Employees, age up to 64 (sixty-four) years old at the Date of Entry and the group or company has selected MHD underwriting terms. No Pre-Existing Conditions will be excluded under the Insurance Plan when agreed by Us. The Insurance Plan will be subject to the General Terms and Conditions including exclusions and limitations in this Policy. For any applicant who is older than 64 (sixty-four) years old at the date of his application, We will require the applicant to submit an individual Application form and health declaration statement for Our underwriter's assessment.

2. COVERED PERSONS, BENEFITS AND SERVICES

2.1. COVERED PERSONS

The covered persons may be:

- Either:

2.1.1. The Insured Person

The Insured Person alone.

The newly insured applicant is eligible to be included for cover under this Policy provided the Insured Person is below age 70 (seventy) years old at their Date of Entry, subject to completion of the appropriate individual Application form and health declaration statement, if the case.

For an applicant, under MHD underwriting, if the Insured Person is 65 (sixty-five) years and above, We will require the applicant to similarly submit the individual Application form and health declaration statement.

The Insured Person is not the contracting insured and does not enter any agreement with Us, only the Policyholder can do this. The Policyholder and We have legal rights under this Policy and We send notices to the Policyholder which is the only entity We have contractual obligations to under the Policy.

- Or:

2.1.2. The Policyholder and the Dependents appointed hereinafter:

If the Policyholder is applying for the insurance as an Insured Person, then he must first apply the cover as the Main Member and is named on the Insurance / membership certificate, as an Insured Person.

Upon the application of the Policyholder (as the Main Member), he may apply the cover for his Dependents, who are:

- Current Spouse or civil partner or any person living permanently in a similar relationship with the Insured Person (who is the Main Member and/or Policyholder) irrespective of gender; and/or
- Child (natural, step-child or legally adopted child), if he is under age 18 and unmarried.
- Dependent children aged 18 to 25 must be in continuous full-time education.

Only one Spouse or civil partner can be considered as a Dependent.

The Date of Entry is when the Policyholder and the Dependents acquire the status of Insured Person once We have approved their application. The coverage shall be terminated for any Insured Persons as soon as they no longer fulfil the afore-defined eligibility conditions.

Adding Dependents

If subsequently, the Main Member and/or Policyholder wish to add his newly married spouse, civil partner or newborn child to the Insurance Plan, the Main Member and/or Policyholder must complete an Application form and health declaration statement(s) for all Dependents including for newborn within the first 30 (thirty) days from birth. The cover will not start until the application has been accepted by Us for that Dependent and We have received premium payment.

Adding newborn children

Any newborn baby may be added to the parent's Policy by paying the applicable premium and enjoy cover commencing at the time of birth of the newborn provided:

a. at least one parent has been covered on this Insurance Plan prior to the child's birth; and
b. the child was not born as a result of assisted reproduction technologies or conception, not adopted or born to a surrogate or neither parent was under any fertility treatment; and

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c. The Policyholder has completed the Application form and We have received this form before the child is 30 (thirty) days old; and
d. the newborn child has been fully discharged from the Hospital; and
e. the newborn is not a premature baby (i.e. where birth is prior to 37 (thirty-seven) weeks gestation).

If the newborn child does not meet any of the above criteria, We will ask for the child's medical history and require an Application form and health declaration statement to be submitted to Us for medical underwriting. We reserve the right to apply particular restrictions to the cover and may offer or decline cover for this newborn child until he has attained 3 months of age (cover can commence thereafter from the 91st day after birth upon our acceptance). If there are any changes to the information declared by the Main Member or Policyholder on the Application form and health declaration statement(s) after the Main Member or Policyholder signs it and before We accept the application, please let us know straight away.

Rights when the Policyholder dies

In the case of the death of the Policyholder, the Spouse or civil partner (at least the age of 18 years old), who is the surviving dependent covered under the Policy will automatically become the (principal) Main Member, i.e. the Policyholder. The benefit under the existing Policy will terminate when any surviving Dependents are no longer eligible under this Policy or for which he has been issued his own separate Policy.

- Or:

2.1.3. Group Plan:

This section only applies to You if the Policy has been issued under a group Insurance Plan and Your Employer/company has agreed to pay Your premiums for You and Your Dependents if they are eligible for cover under the General Terms and Conditions.

The Policy and Insurance Plan is provided under an agreement with Your company, which selects the levels of benefits and programme included, sets out who can be covered, when cover begins, how it is renewed and how premiums are paid. Only the company is the Policyholder and has legal rights under the Insurance Plan. The Policyholder must ensure that the Insurance Plan is made available to You.

If You have taken this Policy as part of an Employer-Employee group or corporate business:

- You may be entitled to additional concessions or benefits to those recorded in the General Terms and Conditions if so agreed in the Policy, or
- You may have terms and conditions that are variations to the General Terms and Conditions.

If this is the case, details of those concessions and/or benefits and/or variations to the terms will be recorded on the Policy schedule endorsement or renewal document (whichever is later). In the event there is a conflict between the concessions or benefits recorded on Your Policy schedule endorsement or renewal document (whichever is later) and those recorded in the General Terms and Conditions, then the Policy schedule endorsement or renewal document (whichever is later) will prevail.

For any Insured Person to be eligible for cover under the General Terms and Conditions, and unless otherwise accepted by Us in writing and shown in the Policy schedule or renewal document (whichever is later), a member must be:

- an Employee, aged from eighteen (18) and below seventy (70), unless otherwise agreed by Us in writing, and must be Actively at work on his/her Eligibility Date. Where an Employee is not Actively at work on his/her Eligibility Date, he will become eligible for coverage as soon as he becomes Actively at work.
- Dependent(s) of the Employee, aged from 1 day to 69 years, unless otherwise agreed by Us in writing and subject to the Employee being covered. The child(ren) who are eligible under this Policy cannot stay on the Policy after the Policy anniversary following his/her eighteen (18) birthday. However, his/her cover may be renewed up to the age of twenty-five (25) years old provided he is unmarried, unemployed and is still a full-time student.

If Your employer ends their company healthcare plan with Us, Your cover will end.

2.2. CHANGING THE LEVEL OF PLAN

Subject to the Insurer's agreement and acceptance, the Policyholder can only apply to change the level of coverage at the Annual Renewal Date of the Policy and by informing the Insurer before the renewal date. All individual or group Plan family members should be Insured on the same Insurance Plan as the Main Member/Employee.

2.3. SCHEDULE OF BENEFITS

The benefits consist of covering medical costs incurred by the Insured Person and are presented in comparison in the Table of Benefits (Annex 1). Some Policy Limits apply for each Period of Insurance, which means that once a limit has been reached, the benefit will no longer be available until You renew Your Insurance Plan. Others apply for the entire insurance period, including the renewal period, which means that once a limit (lifetime) has been reached, no further benefits will be paid, regardless of the renewal of Your health plan.

Medical care to be covered must be recognized by the local medical authorities and provided by authorized practitioners (in compliance with the laws, regulations or others relating to the practice of this profession in the country concerned).

Benefits will be limited to the costs and charges actually incurred that are Reasonable and Customary. In case of all and any benefits specified in Your selected Insurance Plan, the Insurance protection covers exclusively benefits which are Medically Necessary.

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The medical costs must have been incurred in the selected Area of coverage within the Period of Insurance, net of any Co-pay and/or Deductible agreed under the terms of the Policy:

2.3.1. Overall Maximum Limit

We will pay up to the overall limit shown in the Table of Benefits for each Period of Insurance per Insured Person unless otherwise specified in the policy schedule or Insurance/membership certificate. Coverage for this limit does not extend beyond the Area of Coverage shown in Your Insurance Plan.

2.3.2. Cover Outside of Area of Coverage

We will pay up to the limits and/or period as shown in the Table of Benefits for Emergency In-Patient Treatment which arises suddenly whilst the Insured Person is outside the chosen Area of Coverage.

We will, in consultation with the treating Medical Practitioner/Physician, retain the right to determine what constitutes Emergency In-Patient Treatment.

This benefit does not provide cover for Treatment for any condition if the Insured Person has travelled outside his/her Area of Coverage to get Treatment (whether that was the only reason) or for any Treatment which was, or may have reasonably been known about, before travel commenced. Under no circumstance will this benefit be payable for any aspect of pregnancy or childbirth.

Once We have determined, in conjunction with the treating Medical Practitioner/Physician that the eligible medical condition is stabilised, or the health status of the Insured Person allows him to travel back to his Area of Coverage, We will stop paying for Emergency In-Patient Treatment.

For avoidance of doubt, no benefit shall be payable for Emergency In-Patient Treatment arising from a Pre-existing Condition, unless otherwise declared and accepted by Us upon Policy inception.

Please note that all Policy terms, conditions, limitations and exclusions, apply to this benefit exactly as for all other benefits under this Policy.

Please also refer to Section 2.3.6.3. – 'International Emergency Medical Assistance', where applicable.

2.3.3. In-Patient & Day-Patient Benefits

We will arrange and pay Reasonable and Customary charges actually incurred for the Insured Person's In-Patient or Day-Patient admission to the Hospital and for the following Medically Necessary Expenses and services within the limits as shown in the Table of Benefits following an Insured Event and when needed as a result of an eligible disease, Illness or Injury.

2.3.3.1. Hospitalisation costs

Hospital Accommodation, Room and Board

When there is a medical necessity for the Insured Person to stay in Hospital, the Treatment is given and managed by a Specialist, and the length of stay of the Insured Person is medically appropriate, We will pay for accommodation costs in a standard, single-bedded en-suite Hospital room (with bathroom or shower), standard meals, general hospital nursing care. If the cost of Treatment is linked to the type of room, the Insurer pays the cost of Treatment at the rate which would be charged if the Insured Person occupied a Hospital room type appropriate for this Insurance plan.

Parent Accommodation in Hospital

We will pay for the room and board costs for one parent staying in the same Hospital room during the hospitalisation of their Insured child (age up to sixteen (16) years old) and the child is receiving eligible Treatment arising from an Insured Event.

Operating Theatre fees

We will pay for the costs of the use of the operating theatre, surgical appliances used during surgery, post-surgical recovery room and care, Prescribed medicines, drugs and dressings used in the operating or recovery room and during the Insured Person's Hospital stay.

Intensive Care Unit (ICU)/High Dependency Unit (HDU)/Coronary Care Unit (CCU)

We will pay when the Insured Person is treated in an intensive care, high dependency or coronary care facility if:

- the facility is the most appropriate place for the Insured Person to be treated;
- the care provided in that facility is an essential part of the Insured Person's Treatment; and
- the care provided by that facility is required by patients suffering from the same type of Illness or Injury or receiving the same type of Treatment.

Specialist fees

We will pay Specialist, surgeon and anaesthetist fees which are needed during Treatment, surgery, immediately, before and/or after surgery. We will also pay for regular visits and consultations by a Specialist during the Insured Person's stay in Hospital or as a Day-Patient basis, for as long as it is medically necessary.

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Laboratory investigations, X-rays and other diagnostic tests

We will pay for the costs of diagnostic tests used to diagnose, assess the Insured Person's medical condition or to find the cause of Insured Person's Symptom(s) when recommended by the Insured Person's Specialist. This includes pathology, laboratory investigations (e.g. blood and urine tests), radiology and imagistic investigations (i.e. x-rays, ultrasounds) and other diagnostic tests (e.g. ECGs).

Prescribed medicines, drugs and dressings

We will pay for medicines, drugs and dressings which are prescribed by the Specialist for the Insured Person, whilst the Insured Person is receiving In-Patient or Day-Patient Treatment.

Physiotherapy/Speech Therapy

We will pay for Treatment provided by Physiotherapist and/or Speech therapist if this is needed and recommended by a Specialist as part of the Insured Person's Hospital stay for In-Patient or Day-Patient Treatment, but this is not the sole reason and primary Treatment for the Insured Person's Hospital stay.

2.3.3.2. Acute flare-up for Chronic condition

We will pay within the individual benefit limit as shown in the Table of Benefits for the costs of In-Patient Treatment to stabilise an Acute flare-up of the Insured Person's Chronic condition and return the Insured Person to the state of health he was in before the Acute flare-up. Once the Chronic condition has re-stabilised and is again being monitored or controlled on a regular basis, We will no longer provide cover for the Chronic condition under this benefit, it will thereafter be provided under 2.3.4.6 Maintenance of Chronic condition benefit, if this benefit is available under Your selected Insurance Plan.

2.3.3.3. In-Patient Rehabilitation

Provided the Insurance Plan includes this in the Table of Benefits, We will pay up to the limit(s) and/or up to the number of days as shown in the Table of Benefits for a combination of therapies such as physical, occupational and speech therapy for Rehabilitation received during a Hospital stay or in a Rehabilitation center following an Insured Person's immediate discharge from Hospital, after an Insured Event.

We pay In-Patient Rehabilitation for as long as:

- it follows an acute brain Injury, such as a stroke or accident; and
- it is a part of Treatment that is covered by the Policy; and
- a Medical Practitioner/Physician who specialises in Rehabilitation is overseeing the Insured Person's Treatment; and
- We have agreed the costs before the Insured Person starts Rehabilitation; and
- the Treatment could not be carried out on an Out-Patient basis.

For Cobalt, Admiral and Royal Plans: We will not pay for In-Patient Rehabilitation for more than thirty (30) days except in cases such as in severe central nervous system damage caused by external trauma. For such cases, We will not pay for In-Patient Rehabilitation for more than one hundred eighty (180) days.

For Azure Plan: In-Patient Rehabilitation benefit up to the limit stated in the Table of Benefits.

For Blue Plan: Not covered unless otherwise agreed by the Insurer.

This benefit may not be paid unless Pre-authorisation has been provided by Us.

Note: We do not pay for Rehabilitation when the Treatment was given for Mental Health Disorders, psychiatric or psychological disorders.

2.3.3.4. Prosthesis (Prosthetic Implants)/Medical Implants

This benefit shall be payable within Your overall Policy Limits, subject to verification that such internal prosthesis/medical implants are US Food and Drug Administration (FDA) approved, is used for its intended purpose, proven to be effective (i.e. not under clinical trial, assessment or research nature), and as part of Insured Person's Medically Necessary Treatment during surgery and in replacement procedures approved by the Specialist.

2.3.3.5. Durable Medical Equipment, Medical Aids and appliances, External Prosthesis

Provided the Insurance Plan includes this in the Table of Benefits, We will pay up to the limit(s) shown in the Table of Benefits for charges incurred for durable medical equipment, medical aids, appliances and external prosthesis prescribed by a Specialist as Medically Necessary in order to support, aid and be part of a surgical procedure or is an integral to the Insured Person's Treatment of a condition covered under the Policy. This is limited to: abdominal binder, post-surgical mastectomy bra, compression stocking, hearing aids, speaking aids (electronic larynx), wheelchairs, crutches, corrective splint, air boots, arm sling, orthopaedic supports, spinal supports, knee braces and pneumatic walking boots.

For prosthetic body parts such as prosthetic limbs all claims are made within 12 (twelve) months of the amputation or removal of the body part. The repair of the prosthetic limb is covered only when anatomical or functional change or reasonable wear and tear render the item non-functional and the repair will make the equipment usable. The replacement of the prosthetic limb is covered only when anatomical or functional change or reasonable wear and tear renders the item non-functional and non-repairable. Pre-authorization by the Insurer must be obtained for the initial coverage, repair, and/or replacement of prosthetic limbs.

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To be eligible for the rental of durable medical equipment, medical aids and appliances, this benefit must be accessed within the Period of Insurance. The medical equipment, medical aids and appliances should be:

- not disposable, and capable of being used more than once;
- used to serve a medical purpose;
- fit for use in the home; and
- used by an Insured Person who is suffering from the effect of an eligible disease, Illness or Injury.

2.3.3.6. Palliative Care

Provided the Insurance Plan includes this in the Table of Benefits, We will pay up to the limit(s) as shown in the Table of Benefits for charges incurred for Palliative care when the Insured Person is admitted to a specialist Palliative care centre or hospice or at home following written diagnosis confirmation (including medical evidence) by the Medical Practitioner/Physician or Specialist that the Insured Person is suffering from an eligible terminal medical condition, its associated conditions and can no longer have Treatment which will lead to the Insured Person's recovery.

Charges for Palliative care and any Treatment related to an eligible terminal medical condition and its associated conditions will be taken from this benefit and may not be claimed from any other benefits under the Insured Person's Insurance Plan. The charges for Palliative care include Hospital or hospice accommodation, nursing care, Prescribed medicines, physical and psychological care.

The Insured Person must maintain the same level of cover throughout the Palliative or hospice care admission. If the period of Palliative or hospice care falls across to the next Period of Insurance, the Insured Person must pay the premium for the subsequent Year or the benefit will cease at the Policy's Annual Renewal Date.

This benefit will not automatically be upgraded to a higher level of Insurance Plan. In the case of an upgrade in cover, this benefit will be restricted to the level of the original Plan until the Insured Person has been covered under the upgraded Plan for a period of not less than 12 (twelve) months and the annual renewal of the upgraded Plan is affected.

