



Journey

General Conditions of Insurance

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1. Contractual basis

The Insurer underwriting the Insurance Policy is Foyer Global Health S.A., a health insurance company established in Luxembourg under the form of a public limited liability company (société anonyme) having its registered office at 12, Rue Léon Laval L-3372 Leudelange, registered under no. B134.471 in the Luxembourg Trade and Companies Register, supervised by the Commissariat aux Assurances (11, rue Robert Stumper, L-2557 Luxembourg; +352226911-1; caa@caa.lu).

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

- the Application Form;
- the Insurance Certificate;
- the General Conditions of Insurance (this document);
- the Special Conditions;
- the Particular Conditions;
- the Glossaries; and
- any subsequent written agreements concluded between the Insurer, the Policyholder and, where relevant, the Insured Person.

Terms capitalised in the Terms and Conditions of the Insurance shall have the meaning defined in the Glossaries, unless otherwise explicitly stated to the contrary. Words in the singular form include the plural form and vice versa, unless otherwise explicitly stated to the contrary.

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

Within the scope of the maximum reimbursement amount agreed, and depending on the Plan level chosen, the Insurer will refund up to 100% of the Eligible Expenses up to the Annual Overall Limit listed in the Scope of Benefits set out in the Special Conditions, unless reflected otherwise in the Particular Conditions, the Insurance Certificate, or any subsequent written agreement between the Insurer, the Policyholder and, where relevant, the Insured Person.

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

2. Insurance framework

The legal framework of the insurance cover provided under the Insurance Policy and any Benefits received thereunder result from the Insurance Policy, as amended from time to time, as well as any applicable laws, regulations, guidelines, guidance or interpretation issued by a regulatory authority, as amended from time to time.

2.1 Declarations made upon entering the Insurance Policy and throughout its term

2.1.1 Application and Duty to declare

The Policyholder can apply for insurance cover by filling out an Application Form which can be obtained from its insurance intermediary, directly from the Insurer or through the Insurer's website or any other applicable digital channel offered by the Insurer.

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

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

The Insured Person and the Policyholder shall be jointly and severally liable for making sure that any questions asked by the Insurer in relation with the Insurance Policy are answered completely and correctly.

The Policyholder can send the Application Form to the Insurer by post or e-mail, or alternatively, submit it online using the Insurer's online sales portal. The Application Form does not bind either the Policyholder or the Insurer to conclude the Insurance Policy. However, the Insurer shall notify the Policyholder, within 30 days of the receipt of the Application Form, of either an insurance offer, the need for an inquiry or survey, or a refusal to insure. The Insurer has the right to request any data required by law or necessary or useful in relation to the Insurance Policy.

The Insurer will provide insurance cover in good faith, assuming that the Policyholder has correctly and completely answered all the relevant questions raised before the Effective Date (this is known as the 'pre-contractual duty of the Policyholder to disclose information').

2.1.2 Intentional omission or inaccuracy

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

2.1.3 Unintentional omission or inaccuracy

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

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

If the Policyholder refuses the proposed amendment of the Insurance Policy or if such proposal is not accepted within 1 (one) month from the date on which the relevant proposal was received, the Insurer may terminate the Insurance Policy within 15 (fifteen) calendar days.

If the omission or inaccuracy is the fault of the Policyholder and if a Claim arises before the amendment or termination of the Insurance Policy referred to in the preceding paragraphs becomes effective, the Insurer is only required to grant Benefits in accordance with the proportion of the premium actually paid by the Policyholder to the premium that the Policyholder would have been required to pay if the

risk had been fully and accurately declared. However, if the Insurer proves that it would never have insured the relevant risk whose real nature was revealed by the Claim, the Benefits to be paid by the Insurer shall then be limited to the reimbursement of all premiums paid.

2.2 Other declaration obligations during the term of the Insurance Policy

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

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

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

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

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

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

- a) The Insurer shall remain obliged to pay the agreed Benefit if the failure to declare is not attributable to the fault of the Policyholder.