This benefit may not be paid unless Pre-authorisation has been provided by Us.

2.3.3.7. Home Nursing

We will pay up to the number of days and/or limit(s) as shown in the Table of Benefits for the costs incurred for home nursing only when the following conditions are met:

a. when the home nursing starts immediately after the Insured Person's discharge from Hospital, where the Insured Person has been warded and treated as an In-Patient due to an Insured Event; and
b. it is prescribed by the treating Specialist for the continued Treatment for an eligible medical condition which the Insured Person was hospitalised for; and
c. home nursing is provided by a qualified nurse in the Insured Person's home; and
d. such medical conditions are not related to mental illness, psychiatric or psychological disorders; and
e. when such services are essential for medical care and not for the Insured Person's convenience, personal assistance or for domestic reasons.

This benefit may not be paid unless Pre-authorisation has been provided by Us.

Subject to availability of the Table of Benefits, within Your overall Policy Limits, home nursing following a terminal medical condition is payable under Section 2.3.3.6. Palliative Care.

2.3.3.8. Hospitalisation cash benefit

We will pay for hospitalisation cash benefit for each night stay in the Hospital, up to the maximum number of nights and limit (s) as shown in the Table of Benefits when the Insured Person receives:

a. an eligible In-Patient Treatment within Area of Coverage and there has been no charge for the Insured Person's Treatment (free of charge) or if the Insured Person stays in a public Hospital within Area of Coverage and when
b. We would have covered that In-Patient Treatment under the Policy.

The minimum In-Patient stay is one night of stay.

If Your Policy has a Deductible, We will not take this off from the Hospitalisation cash benefit.

This benefit is not available if the cost of Treatment was funded by another party, such as another insurer or for a maternity care Claim.

2.3.3.9. Congenital and Hereditary conditions

(Applicable for In-Patient / Day-Patient Treatment only)

Provided the Insurance Plan includes this in the Table of Benefits, We will pay up to the limit(s) shown in the Table of Benefits for charges incurred for the Treatment of Congenital and Hereditary conditions when manifested and treated within the first 90 (ninety) days of a newborn's life, provided the newborn is added as a covered Dependent under the Policy within 30 (thirty) days of birth and following an eligible maternity Claim by the insured parent.

From the 91st (ninety-first) day following the newborn's birth, the newborn baby will be subject to medical underwriting and there is no cover for Congenital and Hereditary conditions thereafter. This benefit is available under the Cobalt, Admiral and Royal Insurance Plans. This benefit may not be paid unless Pre-authorisation has been provided by Us.

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2.3.4. Out-Patient Coverage

2.3.4.1. Out-Patient Surgery

Provided the Insurance Plan includes this benefit, We will pay up to the limit(s) shown in the Table of Benefits for the cost of surgical procedure performed as an Out-Patient under local anaesthesia. The surgical procedures do not require In-Patient or Day-Patient Treatment.

2.3.4.2. General Practitioner (GP) & Specialist Fees

Provided the Insurance Plan includes this benefit, We will pay up to the limit(s) shown in the Table of Benefits for Out-Patient costs for consultations with Your General Practitioner, family Physician or Specialist to Diagnose and treat a covered disease, illness or Injury or to arrange of any further medical Treatment or as a follow-up Treatment that has already taken place.

This benefit includes Telemedicine where the Insured Person may choose to consult, from an approved telehealth provider virtually for primary care consultation services at one (1) consultation per day. For any prescriptions, via Telemedicine, this is subject to any Out-Patient Prescribed medication, drugs and dressing benefit if this is applicable under Your Policy.

2.3.4.3. Prescribed medicines, drugs and dressings

Provided the Insurance Plan includes this benefit, We will pay up to the limit(s) shown in the Table of Benefits for Out-Patient costs of medicines, drugs and dressings prescribed by Your Medical Practitioner/Physician/Specialist that relate to a covered diagnosed disease, illness or Injury.

This benefit also includes prescribed medicines recommended for an eligible condition during a Telemedicine consultation as stated under Section 2.3.4.2.

2.3.4.4. Laboratory investigations, X-rays and other diagnostic tests (excluding advanced diagnostic tests)

Provided the Insurance Plan includes this benefit, We will pay up to the limit(s) shown in the Table of Benefits for Out-Patient costs of tests prescribed by Your Medical Practitioner/Physician used to Diagnose or to find the cause of Your Symptom(s). This includes pathology, laboratory investigations (e.g. blood and urine tests), radiology and imagistic investigations (i.e. x-rays, ultrasounds) and other diagnostic tests (e.g. ECGs).

We do not pay for MRI, CT or PET scans under this benefit.

2.3.4.5. Physiotherapy

Provided the Insurance Plan includes this benefit, We will pay up to the limit(s) shown in the Table of Benefits for Out-Patient consultations and Medically Necessary physiotherapy when given by a Physiotherapist aimed at restoring the Insured Person's normal physical function for a covered diagnosis and following an Insured Event. The Physiotherapist must mention the need for the specific form of physiotherapy, diagnosis, a clear treatment plan with a starting point and ending point and expected outcome.

The Treatment must be carried out by qualified Physiotherapists who hold the appropriate license and are registered to practice in the country where Treatment is received. After the 12th session/visit, if the Insured Person requires more sessions/visits, the Insured Person must submit an updated medical report/further information. We reserve the right to pre-authorise these additional sessions/visits.

2.3.4.6. Complementary Therapies: Occupational Therapy/ Chiropractic/Osteotherapy/Homeopathy/Acupuncture/Dietician

Provided the Insurance Plan includes this benefit, We will pay up to the limit(s) shown in the Table of Benefits for Out-Patient consultations and Medically Necessary Treatment given by an occupational therapist, chiropractor, osteopath, homeopath, acupuncturist, dietician when needed as a result of a covered diagnosed disease, illness or Injury following an Insured Event.

The therapeutic and diagnostic Treatment must be carried out by qualified therapists who hold the appropriate license and are registered to practice in the country where Treatment is received.

We will require a copy of the medical referral letter from Your Medical Practitioner, family Physician or Specialist and a medical report and Treatment plan from the therapist with a starting point and ending point and expected outcome for our approval.

The complementary or alternative therapy is limited to Treatment provided by these therapists only.

2.3.4.7. Maintenance of Chronic Condition

Provided the Insurance Plan includes this benefit, We will pay up to the limit(s) shown in the Table of Benefits for regular consultations, tests, and prescribed medicines required for the monitoring and maintenance of the stability of a Chronic condition. This benefit is limited to the Treatment of prescribed medicine and does not include other types of medical Treatment (e.g. physiotherapy aimed at maintaining stability).

We do not pay if the Chronic condition is a Pre-existing condition or related conditions unless this has been agreed by Us.

Any Claims relating to Cancer, Congenital and Hereditary conditions, psychiatric conditions that are chronic will not be eligible to be paid from this benefit.

For the Blue and Azure Insurance Plans, the limit(s) as shown in the Table of Benefits is a combined limit for In-Patient and Out-Patient Treatment.

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2.3.4.8. Speech therapy

Provided the Insurance Plan includes this benefit, We will pay up to the limit(s) shown in the Table of Benefits for speech therapy required to restore impaired speech function aimed at the restoration of normal function, after the Diagnosis of a covered acute Illness or Injury and when:

a. required immediately following Treatment which is covered under this Policy following an Insured Event (for example, as part of an Insured Person's follow-up care after he has suffered from stroke or Accident); and
b. it is confirmed by a Specialist to be medically necessary.

For the avoidance of doubt, the exclusion below remains applicable to this benefit:

Treatment relating to neurological development, cognitive development, learning disorders, speech delay, educational problems, behavioural problems, developmental milestones, physical development or psychological development, including assessment or grading of such problems. This includes but is not limited to problems such as dyslexia, dyspraxia, autism spectrum disorder, attention deficit hyperactivity disorder (ADHD) and speech or language problems (such as stammering).

2.3.4.9. Emergency Out-Patient Treatment

We will pay up to the limit(s) shown in the Table of Benefits for the costs of Emergency Out-Patient Treatment (i.e. medical services and Treatment received in the Accident and Emergency (A&E) room of a Hospital or Clinic) which the Insured Person obtains medical attention within 48 (forty-eight) hours of the Accident or the onset of an Emergency Illness, which does not require admission as an In-Patient or Day-Patient in the Hospital.

2.3.5. Further Benefits when specified in the Table of Benefits

2.3.5.1. Psychiatric Treatment

Provided the Insurance Plan includes this benefit, We will pay up to the limit(s) shown in the Table of Benefits for:

a. In-Patient and Day-Patient Psychiatric Treatment received at a registered psychiatric unit of a Hospital providing 24-hour medical supervision and evidence-based Treatment for Mental Health Disorders. This benefit includes room and board hospital accommodation, prescribed medicines, Medically Necessary Treatment related to the condition under the medical supervision of a psychiatrist. Psychotherapy treatment is only covered after the Insured Person was initially diagnosed by a psychiatrist and referred to a clinical psychologist for further In-Patient or Day-Patient treatment. This benefit may not be paid unless Pre-authorisation has been provided by Us.
b. Out-Patient Psychiatric Treatment, refers to consultations and associated costs for psychiatry, psychology or psychotherapy, provided the overall Treatment plan is under the referral of a practicing registered psychiatrist/psychologist. All consultations must take place in the psychiatrist/psychologist office. We will only pay Out-Patient drugs related to the medical condition when prescribed by the psychiatrist.

2.3.5.2. Cancer Treatment

Provided the Insurance Plan includes this benefit, We will pay up to the limit(s) shown in the Table of Benefits for In-Patient, Day-Patient, Out-Patient Treatment of Cancer, if the Treatment is considered by Us to be Medically Necessary for active Cancer Treatment and evidence-based Treatment. This includes chemotherapy, radiotherapy, oncology, Diagnostic Tests/Imaging, consultations, Prescribed medicines, monitoring and follow-up at a Hospital or Specialist Cancer unit as part of an eligible In-Patient, Day-Patient and/or Out-Patient Cancer Treatment, under Your Insurance Plan. There is a limit of up to 120 days per In-Patient admission on this Policy.

For wigs and temporary head coverings required following active Cancer Treatment covered by Your Insured Plan, We will pay such costs not exceeding €200 per Policy Year. If Your Policy has a Deductible, You do not have to pay the Deductible for wigs/ temporary head coverings.

We reserve the right to request the Insured Person to obtain eligible prescribed medicines and pharmacy items for active Cancer Treatment from the Insurer's designated medical network pharmacy. For any other Out-Patient drugs or other drugs that a Medical Practitioner/Physician (GP) could prescribe, shall be covered as part of the Out-Patient drugs and dressings, if this option is available under the Insured's Plan. Where it is also unclear that the diagnostic tests are for Cancer-related medical expenses then those costs will be paid under the appropriate section under the 'Out-Patient' Coverage benefit, if such benefit is available under the Insured Person's Insurance Plan.

Under this benefit, We do not pay for:

- Any diagnostic tests or treatment not considered as clinically appropriate or necessary;
- Diagnostic tests arranged by any person other than the Insured's oncologist;
- Complications that arise from new or experimental drugs or surgical procedures even if we agreed to cover the procedure itself;
- Preventative treatment, such as screening when the Insured does not have symptoms of Cancer. For example, if the Insured had a screen that showed the Insured has a genetic risk of breast cancer, We would not cover the screening or any Treatment to reduce the chances of developing breast cancer in future (such as a mastectomy);
- Medication an Insured Person may need to take after they have been discharged from hospital following bone marrow transplant such as immunosuppressants, antibiotics and steroids used to prevent complications;
- Palliative care – refer to Section 2.3.3.6. Palliative Care.

This benefit may not be paid unless Pre-authorisation has been provided by Us.

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2.3.5.3. Transplant Services

Provided the Insurance Plan includes this in the Table of Benefits, We will pay for Specialist and medical costs incurred while the Insured Person (who is the recipient of the organ) is hospitalised, including anti-rejection drugs (immunotherapy) and related Out-Patient Treatment required prior to and after the transplant (if Out-Patient Treatment benefit is applicable to Your Insured Plan), up to the limit(s) shown in the Table of Benefits in relation to life-sustaining human Organ Transplant (kidney, pancreas, liver, heart, lung, bone marrow, cornea, or heart and lung), and the human organ is from a relative or from a certified, and verified source of donation.

This benefit requires Pre-authorisation and the transplant:

a. must be Medically Necessary and subject to Conventional Treatment;
b. the specific type and length of Treatment will be determined by the type of transplant and underlying medical condition; and
c. the transplant will be carried out in internationally accredited institutions by accredited surgeons and where the organ, tissue or cell procurement is in accordance with World Health Organisation (WHO) guidelines.

We will also pay for medical costs associated with the donor as an In-Patient or Day-Patient when such medical costs and services are rendered in a network facility and where the donation does not lead to the loss of the donor's life and the donated organ, tissue or cell are removed in the same network facility where the transplant occurs. The amount which We will pay towards a donor's medical costs is up to € 20 000 for each organ transplanted, which is included as part of the maximum transplant benefit limit. The medical costs associated with the donor which We will pay towards, will be reduced by the amount which is payable to the donor in relation to those costs under any other insurance policy or from any other source.

In addition to the Policy Exclusions and Limitations, We will not pay for any of the following situations:

a. The costs associated with transportation, donor organ search, procurement of the organ, tissue, cell and any other administration costs;
b. When the donor experiences complications;
c. Organ transplant required because of a Congenital or Hereditary condition, such cover will be provided under Benefit 2.3.3.9. Congenital and Hereditary Conditions.

This benefit may not be paid unless Pre-authorisation has been provided by Us.

2.3.5.4. Advanced Imaging (MRI, CT and PET scans)

We will pay this benefit within Your overall Policy limit for the costs of computerized tomography (CT), magnetic resonance imaging (MRI) or positron emission tomography (PET), when recommended by the Insured Person's Specialist to help Diagnose or assess the Insured Person's Illness or Injury.

2.3.5.5. Routine Maternity Care (applicable to Cobalt, Admiral, Royal Plans only)

Provided the Insurance Plan includes this benefit, We will pay up to the limit(s) shown in the Table of Benefits for routine pregnancy and maternity care (pregnancy and childbirth) detailed in the list below, when an eligible female Insured Person (excluding Dependent child), age 18 years or above is insured under this benefit for a continuous period of at least 12 months from Date of Entry prior to this pregnancy.

In respect of routine pregnancy and maternity care benefits (pregnancy and childbirth), We will pay the following benefits in total per Policy Year. If a pregnancy overlaps two Insurance Policy Years, the Insured is entitled to only a single insurance policy Year's maternity benefit limit subject to this benefit being renewed:

- Standard, single-bed private Hospital room accommodation
- Pre-natal examinations by a Medical Practitioner
- All costs of normal childbirth (obstetrician and midwife fees)
- Post-natal examinations by a Medical Practitioner immediately following the routine childbirth
- Routine newborn care up to seven (7) days
- Non-elective caesarean delivery
- Elective caesarean delivery
- Childbirth at Home – For Childbirth at Home, We exclude the use of any appliances, equipment such as but not limited to TENS machines, birthing pool, etc.

Please take note:
We will not pay for any related maternity care and Treatment relating to surrogacy.
We will not pay for termination of pregnancy, other than miscarriage, ectopic pregnancy and still birth.

2.3.5.6. Maternity Cash benefit (Cobalt, Admiral and Royal plans only)

Provided the Insurance Plan includes this benefit, We will pay up to the limit(s) shown in the Table of Benefits for each night for Maternity Cash benefit, when the childbirth takes place at a public Hospital and provided no cost of the pregnancy and childbirth is claimed under the Insurance Plan. This is eligible for a female Insured Person (excluding Dependent child) age from18 years or above and has been insured under this benefit for a continuous period of 12 months from the Date of Entry of this Benefit prior to the pregnancy. Once we pay the Maternity cash benefit, We will not pay for any Hospitalization Cash benefit.

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2.3.5.7. Complications of Pregnancy (Cobalt, Admiral and Royal plans only)

Provided the Insurance Plan includes this benefit, We will pay up to the limits (s) shown in the Table of Benefits for Complications of pregnancy when an eligible female Insured Person (excluding Dependent child) age from 18 years and above, is insured under this benefit for a continuous period of 12 months from the initial Date of Entry prior to the pregnancy.

This benefit does not provide cover for home births or any complications arising therefrom.

This benefit does not pay for any Treatment relating to surrogacy.

2.3.5.8. Newborn Care

Provided the Insurance Plan includes this benefit, We will pay up to the limits (s) shown in the Table of Benefits for medically essential examinations required to assess the integrity and basic function of the child's organs and skeletal structures carried out immediately following birth and Treatment required for the newborn during the first 30 (thirty) days after birth instead of any other benefits, if at least one parent has been insured by the Policy prior to the newborn's birth.

We will not require information about the newborn's health or a medical examination if an application is received by Us to add the newborn to the Policy within 30 (thirty) days of the newborn's date of birth. If an application is received after 30 (thirty) days of the newborn's date of birth, the newborn will be subject to medical underwriting and We will require the completion of a medical health declaration questionnaire, whereby We may apply special restrictions or exclusions after medical underwriting.

This benefit does not pay for any of the newborn's preventive diagnostic procedures, such as routine swabs, blood typing and hearing tests, preventive Treatment or Out-Patient Treatment.

The newborn care benefits explained above are not available for children who are born following fertility treatment of either parent, assisted reproduction technologies or conception (such as IVF), are born to a surrogate, or have been adopted. In these circumstances children can only be covered by the policy when they are 3 (three) months old (i.e. from 91st day after birth). Cover for the baby will be subject to completion of a medical health declaration questionnaire whereby We may apply special restrictions or exclusions after medical underwriting.

2.3.5.9. Accidental Damage to Natural Teeth

Provided the Insured Person's Insurance Plan includes this benefit We will pay up to the limit (s) shown in the Table of Benefits for necessary Treatment for restorative dental Treatment required to treat or replace natural teeth lost or damaged following an accidental physical Injury to the mouth. The dental Treatment must be carried out by a dentist in a Hospital emergency room or dental Surgery, and Treatment must occur within 7 days of an accidental injury.

This benefit will not cover:

a. Damage to mouth or teeth caused by eating
b. Damage sustained to crowns, dentures, bridge work, or existing false teeth
c. Injuries caused by Accidents or events not covered by this Policy
d. Costs for Treatment that has not yet taken place, even if it is being provided as part of a treatment package.

This benefit is not payable if:

a. the damage was caused by normal wear and tear; or
b. the injury was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn; or
c. the damage was caused by brushing teeth or any other oral hygiene procedure; or
d. the damage is not apparent within seven (7) days of the impact which caused the Injury; or
e. the damage was caused before the period of insurance.

2.3.5.10. Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS)

We will pay up to the individual lifetime benefit limit within the Insured Person's overall Policy limit(s) as shown in the Table of Benefits for the Treatment of medical conditions arising from HIV Infection. We will also pay for Antiretroviral Treatment (ART).

2.3.5.11. Second Medical Opinion

If an Insured Person's medical condition or Diagnosis is complicated, and the Insured Person is unsure about what's happening, We can help. Our team can organise access to a network of leading experts, from anywhere in the world, for a review of Your case.

2.3.6. Assistance

2.3.6.1. Local Ambulance Services

We will arrange and pay within the overall Policy Limit for the Insured Person's transport to the nearest suitable Hospital for Emergency transport to or between Hospitals and when a Medical Practitioner/Physician says that it is Medically Necessary. Type of ambulances covered include road ambulance, air ambulance (if appropriate). Air ambulance services will require Our Pre-authorisation.

2.3.6.2. Repatriation of Mortal Remains

Provided the Insured Person's Insurance Plan includes this benefit, We will pay up to the limits(s) shown for the costs of all necessary arrangements as required under international regulations if the Insured Person dies outside a country that he holds a passport for.

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We will cover the cost of transporting the body back to a port or airport in:

- the country where You normally live (i.e. Principal Country of Residence), or
- a country You hold a passport (Home Country) for.

The relevant exclusions for Section 2.3.6.3. International Emergency Medical Evacuation also apply to repatriation following death.

2.3.6.3. International Emergency Medical Evacuation

Provided the Insured Person's Insurance Plan includes this benefit, We will pay up to the limit(s) shown and within the overall Policy Limit for this Service. The Service is available to any Insured Person who is injured or becomes ill suddenly and needs immediate Hospital Treatment as an In-Patient.

The Service is only available in these circumstances and as follows:

- If the Insured Person is admitted to a Hospital while abroad from their Principal Country of Residence (Country where Insured Person normally live) then, if in the opinion of the Appointed Doctor the medical facilities there are not suitable or adequate, the Insured Person will be entitled to evacuation or repatriation;
- If the Insured Person is admitted to Hospital while in their Principal Country of Residence (Country where Insured Person normally live) then, if in the opinion of the Appointed Doctor the medical facilities in the Principal Country of Residence (Country where Insured Person normally live) are not suitable or adequate, the Insured Person will be evacuated to the nearest place where appropriate services are available;
- Following evacuation, in accordance with the above, the Insured Person concerned shall be entitled to be returned, by regular scheduled airline unless We agree that another means of transport is necessary to their Principal Country of Residence (Country where the Insured Person normally live).

Special meanings are:

- Appointed doctor: a medical practitioner chosen by Us to advise Us on the Insured Person's medical condition and/or need for the service and/or the suitability and adequacy of the medical facilities in the country where the Insured Person's has been admitted to Hospital.
- Service: moving the Insured Person's to another Hospital which has the necessary medical facilities either in the country where the member is taken ill or in another nearby country (evacuation) or bringing them back to their Principal Country of Residence.

We will cover the costs of emergency evacuation if:

- Insured Person is, or need to be, admitted as an emergency In-Patient, and
- Our Appointed doctor and the treating doctor believe the Insured Person's current or nearest medical facilities are not able to provide the Treatment the Insured Person needs.

We will cover the costs of repatriating the Insured Person if We have agreed to cover the Insured Person's emergency evacuation.

We will not cover the cost of evacuating or repatriating the Insured Person if the Insured Person decides to travel elsewhere for Treatment and We believe the nearest medical facilities are adequate for the Insured Person's Treatment. This applies also if the Insured Person decides to want to travel back to the country where he normally lives (i.e. Principal Country of Residence) for his Treatment.

How emergency evacuation and repatriation cover works

If the Insured Person is admitted for a sudden Illness or Injury as an emergency In-Patient and the Insured Person or the treating doctor believe that the local medical facilities are not adequate to treat him, somebody (e.g. hospital, family member) should call Our team. We will appoint a doctor who will be able to assess the facilities and the evacuation or repatriation service detailed at the beginning of this section will apply.

What costs We will cover

If the Appointed doctor decides that the facilities are not adequate to treat the Insured Person, We will cover the reasonable costs of either:

- evacuating the Insured Person to a suitable medical facility for Treatment in the country the Insured Person is in; or
- evacuating the Insured Person to a suitable medical facility in a different country for Treatment.

When the Insured Person is discharged from the medical facility the Insured Person was evacuated to, We will cover the costs of repatriating the Insured Person to one of the following:

- the place or country where the Insured Person normally lives (i.e. Principal Country of Residence)
- a country that the Insured Person holds a passport for.

We will cover these costs so long as We have agreed the method of transport to be used, and date and time of the Insured Person's evacuation or repatriation before it takes place.

We will also cover the cost of any necessary Treatment given to the Insured Person by Our chosen evacuation agency while they are moving the Insured Person.

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However, if the Policyholder, Insured Person or the family member choose to be returned to their Home Country, the costs of subsequent return to the Principal Country of Residence (country where the Insured Person normally live) will be the responsibility of the Policyholder.

Will other members of my family or friends be able to travel with me?

If the Insured Person who needs to be evacuated or repatriated is under 18 (eighteen), We will cover the additional reasonable and necessary transport and accommodation costs for someone, aged 18 (eighteen) or over, to accompany them on their journey. If the Insured Person who needs to be evacuated or repatriated is over 18 (eighteen), We may agree to cover these costs if We believe it is medically appropriate.

Once the Insured Person reaches his evacuation destination, We will not cover the accompanying person's further costs.

What cover do I have if a family member covered by International Private Health Insurance Plans is evacuated or repatriated?

Your cover depends on whether they are evacuated or repatriated either from the location where You both normally live (i.e. Principal Country of Residence) or whether You are travelling together at the time. If You are travelling away from Home with a family member who is covered by International Private Health Insurance Plans and he is evacuated or repatriated, We will pay for Your additional reasonable and necessary transport and accommodation costs that result from the evacuation or repatriation. We will do this if it is medically appropriate for You to travel with the family member.

If You are both at the location where You normally live (i.e. Principal Country of Residence) and he has to be evacuated or repatriated from that location, We will pay for Your additional reasonable and necessary transport costs that result from the evacuation or repatriation. We will do this if it is medically appropriate for You to travel with the family member. We will not cover Your accommodation costs.

What will happen to my travel ticket?

Any unused portion of the travel tickets belonging to You or anyone that We evacuate with You will immediately become Our property. You must give the tickets to Us.

Can I choose to travel to a particular country for Treatment?

The Insured Person can choose to go to a particular country for Treatment, but We will not cover the cost of travelling to that country. Once the Insured Person is in that country, the terms of the Policy apply as normal.

Exclusions that apply to Your cover for emergency evacuation and repatriation

You are not covered for emergency evacuation or repatriation if any of the following apply:

- the medical condition does not need immediate emergency In-Patient Treatment
- the medical condition does not prevent You from travelling or working
- the medical condition is directly or indirectly caused by a deliberately self-inflicted Injury, suicide or an attempt at suicide
- the medical condition is in any way connected with alcohol abuse, drug abuse or substance abuse
- the medical condition is a result of engaging in or training for any sport for which You receive a salary or monetary reimbursement, including grants or sponsorship (unless You only receive travel costs)
- the medical condition is a result of base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than ten (10) metres, trekking to a height of over two thousand and five hundred (2 500) metres, bungee jumping, canyoning, hang-gliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste
- the evacuation would involve moving You from a ship, oil-rig platform or similar off-shore location
- We have not approved and/or arranged the evacuation or repatriation first
- We have not been told about the medical condition within 30 (thirty) days of the condition becoming an emergency (unless this was not reasonably possible)
- the medical condition is a result of nuclear, biological or chemical contamination, war (whether declared or not), act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed
- the emergency occurs when You are on a leisure trip to a destination to which the Government or any Regulatory Department in the Principal Country of Residence or the UK Foreign and Commonwealth Office either advises against all travel or advises against all travel on holiday or non-essential business.

Limits on Our liability under Your cover for emergency evacuation and repatriation

We will not be liable for:

- any failure or delay in providing emergency evacuation or repatriation
- injury or death while the Insured Person is being moved.

These limits do not apply if the failure or delay is caused by Our negligence or the negligence of someone We have appointed to act for Us. Contact details are mentioned in Section 5 Claims Handling and Administration.

Specific conditions applying to Section 2.3.6.3 International Emergency Medical Evacuation.

- Our decision is final, and We are entitled to refuse any request which is incompatible with the Insured Person's medical condition and safety,

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- We will set up the medical team and resources to be used as and when appropriate, to ensure the Insured Person's safety during the Emergency Medical Transfer or Evacuation.
- If the Insured Person rejects the assistance procedures We proposed, then We shall be released from Our obligations under this section.
- If Insured Person or his family member makes his own arrangements, the costs will not be covered. Please take note entitlement to the service does not mean that Your Treatment following evacuation or repatriation will be eligible for benefit. Any such Treatment will be subject to the terms and conditions of Your Plan.

2.3.7. Preventive Treatment

2.3.7.1. Wellness

Provided the Insured Person's Insurance Plan includes this benefit, We will pay following a Waiting Period after each Insured Person joins this Plan, up to the combined limit(s) shown for 'Adult Wellness' (Health Screening) and 'Child Wellness' benefits detailed in the list below. Any charges paid under any one of these benefits shall reduce the remaining benefit limit for the other.

a. Child wellness benefits:

For a Dependent Child who is under 2 (two) years old, We will pay charges incurred for preventive care delivered or supervised by a Medical Practitioner/Physician, whose services are limited to 4 (four) health screenings and Routine Vaccinations. No waiting period applies.

For a Dependent Child who is from 2 (two) to turning 10 (ten) years old, following a 10 (ten) months Waiting Period after the Dependent child joins this Plan, We will pay charges incurred for the purpose of preventive care delivered or supervised by a Medical Practitioner/Physician, whose service is limited to 1 (one) annual health screening and Routine Vaccinations.

For a Dependent Child who is from 10 (ten) to 18 (eighteen) years old, following a 10 (ten) months Waiting Period after the Dependent child joins this Plan, We will pay charges incurred for the purpose of preventive care delivered or supervised by a Medical Practitioner/Physician, whose service is limited to 1 (one) annual health screening.

b. Adult wellness benefits:

For an Insured Person from 19 (nineteen) years old, following a 10 (ten) months Waiting Period after he joins this Plan, We will pay charges for the purpose of preventive care delivered or supervised by a Medical Practitioner/Physician, whose service is limited to 1 (one) annual health screening consisting any of the following:

- General Health Panel
  - Comprehensive Metabolic Panel
  - Complete Blood Count
  - Lipid Profile
- Thyroid Panel
- Mid-stream Urine
- Tuberculosis Skin Test as recommended
- Mammograms for female over 40 (forty) years old
- Digital Rectal Exam
- Investigations
  - Peak Flow test
  - Stress ECG Test
  - Hs C-Reactive Protein
- Imaging – chest x-ray
- Pap Smear for female from 21 (twenty-one) years old
- PSA Test for male from 40 (forty) years old
- Bone Density Test for Insured Person over 50 (fifty) years old (once every 5 (five) years)
- Colonoscopy for Insured Person from 50 (fifty) years old (once every 5 (five) years)
- Whole Abdomen Ultrasound (abdomen & pelvis)

2.3.7.2. Vaccinations

Provided the Insured Person's Insurance Plan includes this benefit, We will pay up to the limit(s) shown for vaccinations (including travel vaccinations such as Tetanus, Hepatitis A, B, Meningitis, Rabies, Cholera, Yellow fever, Japanese encephalitis, Polio Booster, Typhoid, Malaria – tablet form, daily or weekly) and immunizations. This benefit will be made available to any Insured Person from the age of 10 (ten) years old.

2.3.8. Options to Core Benefits

2.3.8.1. Dental Treatment

Provided the Insured Person's Insurance Plan includes this benefit, We will pay up to the limit(s) shown for listed dental services following a Waiting Period after each Insured Person joins this Plan. The charges for certain Treatments are subject to a Co-pay as indicated below.

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Dental covered expenses include:

a. Preventive (6 (six) months waiting period)

- Check-up
- X-ray
- Scale and polish
- Mouth guard

b. Routine and restorative (6 (six) months waiting period) are subject to 20% Co-pay

- Fillings
- Root canal treatment
- Crowns/Bridges
- Implant
- Anaesthesia

c. Orthodontic treatment (2 (two) years waiting period) is subject to 50% Co-pay and up to the age of 18 years old and includes:

- Dental braces
- Retainer

2.3.8.2. Optical (Available when selected with Dental Treatment option)

Provided the Insured Person's Insurance Plan includes this benefit, We will pay up to the limit(s) shown for the cost of one (1) annual vision or eye test and prescription glasses/contact lenses following a 6 months Waiting Period after each Insured Person joins this Plan. Glasses/contact lenses must be prescribed by an ophthalmologist. Sunglasses are not covered.

3. GENERAL CONDITIONS

3.1. INSURANCE CONTRACT

The insurance contract is governed by the policy conditions, the form of analysing the customer's needs (DNT), product information document (PID), the Application form, the offer, the Insurance /membership certificate and the annexes, the declarative/additional documents (if any), the correspondence between the Insurer and the Policyholder, and other documents requested by the Insurer, including but not limited to data about the Insured Person's state of health, the occupation and hobbies.

The insurance contract is concluded between Us (Inter Partner Assistance S.A.) and the Policyholder, the Policyholder has the obligation of informing the Insured Persons about the terms and conditions of the Policy. The insurance contract is concluded nominal, for all eligible Insured Persons and/or group members updating the personnel lists and including the new members in the Policy or group, with respect to the legal coverage and is valid only for the nominated persons.

3.2. FORM AND PROOF OF CONTRACT

The insurance contract and documents must be concluded in writing. If the insurance documents have disappeared due to force majeure or fortuity case and there is no possibility to obtain a duplicate, the existence and content of the insurance documents can be proven with any means of evidence.

The provisions of the above paragraph apply to all modifications of the insurance contract.

The conclusion of the insurance contract is established through the policy wording, Insurance/membership certificate, and the annexes, the declarative/additional documents (if any) issued by MediHelp in Our name (the "Insurer", Inter Partner Assistance S.A.), and through the payment of insurance premium.

The documents that attest the conclusion of an insurance can be signed and certified by electronic means.

3.3. THE OBJECT OF INSURANCE

MediHelp International Plans are Insurance Plans which offers cover for the benefits presented in the Table of Benefits according to the option selected by the Policyholder when applied for the cover.

MediHelp International Plans are not savings or capitalization plans; therefore, it does not serve as a compensation plan and cannot be transformed into an insurance with limited amount.

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3.4. ELIGIBILITY CONDITIONS

The MediHelp International Plans are designed for individuals and groups/ companies.

Any person who wishes to be covered by the Policy is potentially eligible subject to Us receiving the relevant Application and provided they are aged under 70 at their date of Application.