- b) If the failure to declare is due to the fault of the Policyholder, the Insurer shall only be required to pay the agreed Benefit in proportion to the premium actually paid relative to the premium that would have been due if the aggravation of risk had been properly declared. However, if the Insurer demonstrates that it would not have insured the aggravated risk under any circumstances, its liability in the event of a Claim shall be limited to reimbursing the premiums paid for the period following the occurrence of the aggravation.
- c) If the Policyholder has acted with fraudulent intent, the Insurer may refuse all Benefits. In such a case, all premiums due up to the moment the Insurer became aware of the fraud shall remain payable as damages.

The provisions of this clause shall not apply in cases involving changes in the state of health of the Insured Person.

2.3 Cumulative insurance

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

2.4 Right of withdrawal

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

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

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

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

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

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

The amount to be paid:

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

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

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

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

2.5 Entry into force and Effective Date

2.5.1 The Insurance Policy shall be deemed concluded on the date when the Insurer countersigns the Particular Conditions that have been signed by the Policyholder after the submission of the duly signed Application Form.

2.5.2 The Insurance Policy and the cover and Benefits provided for thereunder enter into force and take effect on the Effective Date, and no earlier than the expiry of any applicable Waiting Periods.

No Benefits shall be paid for Claims arising before the Effective Date.

2.5.3 The Insurance Policy is entered into for a period of 12 (twelve) months and is thereafter tacitly renewed year after year for a period of 12 (twelve) months per renewal, if neither of the parties opposes such renewal in accordance with the formalities and notice periods provided for under clause 2.10 of these General Conditions of Insurance.

2.5.4 Insurance coverage will end after a maximum period of 5 (five) consecutive Insurance Years for Policyholders and/or Insured Persons temporarily residing in Germany. The period of 5 (five) Insurance Years shall be calculated by including any renewals of the Insurance Policy as well as any insurance cover obtained by the Policyholder and/or Insured Person under a similar health insurance coverage obtained previously from other insurance companies.

2.6 Inception of newborn babies

Newborns are included as Insured Persons from the moment of birth, without any Waiting Periods and without medical underwriting, provided that the birth mother has been a Policyholder and Insured Person for at least 9 (nine) consecutive months preceding the birth date and a new Application Form for the newborn is submitted within 2 (two) months of birth date. In such case, the relevant Benefits for the newborn apply retroactively as of the first day of the month of the child's birth. The Benefits granted to the newborn as a result of a new Application Form may not be higher or more extensive than the Benefits granted to the birth mother as Insured Person. Newborns can only be insured at the tariffs applicable to any new Insurance Policy concluded as of the date of the relevant birth.

If the birth mother has not completed the Waiting Period for maternity care, expenses related to maternity care will not be covered. However, coverage under the 'newborn care' Benefit remains applicable if the specified conditions are met, even if the birth mother has not completed the Waiting Period for maternity care.

In cases where the birth mother has not been a Policyholder and Insured Person for at least 9 (nine) consecutive months before the birth date and/or if the Insurer does not receive a new Application Form for the newborn within 2 (two) months of the birth date, the newborn shall not be included as Insured Person without undergoing medical underwriting. This means that the newborn's inclusion in the Policy will be subject to a medical risk assessment, which involves completing a medical questionnaire regarding the newborn's health. The Insurer will use this information to determine whether coverage can be granted, and if so, under what terms, conditions, or exclusions.

If the Application Form is received more than 2 (two) months after the birth date, the cover provided for under the Insurance Policy for the newborn shall become effective at the earliest on the day when the Insurer receives the new Application Form. Reporting a birth after the 2 (two)-months period may result in an additional premium charge, which may be applied for medical reasons or following a risk assessment, in addition to the Plan.

The insurance coverage for the newborn must not be higher or more comprehensive than that of either parent insured with the Insurer. For adopted minor children, medical underwriting is applicable, and an extra premium, not exceeding 500%, may be charged for medical reasons or after a risk assessment, in addition to the Plan premium.