The cover is annual and will continue until We receive a termination request, from the contacting party, You (for individuals) or Your employer (if on a company paid scheme). When the insurance starts, the Policyholder has the obligation to send Us the list with eligible members with details like first name and surname of the insured, personal identification numbers (PIN), employment starting date, date of joining the group.

We are entitled to refuse or accept an application submitted by You or by any of Your Dependents and reserve the right to ask for evidence of age, state of health (including medical records) and employment status at any time.

All individual aged below 70 are eligible for this Insurance Plan if they have a proof or residence in Romania. The individual must ensure he complies with any local Insurance regulatory requirements and is insured under the correct Area of coverage. If the Insured Person resides or travels to any country that is not within the Area of coverage, his Plan may provide him with limited coverage for emergency In-Patient, please refer to section 2.3.2 Cover Outside Area of Coverage, for the benefit explanation.

The Insured Persons, as well as their Dependents when relevant, acquire the status of Insured Persons as soon as they are enrolled in Insurance, subject to premium payment.

Adding Dependents:

The Main Member may apply to include his eligible Dependents at any time during the Period of Insurance subject to the payment of the required premium and agreed eligibility requirements.

If the underwriting terms is based on FMU or CPME, the Policyholder must complete and send Us an individual application and health declaration statement where applicable. For group insurance, individual application and health declaration statement where applicable must be completed by the Employee. The Policyholder or Employer must inform Us of all relevant and material facts. With Our agreement, We will inform when cover begins and will not backdate any cover. The Dependents cover will match the cover provided to the existing individuals or members.

- Addition of a Spouse/ civil partner is possible, provided that the application for these Dependents is made within 30 (thirty) days following the date of marriage/legal partnership.
- A newborn child may be added to his contract from the date of birth provided that the Insurer receives a request of adding the newborn child within 30 (thirty) days of his date of birth. After this period, the Insurer will add the newborn child from the date We receive written notification and not from their date of birth of a newborn. This is provided that:

    a. the newborn's parent has been covered under the Policy prior to the date of birth of the newborn; and
    b. the newborn infant was not born following assisted reproduction or conception, fertility Treatment by either parents, adopted or was carried by a surrogate; and
    c. the newborn infant has been fully discharged from the Hospital,
    d. the newborn is not a premature baby (i.e. where birth is prior to 37 (thirty-seven) weeks gestation).

A child not meeting the criteria mentioned above can be added by submitting the Application form, health declaration statement. We may add or decline to provide cover or may offer cover at terms We require.

3.5. COOLING OFF PERIOD

If, when reading the Policy, the Policyholder decides that it does not meet his/her requirements, he should notify Us within 30 (thirty) days of the start/renewal date. On condition that no claims had been made and accept that he cannot make one later, We will refund any premium paid by the Policyholder. The contract between the Policyholder and Us will be nullified, which means it will be treated as if it had never existed.

3.6. OBLIGATIONS OF THE INSURED PERSON

3.6.1. The Insured Person commits to provide the Insurer, through MediHelp International, with the following documents:

a. When applying for membership, an individual Application form and health declaration statement signed by the Insured Person and stating the Insurance Plan, Deductible and payment premium options selected.
b. The Insured Person agrees to justify the statement(s) given to the Insurer at any time.

In the event of omission or misstatement by the Insured Person/Policyholder, the Insurer is entitled either to declare the contract null and void, or to continue applying it under new conditions which the Insurer shall set, or the Insurer may do one or more of the following:

a. Refuse to pay any Claims;
b. Recover from the Insured Person and/or his Dependents any loss caused by the break of obligations; or
c. Refuse to renew the Policy.

The Insurance cover shall enter into force once the agreed premium is paid and received by the Insurer.

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The Insurer, through MediHelp International, commits to give to each Insured Person at the time of enrolment these General Terms and Conditions and inform the Insured Person/Policyholder in writing of the modifications to be made, when appropriate, to their rights and obligations, in particular before any reduction in coverage, any change in the amount of premium or termination of the contract.

The Insured Person shall be liable in case of non-compliance with these obligations.

3.6.2. For Group Plan, the Employer and/or the Employee/Insured Person's obligations are:

a. The Policyholder shall designate a person (the 'group secretary' or 'administrator') to administer this Insurance Policy in accordance with its terms, and any guidance issued by the Insurer from time to time. The group secretary shall also notify the Insurer in writing of any change in the person designated. The group secretary should advise all Employees as soon as practicable, if for any reason this Insurance Policy is terminated or should not be renewed, or this Insurance Policy should be terminated in accordance with the provisions of Section 3.16 Termination or Suspension of Coverage so that such Employees are made aware that all cover has ceased and that benefits will not be payable for Treatment costs incurred after the Termination Date.
b. The Policyholder and/or the Employee/Insured member are responsible for ensuring that all data and information given to the Insurer is sufficiently true, accurate and complete.
c. The Policyholder and/or the Employee/Insured member shall inform the Insurer in writing of any change in the address or contact details or other personal details.
d. The Policyholder and/or the Employee/Insured member must inform the Insurer of any change in the country where the Employee/Insured member or Dependents normally live.
e. The Policyholder and/or the Employee/Insured member shall remain responsible for his obligations under this Insurance Policy, even if the Policyholder and the Employee/Insured member may have delegated all or any part of those obligations to an intermediary or agent who shall be deemed to be the agent of the Policyholder and the Employee/Insured member.
f. The Policyholder and the Employee/Insured member indemnify the Insurer from and against any costs, losses and expenses incurred by the Insurer resulting from the failure of the Policyholder and/or the Employee/Insured member, for any reason to discharge his obligations under this Insurance Policy.

3.7. ALTERATIONS

We may change the premium rates, benefits and terms and conditions of the Policy but any such changes will not apply until the Renewal date following the introduction of such changes. Any premium review is due to international factors, such as the rising cost of medical treatment, as well as personal ones given by the changing of Your age band and for Groups when there are changes in the number of Employees to be included which shall affect membership.

The conditions of this contract take into account the legislative and regulatory provisions in force on the contract's Renewal date. However, if these ones are amended during the contract period, the Insurer reserves the possibility to revise the contract, at the earliest from the effective date of the new provisions.

3.8. SUBROGATION

We shall take the appropriate action and may exercise the rights of Subrogation. This means that if You have suffered from an Injury or loss that has resulted in a Claim under the Policy, We may take over Your right to seek compensation from the party that caused the Injury or loss. The Insured Person shall provide assistance to the Insurer in pursuing the claim for damages against the individuals responsible for the loss, by providing the necessary information and documents, and by facilitating the steps necessary to pursue the recourse for these claims.

3.9. INFORMATION – COMPLAINT – MEDIATION

We aim to provide a first-class service at all times. However, if an Insured person has any complaint regarding the standard of service received under this Policy, the following procedure is available to resolve the situation:

In the first instance the Insured person should write to MediHelp International at:

24, Dr. Ctin Caracas Str., 011155 Bucharest, Romania;
Telephone: (**+40) 311 097 046**;
e-mail: **client@medihelp.ro**.

If We cannot give You a final decision within 4 (four) weeks from the date We receive Your complaint, We will explain why, and tell You when We hope to reach a decision.

Our decision is final and based on the evidence presented. If You feel that there is any new evidence or information that may change Our decision You have the right to make an appeal.

Should the Insured person remain dissatisfied or fail to receive a final answer within 4 (four) weeks of Us receiving Your complaint, You can refer the matter directly to:

Inter Partner Assistance S.A. Avenue Louise 166, 1050, Brussels, Belgium or
email to AXA Assistance: **e-mail: ochranaudaju@axa-assistance.cz**

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3.10. DATA PROTECTION

The Insured person has all rights covered by the legislation in force concerning the protection of individuals with regard to the processing of personal data and the free movement of such data, and from 25 May 2018, Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of individuals with regard to the processing of personal data and on the free movement of such data as it is necessary for the management of the Insurance contract by the Insurer, its appointed Third Party Administrators (TPAs), its service providers, its subcontractors or its reinsurers. The data processing is intended to issue, manage and execute Insurance contracts; the development of statistics and actuarial studies; the recourses, management of Claims and litigation; the implementation of the legal and regulatory provisions in force; the fight against money laundering, financing of terrorism and against fraud; operations related to customer management and business development. The recipients of these data are the duly authorized staff of the Insurer, its appointed Third-Party Administrators (TPAs), its service providers, its subcontractors or its respective reinsurers, social organizations or Insurance intermediaries.

The Insurer, reinsurer and MediHelp International undertake to take every relevant precaution to preserve the security of information and particularly to prevent it being unlawfully accessed, alterated, damaged or communicated to unauthorized persons.

These personal data may be transferred to service providers or subcontractors established in countries outside the European Union. These transfers may only concern countries recognized by the European Commission as having an adequate level of protection for personal data, or recipients with appropriate safeguards. These data will be kept throughout the duration of the contract, until the expiry of both the Limitation periods and the deadlines provided by the storage obligations.

The Insured Person has a right of access, rectification and erasure of his or her personal data. When consent is necessary for processing, he or she has the right to withdraw it. Under regulatory conditions, the Insured Person has the right to request the limitation of data processing or to oppose it.

The Insured Person also has the right to provide guidelines regarding the processing of personal data after his/her death. Any request for the exercise of his/her rights may be addressed to the Data Protection Officers via different means according to preferences, e.g. by email: **dpo@medihelp.ro**.

3.11. REGULATORY INFORMATION AND GOVERNING LAW

Your MediHelp International Plans are International Private Medical Insurance Plans underwritten by Inter Partner Assistance S.A., member of AXA Group, with its registered seat at Avenue Louise 166, 1050, Brussels, Belgium represented on the basis of a power of attorney by the company AXA ASSISTANCE CZ, s.r.o. (Limited Liability Company), with its registered seat at Hvězdova 1689/2a, 140 00, Prague, Identification Number (IČO): 25695215, registered with the Commercial Register maintained by the Municipal Court in Prague under File Reference C 61910.

The Policy has been issued in accordance with and is governed by the Romanian legislation, included but not limited by the provisions of the Civil Code, by the relevant laws regarding Insurances and Reinsurances, by the foreign exchange Regulation, and the specific regulations mentioned in the present Insurance Conditions.

Any dispute arising out of or in connection with the insurance contract shall be settled by the courts of Romania from Inter Partner Assistance headquarters.

All expenses, taxes related to this insurance are paid in accordance with the legal provisions.

The provisions of these General Terms and Conditions are complemented by the legal provisions in the field, including the fiscal legislation (the Fiscal Code and any normative act adopted in its application).

Fiscal deductions: accordingly, with the fiscal legislation, the health private insurance is fiscal deductible on a limit of 400 €/person /year both for the employer as well as for the employee. The present fiscal specifications are valid under the reserve of fiscal code modifications (the Fiscal Code and any normative act adopted in its application).

Insurer is headquartered under Belgian law and is regulated by the National Bank of Belgium. Therefore requirements regarding the Guarantee Fund as defined by the legislation on insurance and reinsurance in force in Romania are not applicable. Protective measures towards Policyholders, Insured Persons and third parties in case of insolvency of the Insurer derive from Belgian law and regulations.

If there are changes to Your Principal Country of Residence, it may not be possible for Us to continue legally to meet Our obligations under Your Policy. In these circumstances, We may cancel Your Policy from the date that You change Your Principal Country of Residence (where You normally live) or on a specified date as agreed between Us and You shall have a right to a prorata refund of the premium for any unused portion of Your Policy.

3.12. SANCTION LIMITATION AND EXCLUSION CLAUSE

The Insurer shall not be deemed to provide cover and shall not be liable to pay any Claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such Claim or provision of such benefit would expose that Insurer to any sanction, prohibition or restriction under United Nations resolutions, or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom, United States of America or any other applicable law or regulation.

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If You or a family member are directly or indirectly subject to economic sanctions, including sanctions against the country where You normally live, We reserve the right to do any of the following:

- immediately end cover (even if You have permission from a relevant authority to continue cover or pay premiums)
- stop paying Claims on Your Policy (even if You have permission from a relevant authority to continue cover or pay premiums)
- cancel Your Policy or remove a family member immediately without notice.

We will inform You if We do any of these.

If You know that You or a family member (or Employees, when this is a group Plan) are on a sanctions list, or subject to similar restrictions, You must let Us know within 7 (seven) days of finding this out.

3.13. OTHER INSURANCE

If there is any other private Insurance covering any of the benefits that are provided under the Policy for which a Claim is made, then the Insured Person, Policyholder must disclose this to the Insurer at the time of submitting the Claim. In these circumstances, the Insurer will not be liable to pay or contribute more than its proper rateable proportion.

If it transpires that the Insured Person, Policyholder has been paid for all or some of the Claim costs by another source or Insurance, the Insurer has the right to a refund of any settlement paid. The Insurer reserves the right to deduct such a refund from the Insured Person's impending or future Claim settlements or to cancel his/her Policy from the inception date without a refund of premium.

Furthermore, if there is a reimbursement from a mandatory social security scheme, the Insurer will reimburse in addition to a mandatory social security scheme based on invoices and according to the Insurance Plan.

3.14. EFFECTIVE DATE OF COVERAGE

Your cover under the MediHelp International Plan starts after You confirm Your first payment on the date shown on the Insurance /membership certificate. The policy is renewed annually (usually after 12 (twelve) months (one Insurance contract year) unless otherwise agreed between Us and You (for individuals) or Your Employer (for groups).

Once the contract has come into effect, the coverage becomes effective for each individual who acquires the status of Insured Person on the following dates:

- Individual Person enrolled on the effective date of the individual Policy.
- Individual Person enrolled after the effective date of the individual Policy on the date the premium is paid, date shown on the Insurance /membership certificate.

The coverage for Dependents, as defined in Section 2, shall take effect at the same time as the coverage for the Main Member or as soon as the persons concerned meet the requirements of cover.

For the Group Plan, the enrolment is effective only when the Policyholder provides the Insurer with the nominative list of members and the staff categories to be covered, stating the Employees and the Dependents that should be covered. The Insurer has the right to refuse to enrol or provide cover, when the criteria set forth in the General Terms and Conditions are not met, or as the result of an underwriting decision. The Insurer may also require any other information that might be considered as necessary and is provided before the enrolment takes effect.

Cover is effective for each member of the covered category on the date the Insurer has received the nominative list mentioned above. Cover is effective for the Dependents on the same date as the Employee, or when they meet the requirements for cover whichever is the latest.

This Policy is issued on the basis that all Employees of the Policyholder are nominated and sponsored by the Policyholder and eligible for coverage under this Policy at the time they are enrolled into the Insurance Policy. The Insurer reserves the right to cancel or modify the terms of this Policy should We find that any Employee was not Actively at work at the time he was enrolled for benefits. Cover for the eligible Dependents must be Insured on the same Plan as the Employee, subject to the agreed eligibility requirements.

If an Employee is not Actively at work on the date he or she would otherwise be eligible for enrolment, then the enrolment date shall be deferred to the first working date of his/her active employment with the Policyholder. If a Dependent is incapacitated or confined to a Hospital on the date that he or she is eligible for cover under the General Terms and Conditions, the enrolment date shall be deferred to the date the Dependent has recovered and discharged from Hospital.

When a new person wants to enrol, when he is eligible or when the Insured Person is removed from the cover, when he is no longer eligible, You must write to Us within 30 (thirty) days, from the Eligibility date of that new person to apply for his/her cover or from when he/she is no longer considered as Employee or Dependent. If the application is approved for the new person, We will then update the list of Insured Persons and issue an endorsement to the Policy accordingly.

Only the Policyholder and the Insurer have legal rights under this Policy. No clause or term of this Policy will be enforceable by any other person or parties.

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3.15. RENEWAL

The individual or group Policy is renewed annually.

Before the end of each Year, We will contact the Policyholder to inform about the new terms and conditions of the Policy. We will renew the Policy on the new terms unless the Policyholder asks Us to make changes or tells Us they wish to cancel. We will collect Your premium using the same payment method that You used for the previous Year.

Premium rates are not guaranteed and the premium payable at Policy anniversary shall be determined at each Policy anniversary date, based on the attained age of each Insured Person, the premium rates then in effect, and any other factors which may materially affect the risks Insured.

For Group plans: Your Employer must pay the premium when it is due. Any renewal notice We send to You or Your Employer is for Your information only and does not prejudice Your Employer's liability to pay the renewal premium on or before the Policy anniversary date. We will decide the premium amount at the start of each Year and tell You how much it is. Your Employer can pay it in the way Your Employer has agreed with Us. It is hereby agreed and declared that the total premium due must be paid and actually received in full by Us on or before the premium due date.

Under the terms of this Agreement, cover is not available to You if the USA is or becomes Your Principal Country of Residence. If the USA becomes Your Principal Country of Residence You must tell Us. Your cover will automatically terminate from the date on which You take up residence in the USA.

Requirements that may apply in the country where You normally live:

It is Your responsibility to make sure You have cover that meets any requirements made by the country where You normally live.

3.16. TERMINATION OR SUSPENSION OF COVERAGE

Except in the event of a reticence, omission or false declaration, the Insured Person may not be excluded from the Insurance against his/her will if he/she is part of the category of Insured Person under the Insurance Plan.

In any event, cover ceases immediately for each Insured Person at the earliest occurrence of any of the following events:

- in the event of failure to pay the premiums under the terms and conditions. At our discretion, We may reinstate the Policy if the outstanding premiums are paid to Us although We reserve the right to make any variation in the cover provided;
- in the event of a false declaration;
- at the initiative of the Insured Person/Policyholder in the event of annual cancellation of its Policy;
- in the event of the death of the Insured Person;
- in the event of liquidation proceedings in relation to the Insurer;
- on the date the Insured Person reaches the legal age of retirement in the country in which he is employed;
- on the date the Insured Person is no longer employed by the Group/Company/Employer;
- in the event of a change of the Principal Country of Residence, – unless the Insured Person/Policyholder or the Company (Group Plan) requests acceptance of change from the Insurer and the request is approved. This is subject to compliance with local legislation of the Principal Country of Residence;
- the USA becomes the Country of Usual Residence of the Insured;
- by unilateral termination by one of the contracting parties, with prior 20 (twenty) days written notification sent to the other party before termination. The restitution of the insurance premium is made according to the legal provisions and the applicability of the Policy conditions, for the period following the unilateral termination, respectively pro-rata temporize, except for cases where it is provided otherwise;
- upon the withdrawal of the Insurer's authorization by the Corespondent Financial Supervisory Authority;
- if the Policyholder/Insured Person/Dependents' personal identification data is found in the Official Lists of individuals and legal entities suspected of committing financing terrorist acts or on the list with persons with international sanctions. The personal identification data are those provided by the CSA Order (now ASF) no. 24/2008 with subsequent modification (Order 5 /2011) on the implementation of the Norms on preventing and combating money laundering and terrorist financing through the insurance market. The Insurer shall have the right to terminate the Certificate of Insurance unilaterally by means of a registered letter addressed to the Policyholder in the event of such circumstances. The Policy shall cease to be valid at 0:00 am of the calendar day immediately following the date of dispatch of the letter sent by the Insurer informing the Policyholder of the termination of the Policy;
- if the Policyholder/Insured Person/Dependents refuses to give information or documents regarding their identification accordingly with CRS reglementations (Common Reporting Standard) or any other legal valid reglementations;
- immediately following the maximum age allowable under this agreement; or
- in case of force majeure according to the current laws.

The coverage for Dependents as defined in Section 2 is terminated (or suspended) at the same time as the Main Member's or Group Member's (Employee) coverage.

The termination of the coverage results in the cancellation of entitlement to benefits for all medical care provided after the termination date, even if they have started or have been prescribed before this date for both the Insured Person (or Employee: under Group Plan) and his/her Dependents.

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4. EXCLUSIONS

4.1. EXCLUDED RISKS AND BENEFITS

The Insurer shall not pay any benefit to any Insured Person which arises or is caused by or associated with directly or indirectly by any one of the following:

1. Any expense, Treatment, medical or dental condition or procedure not specifically stated in this Policy as being Insured;
2. Sums in excess of the Policy Limits;
3. Any sum in excess of € 500 where We were not notified in advance;
4. Costs which would have been incurred if the Insured Event had not occurred;
5. The Deductible or Co-pay specified on the Insurance /membership certificate;
6. Any Claim involving fraud, misrepresentation or concealment or their consequences;
7. Any Claim arising from:
    a. self-inflicted Injury (including suicide or attempted suicide) as a result of wilful acts or gross negligence;
    b. needless self-exposure to peril (except in an attempt to save human life) as a result of wilful acts or gross negligence;
    c. travel undertaken against medical advice
8. Investigations into, and Treatment of loss of hair and any hair replacement unless the loss of hair is due to Cancer Treatment;
9. External Prosthesis and appliances, physical aids, devices unless specified in Your Insurance Plan;
10. Costs relating to Palliative Treatment unless specified in Your Insurance Plan;
11. Treatment for drug and substance abuse (including alcohol) or dependency or other addictive condition and any condition arising therefrom;
12. Contraception, sterilisation (or its reversal), fertilisation, vasectomy, venereal disease, sexually transmitted infections, gender reassignment such as any surgical procedure, counselling and psychotherapy, sexual therapy, or any other form of sexual related conditions or dysfunction; Investigations and/or Treatment for infertility or form of assisted reproduction and any subsequent complications;
13. Any Treatment undertaken solely in order to relieve Symptoms commonly associated with any bodily change arising from any physiological or natural cause such as ageing, menopause or puberty and which is not due to any underlying disease, Illness or Injury;
14. Travel outside the Area of coverage specified on the Insurance /membership certificate for more than the number of days shown in the Table of Benefits in any Period of Insurance;
15. Claims arising from birth injuries or defects, Congenital and Hereditary conditions more than 90 (ninety) days following birth according to the chosen Insurance Plan; or Hereditary or Congenital conditions in the case of children resulting from any fertility Treatment or from any method of assisted reproduction or conception or if adopted or through surrogacy;
16. Artificial heart implantation;
17. Any costs arising after expiry of the current period of Insurance, unless this Policy has been renewed for a subsequent 12 (twelve) months;
18. Costs in excess of € 50,000 (fifty thousand euro) for the lifetime of each Insured Person for care or medical Treatment which arises from human immunodeficiency virus Illness, including acquired immune deficiency syndrome (AIDS) or Aids related complex (ARC) and any similar infections, Illnesses, injuries or medical conditions arising from these conditions, however caused;
19. Drugs and other medicines purchased without a Medical Practitioner/Physician's prescription; genetic testing when those tests are undertaken to establish whether or not You may be genetically disposed to the development of a condition or when You have no Symptoms; routine or preventive medicines, vaccinations and check-ups unless included in the chosen Insurance Plan;
20. Cosmetic surgery or remedial surgery unless required as a direct result of an Accident or surgery for Cancer which occurs during the Period of Insurance and the Insured Person has been continuously covered under the Insurance Plan before the accident or surgery happened. Please note in the case of breast reconstructive surgery following medically necessary mastectomy, We will pay for the initial reconstruction only;
21. Removal of fat or other surplus body tissue and any consequences of such medical Treatment, weight loss or weight problems/ eating disorders, whether or not for psychological purposes;
22. Surgery to correct short or long sightedness or any other eye defect, unless caused as a result of an insured Accident or Illness when occurring during the Period of Insurance; Treatment to correct astigmatism is covered, if the astigmatism is due to the surgical replacement of the lenses of the eye arising from an Insured event. This exclusion will not apply to vision defects arising from keratoconus;
23. Investigations into or Treatment of sleep apnoea, snoring, or other sleep-related breathing problems;
24. Medical Treatment performed by a Medical Practitioner, Physician or consultant/complementary therapist who is related to the Insured Person, unless previously approved by Us. By related, We mean the Insured Person's immediate family member, business associates, business partners, employer or his employee;
25. Medical Treatment associated with cryopreservation, harvesting stem cells, sperm, ovum or umbilical cord for future use; implantation or reimplantation of living cells or living tissue whether autologous or provided by a donor, other than for Tissue Transplants as defined, and not exceeding the Policy limits;

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26. Claims arising as a result of the Insured Person's participation in professional sports (which is as a result of training or taking part in any sport for which the Insured Person is paid or receives grant or sponsorship other than travel costs or if he is competing for prize money) or any hazardous/extreme sport or activity, i.e. such as: motor sports, aerial sports, scuba diving below 30 meters or where a padi certificate is not held, any activity involving animals, speed competition, free climbing or mountaineering (with or without ropes) trekking above 2,500 meters, bungee jumping, parachuting, base jumping, cliff diving, skiing off-piste and racing of any form (other than on foot). If a hazardous sport or activity is not specified in this list, the Insured Person must contact Us to ascertain if it is acceptable for Insurance before cover will apply;
27. Any Claim arising when the Insured Person is under military authority or is engaged in activities involving the use of firearms or physical combat or in an area of military conflict, except in connection with tourist trips made on a private basis during leave;
28. Any expenses relating to search and rescue operations to find an Insured Person in mountains, at sea, in the desert, in the jungle and similar remote locations including air/sea rescue charges for evacuation to shore from a vessel or from the sea;
29. Accommodation and Treatment costs in a nursing home, hydro, spa, nature clinic, health farm or the alike or a Hospital where the establishment concerned has, effectively, become the Insured Person's Home or permanent residence and/or the admission is arranged wholly or partly for domestic reasons or for the convenience of the Insured Person;
30. Rehabilitation unless it forms an integral part of medical Treatment received as an In-Patient and is under the control or medical supervision of a Specialist and is undertaken in a recognised Rehabilitation unit;
31. Medical assessment, grading or Treatment for neurological development, cognitive development, learning difficulties, speech delays, educational problems, development milestones, physical development, psychological development, hyperactivity, attention deficit disorder, autism, dyslexia, behavioural problems or child development;
32. Medical Treatment for mental or nervous disorders, Psychiatric Treatment and the costs of a psychotherapist, psychologist, family therapist or behaviour counsellor if not included on Your chosen Insurance Plan and as shown on Your Insurance /membership certificate;
33. Any Claim in any way caused or contributed to by the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent;
34. Any Claim whatsoever resulting from war, invasion, act of foreign enemy, hostilities (whether war be declared or not), Act of terrorism, civil war, rebellion, revolution, insurrection, military or usurped power or taking part in civil commotion or riot of any kind. Exception: We will pay for each Insured Person per Insured Event provided that the Insured Person is an innocent bystander, and has not been an active participant, and has not acted recklessly or put themselves in danger by entering a known area of conflict; (For the purpose of this exclusion, an act of terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious, ideological or similar purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear).
35. Any expense which at the time of happening is covered by, or would be covered by any other existing private Insurance Policy. If there is any other cover in force which may pay in respect of the event for which the Insured Person is claiming, the Insured Person must tell Us at the time he first contacts Us;
36. Any losses which are not covered by the terms and conditions of this Policy (examples of losses: We will not pay for loss of earnings due to being unable to work as a result of Illness or Injury);
37. Specific exclusion to Section 2.3.5.3. – Transplant Services (Organ and Tissue Transplant). The costs associated with locating a replacement Organ or Tissue (as defined) or any costs incurred for the removal of the Organ or Tissue from the donor, transportation costs of the Organ or Tissue and all associated administration costs, all costs associated with Organ or Tissue not specified within the meaning of words of Organ Transplant or Tissue Transplant benefit.
38. Pregnancy or maternity benefits if not included on Your chosen Insurance Plan and as shown on Your Insurance /membership certificate; Specific exclusions to Section 2.3.5.5 – Routine Maternity care:

    - Terminations of pregnancy, other than miscarriage, ectopic pregnancy and stillbirth;
    - Ante-natal classes, mid-wifery costs when not directly associated with the delivery;
    - Complications which may arise during or as a result of a planned Home birth delivery;
    - The transfer of a pregnant woman to Hospital to give routine childbirth, unless it is Medically Necessary and due to medical complications;
    - Costs of Treatment that has not taken place (e.g. as part of package Treatment).

39. Specific exclusion applying to Section 2.3.6.3. – International Emergency Medical Evacuation:

    - Any subsequent transfer costs arising out of the same Insured Event once We have returned the Insured Person to their place of Residence;

40. Artificial life maintenance for more than 60 (sixty) continuous days if the Insured Person is in a persistent vegetative state and only kept alive by medical intervention such as mechanical ventilation;
41. Pre-Existing Conditions and any related, associated or consequential medical conditions which were not disclosed to the Insurer before the Period of Insurance and which We have not agreed in writing to cover under this Policy. This exclusion applies only to FMU or CPME policies.
42. Treatment or drugs which have not be established as being effective, or which are Experimental and any off-label drugs or pioneering medical or surgical techniques and/or medical devices not approved by the relevant authorities, governmental medical regulatory boards. The drugs must be licensed for use by the European Medicines Agency (EMA) or the US Food and Drug Administration (FDA) if the Treatment is outside Europe and must be used within the terms of that licence.
43. Any medical report fees, administration fees charged by the medical provider or Medical Practitioner or any charges not directly related to medical necessary Treatment such as but not limited to completion or providing of claim forms.
44. Robotic surgery except for prostatectomy, partial nephrectomy and pyeloplasty using the da vinci robot.

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5. CLAIMS HANDLING AND ADMINISTRATION

5.1. PLAN ADMINISTRATOR

The Insurer has appointed MediHelp Customer Care SRL to act as the provider of certain third-party administration services in Europe including management of Pre-authorisation of Claims and their administration in relation in to certain international health Insurance plans designed by MediHelp International and underwritten by the Insurer.

5.2. GENERAL PROCESSES

For Claims enquiries, Policy questions, Pre-authorisation, *evacuation and repatriation requests,

call: **(+40) 311 097 046** or email: **client@medihelp.ro** from Monday – Friday 9.00^{AM} – 5.30^{PM}.

Outside of MediHelp working hours, the following number should only be used in case of emergencies, evacuation and repatriation requests: **(+40) 31 730 99 39**.

* Refer to Section 2.3.6. – Assistance for details on the services available.

5.3. CLAIMS PROCEDURES

You shall be reimbursed for all eligible, Reasonable and Customary medical costs related to the Benefits Plan. For reimbursement of Your medical expenses, You must send Us the following documents:

- All related documents issued by Your treating doctor – medical report or referral letter;
- Detailed invoice for the medical services;
- Receipt of payment;
- Fully completed Claim Form.

The validity of a Claim is up to 6 (six) months from the date of the medical service.
We work with international translators, so it is not mandatory that the Claims are submitted in English.

Any copies, photocopies or duplicates of invoices for any Out-Patient Treatment above € 500 (five hundred euro) per invoice will be accepted. You must retain the originals of these invoices for up to 24 (twenty-four) months from the date of Treatment as during this period, We may ask to receive them.

We may need You to ask for extra information to help Us process Your Claim, for example: medical reports or other information about Your condition. If this is the case, there will be a delay before We are able to make any Claim payment and they must be provided within 30 (thirty) days. Otherwise, the Claim will be automatically rejected until the details are provided.

We will pay for:

- Treatment and conditions included on Your Insurance Plan while You are covered by Your membership
- costs as described in Your 'Table of benefits' as applicable on the date(s) of Your Treatment
- Treatment which is clinically appropriate and suitable for You
- active Treatment of a disease, Illness or Injury that leads to Your recovery, conservation of Your condition or to restore You to Your previous state of health
- costs for Treatment which You have received, but not deposits or advance payments for Treatment to be received in the future, or registration/administration fees charged by the provider of Treatment
- Reasonable and Customary costs. This means that the costs charged by Your Treatment provider should not be more than they would normally charge, and be representative of charges by other Treatment providers in the same area**
- Treatment and conditions included on Your Insurance Plan while You are covered by Your membership after deducting any Deductible or Co-pay for each claim. For Plans with Deductible, the Insured Person is responsible for the Deductible before We will begin to pay any benefit under the Policy. If the Insured Person's eligible claim is less than the Deductible, the Insured Person should still submit the claim to Us, so We can count the benefits due towards each Insured Person's Deductible limit. Once benefits due exceed the chosen Deductible, benefit payments will begin.

In cases where published Insurance industry standard guidelines exist, the Insurer may refer to these industry standard guidelines when assessing and paying Claims. Charges in excess of Insurance Industry published standard guidelines or in excess of Reasonable and Customary costs may not be paid.

We will not pay for Treatment which in Our reasonable opinion is inappropriate based on established clinical and medical practice, and We are entitled to conduct a review of Your Treatment, when it is reasonable for Us to do so.

**Guidelines for fees and medical practice (including established Treatment plans, which outline the most appropriate course of care for a specific condition, operation or procedure) may be published by a government or official medical body

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5.4. PRE-AUTHORISATION AND PAYMENT CARDS

The Insured Person must bear in mind that We must be contacted at least:

- 48 (forty-eight) hours for Out-Patient Treatment,
- 5 (five) days for In-Patient planned Treatment,

for Our Pre-authorisation, before the Insured Person incurs costs for Treatment of any kind which are likely to exceed € 500 (five hundred €) on completion of Treatment, otherwise, We, may not pay the Claim. This sum includes In-Patient, Day-Patient and Out-Patient Treatment, as well as transportation and ancillary costs. For Us to be able to verify eligibility of Your Pre-authorisation request, We will always ask You to advise Us of: onset date and Symptoms, estimated cost, chosen provider, medical service required and speciality and other information that We may be require.

To view a list of providers with whom direct billing can be arranged for hospitalisations, go to:
https://axaglobalhealthcare.com/find-MDH

It is important to note that if We Pre-authorise Treatment which ultimately transpires to have been related to a condition excluded by the Policy, for example, Treatment for an undeclared and unaccepted Pre-existing Condition, the Insured Person will be responsible for all costs, including those settled by Us. In such cases, the Insured Person must repay Us all costs We have paid.