2.7 End of the Insurance Policy

The entitlement to receive any Benefits under the Insurance Policy ceases automatically on the date on which the Insurance Policy is terminated, including for Claims that may have arisen and/or been reported to the Insurer prior to that date. The Claims that occur during the Insurance Year will be honoured however, the Treatments that took place after the end date of the Policy are not covered.

2.8 Termination

2.8.1 Automatic termination

The Insurance Policy shall automatically terminate in the following cases:

- a) Upon reaching the maximum Insurance Period of 5 (five) Insurance Years for individuals temporarily residing in Germany as outlined in section 2.5.4.
- b) In the event of the death of the Policyholder. However, the surviving Insured Persons may renew the Insurance Policy by appointing a new Policyholder, provided that the relevant appointment is declared to the Insurer within 2 (two) months following the death of the initial Policyholder.
- c) When the Policyholder objects to the renewal of the insurance contract after the Insurance Year concludes. Such termination is valid only if the Policyholder can demonstrate that the concerned Insured Persons have been informed of the termination.
- d) If the insurance contract is declared null and void.
- e) If the Insurance Policy has been suspended continuously for 2 (two) years.

A divorce or equivalent separation shall not automatically cause the termination of the Insurance Policy, which shall remain in force in such case.

2.8.2 Optional termination

In the case of multiple covers or insured risks, the termination may relate to one or several of such insurance covers and/or risks.

2.8.3 Termination by the Policyholder

The Policyholder may terminate the Insurance Policy, either in full or for specific Insured Persons, at each renewal date. This right may be exercised upon receipt of the renewal notice from the Insurer, which includes information about the Policy renewal, the premium payable, the premium due date, and the right to terminate.

To terminate, the Policyholder must send a written termination notice to the Insurer no later than 30 (thirty) calendar days from the postmark date of the payment notice. Termination will take effect on the second business day after the postmark date of the termination notice, but not before the renewal date of the Insurance Policy.

If the Terms and Conditions of Insurance are amended according to the terms of these General Conditions of Insurance, the Policyholder may terminate the Insurance Policy within three (3) months of the dispatch of the notification letter from the Insurer informing the Policyholder of the relevant amendment. Termination will take effect three (3) months after the date of notification, which may be the date recorded by the official notification service, the date shown on the receipt of the termination letter, or the day after the letter is handed over to the postal service, whichever applies.

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

The Policyholder may furthermore terminate the Insurance Policy in its entirety if the Insurer has terminated one or more insured risks covered by the Insurance Policy. The termination must occur within 1 (one) month of the postmarked date of dispatch of the termination letter from the Insurer, and shall take effect within 1 (one) month following the date of the bailiff notification of the Policyholder's termination letter, the date indicated on the receipt or the day following the date of remittance of the Policyholder's termination letter to the postal services, as the case may be.

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

2.8.4 Termination by the Insurer

Without prejudice to any other causes for termination provided for in the Insurance Policy, the Insurer may terminate the Insurance Policy with immediate effect if the Policyholder or an Insured Person has obtained or attempted to obtain insurance Benefits fraudulently. This right to terminate shall be forfeited if it has not been used within 1 (one) month from the date on which the Insurer was informed of the facts prompting the termination.

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

2.9 Voidness of the Insurance Policy

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

2.10 Termination formalities and notice periods

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

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

2.11 Repayment of premiums in the event of termination

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

In the case of a partial termination or any other decrease of the insurance cover or Benefits provided for under the Insurance Policy, the preceding paragraph shall only apply to such decrease and to the extent of such decrease.

2.12 Limitation of liability

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

3. Benefits

3.1 Waiting Periods

The Waiting Periods commence on the Effective Date, the details of which are outlined in the Special Conditions.

Without prejudice to the Special Conditions, the following specific Waiting Periods apply to the Insurance Policy: In the case of psychiatric Treatment, psychotherapy, major dental services, pregnancy and childbirth, including complications related to pregnancy and childbirth, prophylactic mastectomy surgery and infertility medical Treatment.