Important note: The Insured Person must make no admission of liability, offer, promise or payment without Our prior consent.

For Emergencies

In case of an Emergency, if the Insured Person is physically prevented from contacting Us immediately, the Insured Person or someone designated by him/her must contact Us on his/her behalf at the soonest practical moment. Alternatively, please ensure that the Hospital is aware of the Insured Person's insurance cover with Us. We will then engage with Hospital's insurance liaison department to enable billing to be taken care of directly. In such cases, it is not uncommon for Hospital to take either a cash deposit or a credit card swipe from the Insured Person until a connection between Us and the Hospital has been achieved. If the Treatment scheduled is eligible for cover, We can confirm the level of benefit applicable to the medical provider and authorise the Treatment, subject to the terms and conditions of the Policy. This is subject to the provider's acceptance of direct payment.

Outside of MediHelp's working hours, the following number should be used in case of emergencies, evacuation and repatriation requests: **(+40) 31 730 99 39**.

In respect of any other costs, the Insured Person will be required to reimburse to Us, within 1 (one) month of Our request to the Insured Person, any costs or expenses We have paid out on the Insured Person's behalf which are not covered under the Policy.

As often as We require, the Insured Person shall submit to a medical examination at Our expense. In the event of the death of an Insured Person We shall be entitled to have an autopsy carried out at Our expense (where this is not forbidden by local law).

The Insured Person must supply Us with a written statement substantiating their Claim, together with (at his/her own expense) all invoices, certificates, information, evidence and receipts that We require.

Where You receive Treatment as an Out-Patient, and where costs are below € 500 (five hundred €) and do not require Pre-authorisation, the costs must be paid for in full by You at the time of receiving the Treatment. You must then submit a Claim to Us for reimbursement.

Please ensure that a Claim form is fully completed by the Insured Person and the treating Medical Practitioner/Physician when possible. Submit this with the detailed receipts and all other information supporting Your Claim, including but not limited to x-rays, test results, medical reports etc., within 6 (six) months from the Treatment date.

5.4.1. Pre-authorization if the Insured Person has U.S. (United States of America) cover:

- Before any Treatment in the U.S., the Insured Person must contact Us for Pre-authorisation of such Treatment and services. Our adviser will confirm the Insured Person's entitlement to the benefit for the proposed Treatment, help find a suitable Medical Network Provider and arrange direct billing with them.
- If the Insured Person chooses to have his/her Treatment in the U.S. without Our Pre-authorisation, the eligible benefit may not be paid beyond 50% of Reasonable Customary costs after deduction of any Deductible or Co-Pay.
- In the case of serious Accident requiring immediate Emergency In-Patient Treatment You or Your family member must contact Us within 72 (seventy-two) hours of such Accident. The benefit for eligible Treatment is paid at Reasonable and Customary costs..

5.4.2. Payment cards

Payment cards can only be used for the provision of medical services charges up to € 500 (five hundred €) by a registered Medical Practitioner/Physician or medical provider.

The Insured Person will receive from MediHelp a debit card (payment card) at the start date of the Policy which should be activated as soon as this is received. Failure to do so may reduce the possibility to use the card when needed, especially in case of emergencies.

Payment cards allow to pay the costs of the medical services directly to the medical provider of Your choice. The cardholder needs to inform MediHelp by phone **(+40 311 097 046)** or e-mail: **client@medihelp.ro** at least 24 (twenty-four) hours before the medical appointment providing at least the following information: onset date and Symptoms, estimated cost, chosen provider, medical service required and speciality.

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In maximum 48 (forty-eight) hours from the date of receiving Treatment, MediHelp should receive from the customer all relevant documents (e.g. medical report, invoice etc.).

5.5. MEDICAL ASSESMENT

We reserve the right to have the health status of the Insured Person and the medical care provided to him checked and verified by our Medical Advisor. We may request if necessary, all supporting documents, assessments or examinations to assess the benefits.

6. PREMIUMS

6.1. PREMIUM RATES, CALCULATION BASIS AND PAYMENT

You/Your employer have taken out the Policy with Us and are responsible for paying the premiums due under the Policy. If You/Your employer fail to pay those premiums or comply with the terms and conditions of the Policy, We may terminate the Policy and refuse to pay Claims.

The first payment must be made on or before the Date of Entry You wrote on the Application form, which will be the starting date of Your Policy. If the first payment is not made on or before the starting date mentioned on the Application form, the Policy will be automatically cancelled by Us with immediate effect.

The starting date of the Policy must be within maximum 1 (one) month period from the date You signed the Application form. If between this period there are changes in any of the information on the Application form, please contact Us immediately as We will work out Your cover based on the information We receive.

The following installments must be paid on the due dates mentioned on the payment notification:

1. Premiums become due on the date mentioned in the payment notification. If the premium is not paid on the due date, a 30 (thirty) days grace period will apply and Your Policy remains active. If the payment is not made by the end of the grace period, the Policy will be suspended and remains as such for a period of an additional 30 (thirty) days. If the premium remains unpaid, the Policy will be automatically cancelled as of the premium due date. During the suspension period, no Pre-authorisation is made, and this also applies to Treatment that We have already Pre-authorised, and no Claim is paid. Once You have paid Your premiums and Your Policy is reactivated, We will consider Your Claims.

   Once we have cancelled Your Insurance Plan/Policy, You/Your employer will have to reapply for cover and You will have to complete a new Application form, which will be subject to underwriting.

2. The premium can be paid annually, semi-annually, quarterly or monthly according to the Application form. The Policyholder is responsible for paying the premiums. The payments of premiums can be made by bank transfer/ online payment platform in the account specified by Us on the payment notification.

3. The premiums are paid in € = Euro.

Insurance premium shall be calculated upon the assessment of the risk and the amount depends on the chosen Insurance Plan, the ages of the Insured Person, Deductible, and any optional Insurance Plans. The premiums amount, net of taxes, are set out on the Insurance /membership certificate issued to the Insured Person.

The premiums may be revised annually according to the provisions of this Agreement and according to the technical results of the portfolio. However, the revision of the premiums is effective at the Policy Annual Renewal Date

7. DEFINITIONS

The following definitions apply to benefits included in Your Insurance Plan and to some other commonly used terms. The benefits You are covered for are listed in Your Table of Benefits. Wherever the following words/ phrases appear in Your contract documents, they will always be defined as follows:

Accident means a sudden and unforeseen bodily Injury caused by violent or external means.

Acute flare-up means a sudden and unexpected deterioration of a Chronic condition that is not part of the normal progression of a Chronic condition.

Accidental dental treatment means dental treatment necessary as a result of an Accident caused by an extra-oral impact, received within 7 days from the date and time of the accident for the immediate relief of pain caused by natural teeth being lost or damaged.

Annual Renewal Date means the day after the expiry date as shown on the Insurance/Membership certificate.

Ambulance Services means the necessary medical transportation to hospital or between the nearest suitable Hospitals.

Application form means the application filled in and signed on his own responsibility by the Policyholder, and the Main Member, which contains the necessary information and consent for the conclusion of the Insurance policy and the questions and answers must be carefully read before signing.

Area of coverage means one of the following areas: Europe, Europe plus Israel, Worldwide excluding USA (WW excl USA) or Worldwide (WW). Your cover is restricted to the Area of coverage stated on Your Insurance/membership certificate.

Europe: Albania, Andorra, Armenia, Azerbaijan, Austria, Belarus, Belgium, Bosnia Herzegovina, Bulgaria, Channel Islands, Cyprus, Croatia, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Gibraltar, Great Britain, Greece, Greenland, Hungary, Iceland, Ireland, all islands of the Mediterranean, Isle of Man, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Madeira, Malta, Moldova, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Romania, Russia, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Turkey, Ukraine, Vatican State.

USA: continental USA, Alaska, Hawaii, Puerto Rico, Northern Mariana Islands, Guam, American Samoa and the Virgin Islands of the United States.

Cancer means malignant tumour, tissues, or cells, characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Cancer Treatment refers to Medically Necessary Treatment intended to shrink, stabilize or slow the spread of Cancer or related to the diagnosis of Cancer received as an In-Patient, Day-Patient or ambulatory/Out-Patient including but not limited to radiotherapy, chemotherapy or targeted therapy. This benefit covers eligible expenses from the point of diagnosis to pre- and post-hospitalisation, planning, carrying out Cancer Treatment as prescribed by an oncologist which includes tests, scans, imaging, consultations, Prescribed Medicines, monitoring and follow-up at a Hospital or specialist Cancer unit and excludes Treatment that is provided solely to relieve Symptoms. We reserve the right to request the Insured Person to obtain eligible prescribed pharmacy items from the Insurer's designated network pharmacy, if applicable. All treatment and prescribed pharmacy items must be pre-authorized by the Insurer. Once the Medically Necessary Cancer Treatment has completed and the Insured Person is in complete remission, any consultation, medicines, monitoring or follow-ups will be paid under the ambulatory/Out-Patient benefit as long as the member remains an Insured Person under this Policy and on condition that the Insurance Plan includes this benefit.

Claim means Your request for payment of benefits under the Policy concluded on the basis of MediHelp International Plans.

Childbirth at Home means a home childbirth in a non-clinical setting using natural childbirth methods attended by a midwife with expertise in managing home births.

Chronic Condition means a disease, Illness or Injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires Your rehabilitation or for You to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back

Commencement Date means the date on which the Insurance protection becomes effective, as specified on the Insurance / membership certificate, not earlier than the date of payment of insurance premium.

Complications of Pregnancy means the medical conditions related to pregnancy and childbirth and shall cover: Antiphospholipid syndrome, Cervical incompetence, Ectopic pregnancy, Gestational diabetes (if the Insured Person has exclusions because of past medical history related to diabetes, then this will not be covered since this is specifically excluded), Hydatidiform mole – molar pregnancy, Hyperemesis gravidarum, Obstetric cholestasis, Pre-eclampsia / Eclampsia, Rhesus (RH) factor, Miscarriage requiring immediate surgical intervention, Post-partum haemorrhage, Retained placental membrane.

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Congenital and Hereditary conditions means a medical condition, abnormality, deformity, disease, Illness that have been present at birth or inherited or passed down through the generations of Your family or any deformity arising during the antenatal stages of pregnancy or caused during childbirth. Cover for Congenital and Hereditary conditions are limited to In-Patient Treatment/Day-Patient Treatment only and as specified in the Table of Benefits.

Conventional Treatment refers to Treatment that:

- is established as best medical practice and is practised widely; and
- is clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the Treatment is provided; and has either:
- been shown to be effective for Your Insured 's medical condition through substantive peer reviewed clinical evidence in published authoritative medical journals; or
- been approved by NICE (The National Institute for Health and Care Excellence) or the relevant government authorities and/or recognized medical association of the country where the Treatment is sought and as a Treatment which may be used in routine practice.

If the Treatment is a drug, the drug must be:

- licensed for use by the European Medicines Agency or the Medicines and Healthcare products Regulatory Agency or Authority in the locality where Treatment is provided or the Food and Drug Administration (FDA) in the US; and
- used according to that license and dosage for which it is approved for.

Conventional Treatment will also apply to the use of related medical equipment or consumables.

Co-pay means the uninsured percentage of the cost which the Insured Person must pay towards the cost of an eligible Claim. The insurer is responsible for paying the remainder.

Deductible means the annual amount each Insured Person must pay for each Period of Insurance before the Policy will pay certain benefits. Deductible amounts are set out in the Insurance / membership certificate. On the Insurance Plans Cobalt, Admiral and Royal, the Deductible is applied only on In-Patient benefits. On the Insurance Plans, Blue and Azure, the Deductible is applied to all benefits.

Date of Entry means the date on which an Insured Person was included under the chosen Insurance Plan.

Day-Patient means Treatment provided in a Hospital where an Insured Person is admitted but it is not Medically Necessary to stay in the Hospital for one or more nights.

Dependent means as indicated on the Application or Insurance /membership certificate, the Spouse of the Insured Person (or civil partner of the same or opposite sex) who is not legally separated from him/her; and the Insured Person's child, including illegitimate children (step-child, foster child or legally adopted child) aged under 19 (nineteen) on the date when the Insured Person has been granted an Insurance protection on the basis of the MediHelp International Plan for the first time or at any subsequent Renewal of the Policy (or up to 25 (twenty-five) years old if it is evidenced that such child is continuing in full-time education, unmarried, unemployed) and is financially dependent on the Insured Person for support.

Diagnose means the determination by a qualified Medical Practitioner/Physician of which disease or condition explains an Insured person's Symptoms and signs.

Diagnostic Tests means investigations, such as x-rays or blood tests, to find or help to find the cause of Insured Person's Symptom.

Dietician means a practitioner who must be fully trained and legally qualified and permitted to practice by the relevant authorities in the country where the Treatment is received.

Emergency Medical Transfer or Evacuation means the emergency transportation when approved by Our appointed 24-hour Assistance Centre, and medical care during such transportation, to move an Insured Person who suffers a critical medical condition to the nearest suitable Hospital where appropriate care and facilities are available, which may not necessarily be in the Insured Person's Country of Residence.

Emergency Out-Patient Treatment means Treatment Medically Necessary as a result of an Accident or sudden Illness, received in a Casualty/Emergency room within 48 (forty-eight) hours of the Accident and the onset of the Illness, but which does not require admission to Hospital as an In-Patient or Day-Patient.

Emergency Treatment means Treatment that commences within 24 hours of an Illness or Accident happened causing direct threat to health and requiring urgent medical attention.

Experimental refers to Treatment modality or medication whose efficacy and safety are yet to be established and lack the authoritative evidence-based clinical studies. These are also Treatment modalities or medicines which are not generally accepted by the medical community as proven to be effective or recognized by the professional medical organizations as conforming to accepted medical practice. This definition also includes equipment used for purposes other than those defined under their license or which is undergoing study, research, or testing.

General Terms and Conditions refers to this document.

Home means the Insured Person's primary and/or secondary Home(s) within the Country or Countries of Residence as stated on the Application form and shown in the Insurance /membership certificate.

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Hospital means any establishment which is licensed as a medical or surgical Hospital in the country where it operates and where the patient is permanently supervised by a Medical Practitioner/Physician. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.

Hospitalization/Maternity Cash Benefit means a daily cash benefit that is paid by Us, if You have received Treatment in a public Hospital, You have stayed overnight, and You have not received any charges from the Hospital (free of charge).

Illness means any sickness, disease, disorder or alteration in the Insured Person's medical condition marked by a pathological deviation from the normal health state diagnosed by a Physician.

Insurance /membership certificate refers to a document stating conditions of coverage forming part of the Insured Person's Policy, stating the names of the Insured Persons, the Area of coverage, the Period of Insurance, the chosen Plan, any optional extensions selected and any special provisions which apply to the Policy.

Insured Person refers to the Main Member and his/her Dependents (for Group Plan refers to Employees and his/her Dependents, if agreed) as stated on the Insurance /membership certificate, whose health state represents the insurance object and is the basis of the Policy concluded in the frame of MediHelp International Plans for the purpose of obtaining Insurance protection for itself and/ or its Dependents and to whom the benefit of services included in the present insurance contract are provided.

Insurer means the Insurance company that provides the Insurance cover, Inter Partner Assistance S.A.

Immunisations and Boosters means medication required for Immunisations and necessary Boosters which are a regulatory requirement in the Country of Residence or other similar medications.

Injury means physical damage or harm caused to the body as a result of an Accident.

In-Patient means Treatment provided in a Hospital, where an Insured Person is admitted and for medical necessity occupies a bed for one or more nights but not exceeding 12 months in total for any one Insured Event.

Insured Event means an Accident or Illness, pregnancy and childbirth (if applicable) or in case of the selected Insurance Plan and benefits stated in the Agreement occurring during the Period of Insurance, within the Area of cover, which entitles the Insured Person to receive benefits under the Policy concluded in the frame of the MediHelp International Plans; an Insured Event is deemed to include Accident or Illness occurring outside the Area of coverage if for the purposes of Emergency In-Patient Treatment only within the applicable policy scope and limit.

Insurance Plan means level of benefits as detailed on the Insurance /membership certificate.

Limitation Period refers to the period beyond which a party's rights may no longer be invoked.

Main Member means an individual member who We have agreed to cover under the Policy.

Medical Advisor (s) means the Medical Practitioner/Physician/Specialist We choose to advise on Claims under the Policy concluded on the basis of MediHelp International Plan.

Medical Expenses means expenses incurred for Treatment following an Accident or Illness as a result of an Insured Event.

Medically Necessary means the appropriate provision of diagnostics or Treatments to Diagnose, or treat an Illness, Injury, condition, disease in keeping with its signs and Symptoms and that meet accepted standards of medicine for a medically appropriate duration.

Medical Practitioner/Physician means a legally licensed doctor recognized by the law of the country where Treatment covered under the Policy is provided and who, by rendering such Treatment is practicing within the scope of his/her license and training.