- (i) In the case of psychiatric Treatment, psychotherapy, and major dental services, the Waiting Period is 10 (ten) months from the Effective Date.
- (ii) In the case of pregnancy and childbirth, the Waiting Period is 12 (twelve) months from the Effective Date, irrespective of the number of Insured Persons.
- (iii) In the case of prophylactic mastectomy surgery, the Waiting Period is 24 (twenty-four) months from the Effective Date.
- (iv) In the case of infertility Medical Treatment, the Waiting Period is 24 (twenty-four) months from the Effective Date for both spouses or partners.

If the Insurance Policy is amended in order to extend the Benefits provided thereunder, the Waiting Periods shall apply to the relevant new Benefits granted under the amended Insurance Policy, in accordance with the agreed Plan level.

3.2 Timeline for the reporting of Claims

Without prejudice to the provisions of the present General Conditions of Insurance, the Policyholder and/or the Insured Person must report any Claim to the Insurer within three (3) months.

3.3 Obligations and formalities to be completed when making a Claim

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

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

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

The following conditions apply:

- a) Unless otherwise agreed upon by the Insurer, the Policyholder and/or Insured Person shall directly forward all relevant documents and information, such as invoices and proof of payment, to the Insurer or relevant Service Centre when an insured event occurs.
- b) Hospital Treatments shall be reported as soon as possible to the relevant Service Centre after the commencement of such Treatment.
- c) The Insured Person shall allow the Insurer or the Service Centre to gather any necessary information, especially concerning the release of medical professionals from their duty of confidentiality.
- d) The Policyholder and the Insured Person are expected to exercise cost-conscious behaviour in the event of a Claim, by limiting expenses for Treatment to what is necessary.

If the Policyholder and/or Insured Person fails to comply with the obligations imposed upon them under the Insurance Policy, the Insurer may not be required to pay the Benefits, or may limit the Benefits, in accordance with the terms of the Insurance Policy.

If the failure of the Policyholder and/or the Insured Person to comply with the obligations imposed upon them under the Insurance Policy results in a loss for the Insurer, the insurance Benefits may be reduced in proportion to the loss suffered.

If the Policyholder and/or the Insured Person do not comply with the obligations imposed upon them under the Insurance Policy with fraudulent intent, the Insurer shall be entitled to decline the cover provided for under

the Insurance Policy and to refuse the payment of any insurance Benefits.

3.4 Payment of Benefits

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

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

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

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

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

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

or replaced and the services relating thereto must be indicated.

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

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

The Insurer is entitled to pay its Benefits to the person who submits the supporting documents and information in due form to the Insurer. In the event of doubts, the Insurer shall pay the reimbursement amount to the Policyholder and any such payment shall validly discharge the Insurer from its relevant obligations under the Insurance Policy.

Invoices are reimbursed in the currency agreed with the Insured Person. Foreign-currency costs are converted at the actual rate applicable on the day that the invoice was issued. This is unless the Insured Person can submit bank vouchers proving that they were purchased at a less advantageous rate in order to pay the invoices.

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

The rights to the Benefits granted under the Insurance Policy shall not be assigned, transferred or pledged.

3.5 If there is an Accident or Emergency

The Insured Person has the convenience of contacting the relevant Service Centre 24/7, 365 days a year, particularly following a significant event such as an Accident, Emergency, or inpatient Treatment. The addresses, phone numbers, and email addresses can be found on all relevant documents and the Service Card.

3.6 Subrogation

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

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

The subrogation shall not have the adverse effect on the Insured Person of resulting in the Insured Person only being partially compensated by the payment of Benefits under the Insurance Policy. In this case, the Insured Person may exercise its rights, for the amounts that remain owed to the Insured Person, in priority to the Insurer.