MediHelp International Broker de Asigurare SRL means MediHelp with its registered seat in Romania, Bucharest, 24, Dr. Constantin Caracas Str., district 1, 011155.

MediHelp International Plans means the suite or products created by MediHelp International Broker de Asigurare SRL, namely Blue, Azure, Cobalt, Admiral and Royal.

MediHelp Customer Care SRL is the Plan administrator of the Policy.

Mental Health Disorders or Illness means any disorder or illness associated with substantial distress or impairment which impacts the Insured's ability to function in a major life activity, such as employment. These disorders must meet international criteria classification.

Newborn Care means costs of Treatment of a covered medical condition for a new-born baby up to 30 (thirty) days after the date of birth provided that the newborn is added to the Plan within 30 (thirty) days of birth and premium is paid. In circumstances where We require details of the newborn baby's medical history before the baby is added to the Plan, We reserve the right to apply specific restrictions to the cover We will offer. We do not pay for Newborn Care benefits for babies born as a result of Assisted Reproduction Technologies or Conception, born to surrogate or who have been adopted or parent was under fertility treatment as these children can join after 3 (three) months (from the 91st day) after birth, and once We have completed the medical underwriting.

Organ Transplant means medical Treatment incurred in respect of kidney, heart, heart-lung, liver, pancreas transplants, and does NOT include the implantation of an artificial heart. In the circumstances where the Organ Transplant is required because of a Hereditary or Congenital anomaly, the cover shall be limited under the benefit provisions – Congenital and Hereditary conditions, if applicable under the Insured Person's chosen Plan.

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Out-Patient means medical Treatment provided to the Insured Person or recommended by a Physician when it is not Medically Necessary for an Insured Person to be admitted as an In-Patient or Day-Patient in a Hospital or any other medical facility for medical care.

Overall Maximum Limit means the maximum We will pay for all benefits in total, per Insured Person, per contract Year.

Palliative means Treatment where the diagnosed condition of an Insured Person has a prognosis of a terminal Illness and is without cure. The primary purpose of this Treatment is for the relief of symptoms rather than to cure the Illness or Injury causing the symptoms. This benefit requires Pre-authorisation with written acknowledgement from the Physician that the medical condition has reached a terminal stage and can no longer have Treatment which will lead to the Insured Person's recovery. Hospice and Palliative Care includes Hospital, home or hospice accommodation, and nursing care by a qualified nurse and excludes transportation costs, or any supplies or services not covered by this Policy.

Period of Insurance means the period specified on the Insurance /membership certificate for which the appropriate premium has been paid.

Physiotherapy means Treatment recommended by a Physician/ Physiotherapist for medical reasons following an Insured Event and provided by a licensed Physiotherapist.

Physiotherapist means a practitioner who must be fully trained and legally qualified and permitted to practice by the relevant authorities in the country where the Treatment is received.

Policyholder means a natural or moral person or a legal entity having no legal personality who is a party to the Policy concluded for the benefit of Insured Persons as well as a natural person who concluded the Policy to obtain an Insurance protection for itself or for itself and its Dependents. The contracting party concludes the insurance contract with the Insurer and bears the responsibility regarding the payment of the insurance premium.

Policy/Plan means a document confirming the conclusion of insurance contract between the Policyholder and Us. The full terms of Your Policy/Plan are set out in the latest versions of:

- any Application form We ask You to fill in
- Insurance/membership certificate
- this General Terms and Conditions
- electronic membership card.

Policy Limits means the financial limits of Our liabilities towards Insured Persons', for specific benefits applicable per Insured Event, per Year of insurance, or lifetime, indicated in the Table of Benefits. Lifetime refers to maximum aggregate limit for the whole of the Insured Person's membership on the Policy.

Pre-authorisation means the confirmation needed from Us before receiving Treatment for selected benefits. Please note that if You fail to obtain Pre-authorisation for any Treatment above €500 or for the benefits requiring Pre-authorisation before You start Treatment, We reserve the right of not paying these costs because the claim was not pre-authorised.

Pre-existing Condition means any disease, illness or injury that:

- You have received medication, advice or treatment or investigations for in the last 5 (five) years before the start of Your cover, or
- You have experienced Symptoms of in the last 5 (five) years before the start of Your cover, whether or not the condition was diagnosed or investigated.

Premature baby means a baby born before the start of the 37th week of pregnancy.

Prescribed medicines, drugs and dressings refers to medication and dressings whose sale and use is legally restricted subject to the order and prescription of a Medical Practitioner/Physician/Specialist that is used for the Treatment of the disease/illness/injury You are covered for.

Preventive treatment refers to an adult routine examination and includes a review and record of the patient's complete medical history, a check of all body systems and a review and discussion of the exam results with the patient; well-child examinations include a review and record of the child's complete medical history, a check of all body systems in accordance to normal growth and development, and provide immunisation/routine vaccinations up to age of 10.

Principal Country of Residence means the country where the Insured Person lives and has his/her primary and/or secondary Home(s) for at least 6 months per Year, as stated on the Application form and specified on the Insurance /membership certificate.

Prosthesis refers to an artificial substitute or replacement for part of the body including but not limited to artificial heart valves, eyes, joints and limbs needed as part of the surgical procedure or integral to the Treatment of a condition You are covered for. For prosthesis, You needed to be covered by Us before the Accident or Surgery that has led to the need of the prosthesis and all Claims are made within 12 (twelve) months of the amputation or removal of the body part.

Psychiatric Treatment refers to an acute psychiatric, psychological or mental Illness, or any other condition normally treated by a psychiatrist or psychologist following a referral by a general practitioner or Physician. For the purposes of this Policy, an acute mental or psychiatric Illness is a mental, nervous or eating disorder associated with present distress or substantial impairment of the ability to function in a major life activity such as employment. The Illness must be clinically significant and not an expected response to a specific life event such as bereavement, relationship or academic problems or acculturation. For this Policy, an eating disorder is any psychological disorder such as anorexia nervosa or bulimia. In-Patient Psychiatric Treatment must be at a registered psychiatric unit of a medical provider providing evidence-based Treatment of psychiatric Illness with 24-hour medical supervision.

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Rehabilitation means Treatment(s) designed to facilitate recovery from Injury, Illness, or disease (excluding mental Illness or disorders) so as to regain maximum self-sufficiency, form and function in as near normal manner as possible.

Reasonable and Customary (R&C) refers to the Medically Necessary fees or expenses incurred for Treatment, medical care, services and/or supplies which shall be considered by Us or by Our Medical Advisors to be Reasonable and Customary to the extent that they do not exceed the usual level of charges for similar Treatment, medical care, services and/or supplies in the country where these were incurred and includes fees or charges that would not have been incurred if no Insurance had existed.

R&C refers to expenses paid for the Treatment, medical care, services and/or supplies which We or Our medical team considers Reasonable and Customary and which could not have reasonably been avoided without negatively affecting the Insured Person's medical condition. These expenses must not be more that the general level of charges of other medical care providers with similar standing in the locality, for giving like or comparable Treatment, medical care, services and/or supplies to individuals of the same gender, of comparable age, for a similar disease, Illness or Injury.

We normally calculate what is Reasonable and Customary (R&C) based on the average negotiated cost of the Treatment within the network applicable to Your Policy in the country or area in which Treatment is received. Where no network or no negotiated cost exists in a network Hospital, or the Treatment is not available in a network Hospital, We will base that calculation on a combination of Our global experience, substantiated by statistical information from government health departments and information collected from independent medical specialists and surgeons practicing in the country or area where Treatment is received.

For the avoidance of doubt when comparing Treatment, We will also consider the complexity of the procedure, and the standard of the medical facility where the Treatment is received. If Your Treatment requires more than one Specialist or surgeon present at the same operative (surgical) session, We shall review the medical necessity in the management of such surgical problem or medical condition in terms of the different trained skills and complexity of the services provided as an identification to cover the total services. No additional benefits or cost is payable for surgical assistants. In the event of any differences in opinions between Our Medical Advisors or Physicians and Your Physician, Our Medical Advisors opinion shall prevail.

Renewal of the Policy means conclusion of Policy on the basis of MediHelp International Plan for the second and following Period of Insurance as well as granting insurance protection for the second and following Period of Insurance.

Routine newborn care means standard and customary examinations of a newborn required to assess the basic integrity and function of the child's organs and skeletal structures.

Routine Vaccinations mean vaccinations provided up to 10 years of age and may include Diphtheria, Hepatitis A & B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, varicella, Haemophilus Influenza B, Rotavirus, Meningococcus and Pneumococcal Conjugate.

Speech Therapist means a practitioner who must be fully trained and legally qualified and permitted to practise by the relevant authorities in the country where the Treatment is received.

Specialist means a surgeon, anaesthetist or Physician who is legally qualified to practise medicine or surgery following attendance at a recognised medical school, is recognised by the relevant authorities in the country in which the Treatment is received as having specialised qualification in the field of, or expertise in the Treatment of the disease, illness or injury being treated. By 'recognised medical school' We mean a medical school which is listed in the World Directory of Medical Schools, as published from time to time by the World Health Organisation.

Spouse is the person married to the Policyholder or Employee/group member, who is not separated or divorced according to a judgement with the status of res judicata. This is a legally registered union between two people of different or same gender. In this Policy, a civil partner is treated as a Spouse.

Symptom means any manifestation, sensation or change in bodily function, whether physical or psychological, that is declared by the Insured Person or can be found in medical documents prior with 5 (five) years to his Date of Entry in insurance and after the Date of Entry that can be correlated from a medical point of view with a pathological condition or a disease process.

Subrogation means Our right to act as Your substitute to pursue any rights You may have against a third party who is liable for a Claim paid by Us under the Policy.

Table of Benefits means the document attached to and forming part of these General Terms and Conditions, stating inter alia the benefits provided under the respective plans and financial limits for these benefits.

Therapist consultations and Complementary Medicine refers to consultations by an approved, registered osteopath, chiropractor, acupuncturist, homeopath in the Country where the Treatment is received, after referral from a general practitioner or Specialist. This does not include chiropody or podiatry.

Tissue Transplant means medical Treatment incurred in respect of bone marrow, cornea and other tissue/cell transplants approved by our Medical Advisor. In the circumstances where the Tissue Transplant is required because of a Hereditary or Congenital anomaly, the cover shall be limited under the benefit provisions – Congenital and Hereditary conditions, if applicable under the Insured Person's chosen Plan.

Treatment means any dental, surgical or medical services (including diagnostic tests) that are needed to Diagnose, relieve or cure a disease, illness or injury under the direction of a recognised healthcare specialist.

Waiting period means a period of time commencing on the start date of the Policy or the date when an Insured Person is included under the Plan, during which the Insured Person is not entitled for particular benefits.

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We /Us/Our means the Insurer.

Year means the 12 (twelve) months from the Policy start date or last renewal date.

You/ Your means the Insured Person, the Main Member and/or Your Dependents.

Additional Definitions applicable for Group Plans:

Actively at work refers to an Employee who is at work on the Policy commencement Date and performing every duty of his/her present occupation on a customary basis. An Employee shall also be deemed as Actively at work if he is on annual leave and is not absent from work due to Illness, Injury, or other form of disability. If an Employee is not Actively at work on the Policy Commencement Date, he will not be covered.

Eligibility date means the date or period stated in Your Insurance/membership certificate and/or endorsement on which a member becomes eligible for cover under this Policy.

Employee(s) refers to individuals currently employed by the Employer/company (and/or a company group) who are Actively at work on the date they are eligible for cover under this Policy and accepted by the Insurer as members under the plan or any other category of alternative members as set in the current group membership listing (as amended throughout the course of the Year).

Employer means the legal entity that employs the Employee and that is responsible for the payment of premiums under this Policy.

Group Policy anniversary date means the group renewal date when the premiums for the group are reviewed. The first group anniversary date will be twelve (12) months after the start date of the group scheme and at each twelve (12) months period thereafter. For interpreting Your Policy, all references to Policy anniversary will be defined to mean the group anniversary date.

The limits are applied per Insurance Year unless otherwise mentioned in current General Terms and Conditions

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Note: NA means "not available"
Please refer to the policy terms and conditions applying to these benefits.
All benefits shall be subject to the provisions of this policy.
All the limits are subject to the Yearly or Benefit Maximum limit, including those benefits which indicate 'In Full'.
All limits payable are for an eligible Medical Condition and they are subject to 100% Reasonable and Customary Charges.

[1] Pre-authorisation if the Insured Person has U.S. (United States of America) cover:

- Before any Treatment in the U.S., the Insured Person must contact Us for Pre-authorisation of such Treatment and services. Our adviser will confirm the Insured Person's entitlement to the benefit for the proposed Treatment, help find a suitable Medical Network Provider and arrange direct billing with them.
- If the Insured Person chooses to have his/her Treatment in the U.S. without Our Pre-authorisation, the eligible benefit may not be paid beyond 50% of Reasonable Customary costs after deduction of any Deductible or Co-Pay.
- In the case of serious Accident requiring immediate Emergency In-Patient Treatment You or Your family member must contact Us within 72 (seventy-two) hours of such Accident. The benefit for eligible Treatment is paid at Reasonable and Customary costs.

INSURANCE PLANS	BLUE	AZURE	COBALT	ADMIRAL	ROYAL	
OVERALL MAXIMUM LIMIT	€ 500 000	€ 1 200 000	€ 1 500 000	€ 2 000 000	€ 3 000 000	
Area of coverage	Europe / Europe + Israel		Worldwide excluding USA / Worldwide[1]			
Deductible	All Benefits Nil / € 75 / € 150 / € 250 / € 500 € 1 000 / € 2 500 / € 4 500		In-Patient only Nil / € 150 / € 300 / € 625 / € 1 250 / € 2 500 / € 6 250			
IN-PATIENT (DAY OR NIGHT)						TERMS AND DEFINITIONS
Hospital Costs (including accommodation)	In Full	In Full	In Full	In Full	In Full	We will pay for hospital room and board costs for a standard single en-suite room including general nursing care.
Parent Accommodation	In Full	In Full	In Full	In Full	In Full	We will pay for the room and board costs of one parent staying in hospital with their insured child up to the age of 16 (if the child is a member receiving treatment that is covered under the Policy).
Operating Theatre Fees	In Full	In Full	In Full	In Full	In Full	We will pay for the costs of the operating room, surgical appliances used during the surgery, post-surgical recovery room and care, prescribed medicines, dressings and equipment used during surgery and during the insured person's hospital stay.
ICU/HDU/CCU (intensive care/ high dependency / Coronary Care unit)	In Full	In Full	In Full	In Full	In Full	We will pay for the medically necessary admission and/or transfer to a High Dependency Unit or Intensive Care Unit or Coronary Care Unit.
Specialist Fees	In Full	In Full	In Full	In Full	In Full	We will pay for the specialists, surgeons and anesthetists's fees both in surgery and immediately before or after surgery, on the same day. We will pay for surgeon's consultations while admitted in hospital as long as medically necessary either to discuss Your surgery or for treatment related to a non-surgical stay (such as being admitted for pneumonia).
Laboratory investigations, X-Rays and other diagnostics tests	In Full	In Full	In Full	In Full	In Full	We will pay for the costs of tests used to diagnose or assess Your condition. This includes laboratory investigations (such as blood tests), imagistic investigations (such as x-rays or ultrasounds) and other diagnostic tests (such as ECGs).
Physiotherapy / Speech therapy	In Full	In Full	In Full	In Full	In Full	We will pay for treatment provided by Physiotherapist and Speech therapist if required and recommended by a Specialist as part of the overall treatment plan whilst admitted to hospital.
Acute flare-up for Chronic condition	€ 1 000	€ 1 000	In Full	In Full	In Full	We will pay for the costs of an admission to hospital for an acute flare-up of a chronic condition that requires active medical treatment, for the period of that admission only.