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

3.7 Statute of limitations

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

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

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

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

4. Payment and charging of premiums

4.1 Payment of premiums

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

If the Insurance Policy encompasses multiple insured risks, the aggregate amount of premiums due is considered a single, indivisible premium.

The premium is typically an annual premium and may be paid in various instalments. The first premium or instalment must be paid as stated in the invoice, once the Insurer accepts the Application Form and issues the Insurance Policy.

The insurance cover provided for under the Insurance Policy does not begin until the first premium or premium instalment has been paid in full.

Subsequent premiums are to be paid in accordance with the agreed payment frequency. The payment terms for the premiums, the due date and the amount of the premium are specified in the Insurance Policy. Any amendment to these terms requires the express written consent of the Insurer.

If the Policy terminates during an active invoicing period, the premium will be adjusted proportionally. An active invoicing period is the span of time for which the Insurer has issued an invoice and expects payment for coverage.

For newborns already included as Insured Persons on their birthday, premiums are due from the date of the child's birth. For newborns retroactively covered as Insured Persons based on an executed Application Form received by the Insurer within 2 (two) months of their birth, the premium is due as of the date of the signature of the relevant Application Form.

4.2 Paying other charges and insurance premium tax (IPT)

If the Country of Residence of the Policyholder is within the EU/EEA, the Insurer must invoice the Policyholder for the statutory charges, dues or taxes associated with the Insurance Policy. Any local tax rates that apply will be shown in the Insurance Policy. The Insurer will

collect the insurance premium tax and dues or charges together with the insurance premium.

If the Country of Residence is outside the EU/EEA, the Policyholder is responsible for the registration and payment of local taxes and other charges that may occur for the insurance.

4.3 Charging premiums

The premium to be paid for the Insurance Policy depends on the state of health of the Insured Person (at the time when the relevant Application Form is being accepted by the Insurer), the individual premium according to the current table of premiums and the age of the Insured Person on the first day of the Insurance Year. The age bands are set out as follows: 0 to 19, 20 to 24, 25 to 29, 30 to 34, 35 to 39, 40 to 44, 45 to 49, 50 to 54, 55 to 59, 60 to 64, 65 to 69, 70 to 74, 75 to 79 and 79+. The premium tables can be found on our website <https://globalhealth.insurance>. The method for the calculation of premiums is set out in the Insurance Policy.

4.4 Adjustment of costs/premiums

The agreed insurance premium is subject to change depending on:

- The actual Claims costs no longer corresponding to the technical calculation basis on the Plan or if the observed cost trend in the health care system gives reason to assume that the actual costs will become disproportionate to the calculated costs in the following Insurance Year. The actual Claims costs mean the global/overall actual Claims cost of the last years of the Insurer's individual business.
- The change of age band. If the beginning of a new Insurance Year involves the change of age band here above mentioned and specified in the table of premiums, the Insurer will also adjust the premium according to the new age band;
- Changes to applicable legislation.

The Insurer is furthermore entitled to pass on to the Policyholder all increases in statutory charges, dues or taxes or similar payments. Once per year, these changes will be assessed and consequently, premiums may be adjusted should this become necessary. The Insurer will inform the Policyholder in

writing about any premium change at least 3 (three) months before the beginning of the next Insurance Year. The change will then apply from the beginning of the next Insurance Year.

If the Policyholder does not agree with the premium change, it may terminate the Insurance Policy within 3 (three) months of receiving the relevant notice. The Insurance Policy will end on the date on which the change would otherwise become effective.

4.5 Consequences of late payment

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

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

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

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

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

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

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

4.6 Contractual currency

The euro (EUR) is the basic currency for all Plans.

Notwithstanding the foregoing, the Policyholder may choose US dollars (USD), pounds sterling (GBP) or Swiss francs (CHF) as the contractual currency. The Insurer reviews the exchange rates for these currencies twice a year and changes them when necessary. This may result in higher or lower premiums if the Insurer must bring the contractual currency into line with the rate of exchange of the euro. The Policyholder and Insured Person expressly agree and accept to bear any currency risks arising from the choice to apply a currency different from the euro (EUR) to the Insurance Policy and to indemnify and hold harmless the Insurer against any direct or indirect losses suffered in connection thereto.

5. Miscellaneous provisions

5.1 Amendment of the Insurance Policy

The Policyholder and Insured Person acknowledge and agree that the Insurer may amend or change the Terms and Conditions of the Insurance Policy in accordance with the provisions set out herein.

The Insurer shall notify the Policyholder in writing about the contemplated amendments or changes at least 3 (three) months before the beginning of the next Insurance Year. The Policyholder undertakes to inform the Insured Person of such contemplated amendments or changes. The relevant amendment or change shall then apply from the beginning of the next Insurance Year.

If the Policyholder does not agree to the proposed amendment or change, it may terminate the Insurance Policy by written notice addressed via registered letter to the Insurer within 3 (three) months of receiving the notice. The Insurance Policy shall in such case end on the date on which the change would otherwise become effective.

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

5.2 Change of Insurance cover

Changes in insurance cover (currency, area of coverage, Deductible, Co-Payment, Out-of-Pocket Maximum, Plan level) are only possible from the beginning of the next Insurance Year, and only if the Insurer agrees in writing.

Depending on the agreed Plan level, new Waiting Periods shall apply accordingly for the additional insurance cover. Illnesses and their consequences, as well as the consequences of Accidents which have occurred during the previous insurance term, and which constitute an increased risk according to medical findings may be excluded from the changed insurance cover. This also includes the Treatment and delivery associated with an existing pregnancy.

If health related risk loadings were payable prior to the change of the insurance cover, these premium loadings

shall also be levied on the new Plan premiums at the same percentage rates unless agreed otherwise. The premium loadings will change to the same extent that premiums change (e.g. due to adjustment).

The previous insurance cover shall continue to apply if a requested change of insurance cover does not become effective because the right of withdrawal has been exercised.

The Insurance Year shall remain unchanged following change of the insurance cover.

5.3 Data protection

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

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

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

When the communication of data protected by professional secrecy in insurance matters takes place within the framework of sub-contracting and technologies using cloud computing are set up at the Insurer's initiative within the meaning of Article 300, 2bis, second paragraph of the amended law of 7 December 2015 with a third-party service provider other than those referred to in this Article 300, the Policyholder expressly consents to any subcontracting, including cloud computing. The Policyholder can access the details of these sub-contracting (sub-contracting table) at any time under the link <https://groupe.foyer.lu/en/transparency>. The Policyholder can also request a hard copy of the sub-contracting table.

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

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

If within 2 (two) months of a change in the sub-contracting table the Policyholder has not objected in writing, the Policyholder shall be deemed to have irrevocably accepted the subcontracting in question. In case of an objection by the Policyholder, this must be notified to the Insurer by registered letter. This will be valid as a cancellation at the next expiry of the contract only.

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

The Policyholder shall be duly informed that:

- If it objects to a change in the sub-contracting table, this opposition will have consequences on an optimal management of the insurance contract(s) and on the level of service provided, and therefore the opposition is valid as a cancellation on the next due date.
- If it holds several insurance contracts with the Insurer, it is required for the Policyholder to notify one objection per insurance contract.

Data protection including the processing of health data

In accordance with Regulation EU 2016/679 of the European Parliament and of the Council of April 27, 2016 on the protection of individuals with regard to the processing of personal data and on the free movement of such data and in accordance with the

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

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

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

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

The persons concerned have a right of access, limitation, deletion within the legal limits, rectification and portability concerning their data, which they may exercise by sending a written request to the address of the data controller using the form available on the website.

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

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

5.4 Sanctions

In the interest of all parties, the Insurer must comply with applicable local, European and international rules and regulations, including sanctions regulations. The Insurer is not required to grant or pay any insurance Benefits or to guarantee any insurance cover under this Insurance Policy if the performance of the insurance cover or the provision of a Benefits would expose the Insurer to the risk of incurring any sanction, penalty, prohibition, liability or restriction under such rules and regulations.