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INSURANCE PLANS	BLUE	AZURE	COBALT	ADMIRAL	ROYAL	TERMS AND DEFINITIONS
Rehabilitation (Subject to Our Pre-authorisation)	NA	€ 2 000	In Full up to 30 days / each condition	In Full up to 30 days / each condition	In Full up to 30 days / each condition	We will pay for In-Patient rehabilitation costs for a combination of therapies such as physical, occupational and speech therapy for Rehabilitation. We pay In-Patient Rehabilitation for as long as: • it follows an acute brain Injury, such as a stroke or accident; and • it is a part of Treatment that is covered by the Policy; and • a Medical Practitioner/Physician who specialises in Rehabilitation is overseeing the Insured Person's Treatment; and • We have agreed the costs before the Insured Person starts Rehabilitation; and • the Treatment could not be carried out on an Out-Patient basis.
Psychiatry (Subject to Our Pre-authorisation)	NA	NA	NA	In Full (up to 30 days)	In Full (up to 60 days)	In-Patient and Day-Patient Psychiatric Treatment received at a registered psychiatric unit of a Hospital providing 24-hour medical supervision and evidence-based Treatment for Mental Health Disorders. This benefit includes room and board hospital accommodation, prescribed medication, Medically Necessary Treatment related to the condition under the medical supervision of a psychiatrist. Psychotherapy treatment is only covered after the Insured Person was initially diagnosed by a psychiatrist and referred to a clinical psychologist for further In-Patient or Day-Patient treatment.
Prosthesis (Prosthetic Implants)	In Full	In Full	In Full	In Full	In Full	We will pay for internal prosthesis/medical implants needed as part of Your treatment. These must be approved by US Food and Drug Administration (FDA) and are used for their intended purpose and proven to be effective.
Durable Medical Equipment, Medical Aids and appliances, External Prosthesis (Pre-authorisation by the Insurer must be obtained for the initial coverage, repair, and/or replacement of prosthetic limbs)	NA	NA	€ 2 500	€ 2 500	€ 2 500	We will pay towards the costs of any items, supplies or equipment used in the course of medical treatment or home care. This is limited to: abdominal binder, post-surgical mastectomy bra, compression stocking, hearing aids, speaking aids (electronic larynx), wheelchairs, crutches, corrective splint, air boots, arm sling, orthopaedic supports, spinal supports, knee braces and pneumatic walking boots. For external prosthetic body parts such as prosthetic limbs all claims are made within 12 (twelve) months of the amputation or removal of the body part.
Palliative Care (Subject to Our Pre-authorisation)	NA	NA	€ 5 000	€ 10 000	€ 20 000	We will pay towards the costs of palliative care (whether in a hospice or at home) if You have received a terminal diagnosis and can no longer receive active medical treatment leading towards Your recovery.
Home Nursing (Subject to Our Pre-authorisation)	€ 1 000	€ 5 000	In Full (up to 30 days after hospitalisation)	In Full (up to 30 days after hospitalisation)	In Full (up to 30 days after hospitalisation)	We will pay for the costs of home nursing if You have been in hospital receiving treatment which was covered under this plan but only if it immediately follows discharge from hospital, You require active medical support, is managed by a qualified nurse and was prescribed by Your treating specialist. We will not pay for social and domestic support. We will not pay for home nursing related to mental illness, psychiatric or psychological disorders.
Hospitalization Cash benefit (only applicable when there was no charge or hospitalisation in a public hospital)	€ 100 per night up to 10 nights	€ 100 per night up to 10 nights	€ 100 per night	€ 120 per night	€ 150 per night	We will pay a cash benefit for each night You spend in a hospital where You are not charged for Your admission (ie: at a public hospital).
Congenital and Hereditary conditions (Subject to Our Pre-authorisation)	NA	NA	In Full (only up to 90 days after birth)	In Full (only up to 90 days after birth)	In Full (only up to 90 days after birth)	We will pay for the In-Patient/Day-Patient treatment of congenital and/or hereditary conditions. By congenital we mean any abnormalities, deformities, diseases, illnesses or injuries present at birth whether diagnosed at the time or not. By hereditary we mean any abnormalities, deformities, diseases or illnesses present at birth that are only present because they have been passed down through Your family. After the specified days, the newborn will be subject to underwriting.
Cover Outside of Area of Coverage (Emergency In-Patient Treatment)	Up to 30 days within a limit of € 30 000	Up to 30 days within a limit of € 30 000	€ 50 000	€ 50 000	€ 50 000	We will pay only for emergency In-Patient treatment. Covered until stable for transfer.

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INSURANCE PLANS	BLUE	AZURE	COBALT	ADMIRAL	ROYAL	
OUT-PATIENT		€ 12 000 OVERALL LIMIT				TERMS AND DEFINITIONS
Out-Patient Surgery	NA	In Full	In Full	In Full	In Full	We will pay for the costs of a surgical procedure performed as an Out-Patient under a local anaesthesia.
General Practitioner & Specialist Fees	NA	€ 1 000	NA	€ 5 000	In Full	We will pay for consultations with Your GP, Family Doctor or Specialist to diagnose and treat a medical condition or to arrange further medical treatment or as a follow up to treatment that has already taken place. It includes Telemedicine consultation – only one consultation per day, from an approved telehealth provider.
Prescribed medicines, Drugs and Dressings	NA		NA			We will pay for the cost of drugs and dressings prescribed by Your medical practitioner that will only be used for the treatment of a disease, illness or injury. It includes prescribed medication during the Telemedicine consultation.
Laboratory investigations, X-Rays and other diagnostics tests	NA	€ 2 000	NA			We will pay for the costs of tests used to diagnose or assess Your condition. This includes laboratory investigations (such as blood tests), imagistic investigations (such as x-rays or ultrasounds) and diagnostic tests (such as ECGs).
Physiotherapy (Subject to Pre-authorisation after 12th session/visit)	NA	€ 1 800	NA			We will pay for consultations and Medically Necessary physiotherapy when given by a Physiotherapist aimed at restoring Your normal physical function for a covered diagnosis and following an Insured Event. The Physiotherapist must mention the need for the specific form of physiotherapy, diagnosis, a clear treatment plan with a starting point and ending point and expected outcome. After the 12th session, if the Insured Person requires more sessions, the Insured Person must submit further information/an updated medical report.
Complementary Therapies: Occupational Therapy/ Chiropractic/ Osteotherapy/ Homeopathy/ Acupuncture/ Dietician	NA	NA	NA			We will pay for the costs of treatment provided by a registered therapist, such as an Occupational Therapist and Complementary Therapist (acupuncture, homeopathy, chiropractic treatment, osteopathy or dietician). We will not pay for sexual therapy.
Maintenance of Chronic conditions	€ 1 000 (within In-Patient limit)	€ 1 000 (within In-Patient limit)	NA			We will pay for the ongoing management of chronic conditions. We define chronic as a condition that does not respond to active medical treatment and requires ongoing management (for example diabetes, or back pain). For the Blue and Azure Insurance Plans, the maximum limit shown applies for both In-Patient and Out-Patient treatment, for Acute flare-ups, maintenance of Chronic conditions and as such any claims paid under one of those two Benefits reduce the remaining aggregate annual limit available for both. We will pay for regular consultations, tests, and prescribed medicines required for the monitoring and maintenance of the stability of a Chronic condition. This benefit is limited to these Treatment and does not include other medical Treatment (e.g. physiotherapy aimed at maintaining stability).
Speech therapy	NA	NA	NA			We will pay for speech therapy in order to restore speech following an accident or for a condition (ie: stroke), under the recommendation of Your specialist. We will not pay for developmental delay or language disorders.
Psychiatric Treatment	NA	NA	NA	Up to 20 visits included within the above limit of € 5 000	Up to 30 visits included within the above limit	We will pay for the consultation and associated costs for psychiatry, psychology or psychotherapy provided the overall treatment plan is under the referral of a practicing registered psychiatrist/ psychologist. All consultations must take place in the psychiatrist/psychologist office. We will only pay Out-Patient drugs related to the medical condition when prescribed by the psychiatrist.

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INSURANCE PLANS	BLUE	AZURE	COBALT	ADMIRAL	ROYAL	
Emergency Out-Patient treatment	€ 500	€ 12 000	In Full	In Full	In Full	We will pay for the costs of emergency Out-Patient treatment (ie: services provided in Accident and Emergency Room as an Out-Patient) up to the limits provided.
FURTHER BENEFITS						TERMS AND DEFINITIONS
Cancer treatment (Subject to Our Pre-authorisation)	In Full (In-Patient) NA (Out-Patient) Wig and temporary head covering up to € 200	In Full Wig and temporary head covering up to € 200	In Full Wig and temporary head covering up to € 200	In Full Wig and temporary head covering up to € 200	In Full Wig and temporary head covering up to € 200	We will pay for fees specifically related to active Cancer Treatment and this includes chemotherapy, radiotherapy, oncology, diagnostic tests, prescribed medicines, and the cost of a wig or temporary head covering following chemotherapy. Cancer Treatment is subject to a limit of up to 120 days per In-Patient admission.
Transplant Services (Subject to Our Pre-authorisation)	€ 250 000 / Lifetime (Organ Transplant) € 25,00 (Tissue Transplant) Donor Costs: up to € 20 000	€ 250 000 / Lifetime (Organ Transplant) € 25,00 (Tissue Transplant) Donor Costs: up to € 20 000	In Full (In-Patient) € 20 000 (Out-Patient) Donor Costs: up to € 20 000	In Full (In-Patient) € 30 000 (Out-Patient) Donor Costs: up to € 20 000	In Full (In-Patient) € 45 000 (Out-Patient) Donor Costs: up to € 20 000	Treatment for and in relation to life-sustaining in case of transplant of human organs, tissues and cells, including but not limited to kidney, pancreas, liver, heart, lung, bone marrow, cornea, or heart and lung, in respect of the insured person as a recipient. The transplant will be carried out in internationally accredited institutions by accredited surgeons and where the organ, tissue or cell procurement is in accordance with World Health Organisation (WHO) guidelines. Where Your policy includes donor expenses, we will only pay for hospitalisation medical costs associated with the donor as an In-Patient or Day-Patient when services are rendered in a network facility and where the donation does not lead to the loss of the donor's life and the donating of organs, tissues or cells are removed in the same network facility where the transplant occurs. Costs associated for the donor search or procurement of the organs, tissues or cells are excluded. Cover includes the cost of anti-rejection medication (immunotherapy). The specific type and length of treatment will be determined by the type of transplant and underlying medical condition.
Advanced imaging (MRI, CT,PET)	In Full	In Full	In Full	In Full	In Full	We will pay for the costs of CT, MRI or PET scan (or combination of these scans) when recommended by Your Specialist.
Routine Maternity Care	NA	NA	€ 3 000 (Waiting period: 12 consecutive months of membership)	€ 7 500 (Waiting period: 12 consecutive months of membership)	€ 10 000 (Waiting period: 12 consecutive months of membership)	Maternity costs incurred after the initial 12 months of continuous membership (from the effective start date) will be eligible for consideration. The coverage includes hospital charges, obstetrician and midwife fees for normal childbirth, pre-natal care and post-natal care (immediately following childbirth) and up to seven days routine care for the baby. We will pay for Elective C-sections and Childbirth at home. We will not pay for termination of pregnancy, other than miscarriage, ectopic pregnancy and still birth.
Maternity Cash Benefit (payable when Routine Maternity care is free of charge)	NA	NA	€ 300 (Waiting period: 12 consecutive months of membership)	€ 300 (Waiting period: 12 consecutive months of membership)	€ 350 (Waiting period: 12 consecutive months of membership)	Subject to a Waiting period of 12 months of continuous membership (from the effective start date), this benefit will be eligible for consideration. We will pay a cash benefit for each night You spend in a hospital during childbirth where You are not charged for Your admission (ie: at a public hospital). Please take note: a) if payable, this benefit replaces the Hospital Cash Benefit; b) if payable, we will pay either this Maternity Cash Benefit or Routine Maternity Care (Pregnancy & chilbirth) benefit.

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INSURANCE PLANS	BLUE	AZURE	COBALT	ADMIRAL	ROYAL	TERMS AND DEFINITIONS
Complications of pregnancy	NA	NA	In Full (Waiting period: 12 consecutive months of membership)	In Full (Waiting period: 12 consecutive months of membership)	In Full (Waiting period: 12 consecutive months of membership)	Subject to a Waiting period of 12 months of continuous membership (from the effective start date) this benefit will be eligible for consideration. We will pay for the costs of a Medically Necessary Caesarian Section arising as a result of a complication, including conditions such as Antiphospholipid syndrome, Cervical incompetence, Ectopic pregnancy, Gestational diabetes (if the Insured Person has exclusions because of past medical history related to diabetes, then this will not be covered since this is specifically excluded), Hydatidiform mole – molar pregnancy, Hyperemesis gravidarum, Obstetric cholestasis, Pre-eclampsia / Eclampsia, Rhesus (RH) factor, Miscarriage requiring immediate surgical intervention, Post-partum haemorrhage, Retained placental membrane.
Newborn care	NA	NA	€ 10 000	€ 25 000	€ 100 000	We will pay for the costs of treatment for a newborn baby up to 30 days after the date of birth. Children can be added as a dependent onto their parent's policy within 30 days of birth with no exclusions. The newborn care benefits are not available for children who are born following parent's fertility treatment, assisted reproduction technologies or conception (such as IVF), are born to a surrogate, or have been adopted.
Accidental dental damage to natural teeth	NA	NA	NA	€ 500	€ 1 000	We will pay towards treatment of damaged teeth following an accident. The dental Treatment must be carried out by a dentist in a Hospital emergency room or dental Surgery, and Treatment must occur within 7 days of an accidental injury. We will not pay for the repair of dental implants, crowns or dentures.
HIV/ AIDS	€ 50 000 / lifetime	€ 50 000 / lifetime	€ 50 000 / lifetime	€ 50 000 / lifetime	€ 50 000 / lifetime	We will pay for medical treatment which arises from, or is in any way related to Human Immuno-Deficiency Virus (HIV) and/ or HIV related illness, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and any similar infections, illnesses, injuries or medical conditions arising from these conditions.
Second medical opinion service	Included	Included	Included	Included	Included	For medical condition or diagnosis that is complicated, we can help You organise access to a network of leading experts, from anywhere in the world, for a review of Your case.
ASSISTANCE						TERMS AND DEFINITIONS
Local Ambulance Services (Air ambulance services subject to Our Pre-authorisation)	In Full	In Full	In Full	In Full	In Full	We will arrange and pay within the overall Policy Limit for the Insured Person's transport to the nearest suitable Hospital for Emergency transport to or between Hospitals and when a Medical Practitioner/Physician says that it is Medically Necessary.
Repatriation of Mortal Remains (Subject to Our Pre-authorisation)	NA	€ 10 000	€ 10 000	€ 10 000	€ 10 000	We will pay towards the costs of repatriating Your mortal remains in the event You die away from Your home country/country of residence. We will make all necessary arrangements as required under international regulations.
International Emergency Medical Evacuation (Subject to Our Pre-authorisation)	NA	€ 25 000	In Full	In Full	In Full	In the event of an emergency whereby the local medical facilities are unsatisfactory and unable to provide the level of medical care You need We will pay to either evacuate You to the nearest medical centre or to repatriate You to Your home country/country of residence. The most appropriate means of transport available locally will be used (ie. regular scheduled, charter airline, or a specially chartered air ambulance). We will arrange and pay the reasonable travel costs of one person to accompany the Insured Person; in addition, We will pay for that person's overnight accommodation up to EUR 50 each night for a maximum of 10 nights. We will arrange for Repatriation to Your home country once fit to travel.

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INSURANCE PLANS	BLUE	AZURE	COBALT	ADMIRAL	ROYAL	
PREVENTIVE TREATMENT – WELLNESS						TERMS AND DEFINITIONS
Health Screening Waiting Period of: 10 consecutive months of membership	NA	NA	NA	€ 500	€ 750	From age 2 to turning 10 years, we will pay charges incurred for the purpose of preventive care delivered or supervised by a Medical Practitioner/Physician, whose service is limited to 1 annual health screening and Routine Vaccinations. From age 10 and up, we will pay towards one annual health screening.
Child (Baby) Wellness	NA	NA	NA			No waiting period applies. For a Dependent Child who is under 2 years old, we will pay charges incurred for preventive care delivered or supervised by a Medical Practitioner/Physician, whose services are limited to 4 health screenings and Routine Vaccinations.
Vaccinations	NA	NA	NA	€ 200	€ 350	No waiting period applies. From age 10 years and up we pay towards vaccinations and immunizations including travel vaccinations.
OPTIONAL PLAN DENTAL (MUST BE SELECTED WITH OPTICAL OPTION)						TERMS AND DEFINITIONS
Preventive	NA	NA	€ 2 500 (Waiting Period: Preventive/ Routine/ Restorative – 6 consecutive months of membership; Orthodontic – 2 consecutive years of membership)	€ 2 500 (Waiting Period: Preventive/ Routine/ Restorative – 6 consecutive months of membership; Orthodontic – 2 consecutive years of membership)	€ 2 500 (Waiting Period: Preventive/ Routine/ Restorative – 6 consecutive months of membership; Orthodontic – 2 consecutive years of membership)	Preventive dental (ie: check-up, X-ray, scale and polish, mouth guard) and 0% Co-pay.
Routine and Restorative						Routine and Restorative (ie: fillings, root canal treatment, crowns/bridge, implant, anesthesia) and 20% Co-pay.
Orthodontic						Orthodontic benefit has 50% Co-pay and is covered up to the age of 18 on this option.
OPTIONAL PLAN OPTICAL (MUST BE SELECTED WITH DENTAL OPTION)						TERMS AND DEFINITIONS
Optical	NA	NA	€ 200 (Waiting period for parent: 6 consecutive months of membership)	€ 200 (Waiting period for parent: 6 consecutive months of membership)	€ 200 (Waiting period for parent: 6 consecutive months of membership)	We will pay towards costs of one annual vision/eye test and prescription glasses/contact lenses where prescribed by an opthalmologist only.

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