More specifically, 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 the Insurer to any risks related to sanctions legislations, prohibitions or restrictions, including but not limited to financial, economic and trade sanctions laws, regulations or resolutions adopted by any relevant authority, including but not limited to the United Nations, the European Union, the United States of America, the United Kingdom and any other jurisdiction relevant to this insurance contract.

Sanctioned persons

The Insurer will not provide insurance cover to, will not accept premium payment from, and will not be liable to pay any Claim or provide any Benefit to a sanctioned person as designated by a relevant authority.

The provision of insurance cover to an Insured Person, including eligible members and their dependents, will be immediately suspended and/or terminated, as appropriate and in accordance with applicable law, in the event they are designated as a sanctioned person by any relevant authority.

Sanctioned jurisdictions

The Insurer will not provide insurance cover and will not be liable to pay any Claim or provide any Benefit related to a cover involving a sanctioned jurisdiction.

This means that (i) no insurance cover can be provided where involving a sanctioned country or territory in any way, (ii) no payment of premium, payment of Claim or provision of Benefit can be made from or to a bank account open in a sanctioned jurisdiction or in a sanctioned jurisdiction government-controlled bank,

and (iii) no guarantee of payment can be provided by the Insurer to a provider established in a sanctioned jurisdiction or having any shareholding consisting of nationals or residents of a sanctioned jurisdiction or sanctioned persons whatever their ownership.

Nationals or residents of a sanctioned jurisdiction and those persons having travelled to a sanctioned jurisdiction in the past will only be covered when physically located outside sanctioned jurisdictions and provided they do not qualify as sanctioned persons.

No evacuation or Repatriation of an Insured Person will be carried out from a sanctioned jurisdiction.

The list of sanctioned jurisdictions, which is evolving and updated from time to time, includes but is not limited to Afghanistan, Belarus, Iran, Myanmar (Burma), North Korea, Russia, Russia-occupied or annexed regions of Ukraine (including Crimea, Donetsk, Kherson, Luhansk, Sevastopol and Zaporizhzhia), South Sudan, Syria and Yemen. The latest list of sanctioned jurisdictions is available at <https://www.globalhealth.insurance/conditions>.

Restricted jurisdictions

The Insurer will not provide guarantees of payment to Hospitals and will not make payments to bank accounts open in a restricted jurisdiction.

No evacuation or Repatriation of an Insured Person will be carried out from a restricted jurisdiction.

The latest list of restricted jurisdictions, which is evolving and updated from time to time, is available in the Insurer's Download Centre at <https://globalhealth.insurance/conditions>.

Terms and Conditions update

The Insurer reserves the right to adjust the Terms and Conditions of the Insurance Policy and cover immediately and without notice in the event of any change in the political situation of a covered jurisdiction, including but not limited to such jurisdiction's designation as a restricted or a sanctioned jurisdiction or the evolution of sanctions imposed on that jurisdiction.

Insurer liability

The Insurer cannot be held liable for any kind of damage, whether financial, physical or psychological,

resulting from a refusal of insurance cover or a non-payment of Claim or provision of Benefit involving a sanctioned person or a sanctioned or restricted jurisdiction.

Policyholder event of default

In the event the Policyholder has provided incomplete or incorrect information on any Insured Person, including but not limited to information on their identification and/or their geographical location, the Insurer may, at its entire discretion, either require the Policyholder to take necessary remedial action in a determined time, suspend the insurance cover and/or terminate the insurance cover immediately for cause and without prior notice, in accordance with the relevant applicable contractual provisions.

5.5 Notifications

Unless specifically provided to the contrary, all notifications from the Insurer to the Policyholder are deemed validly made if mailed by post to the Policyholder's last known address as reflected in the Insurer's records.

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

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

5.6 Disputes

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

- a) The senior management of the Insurer,
Foyer Global Health S.A.
12, rue Léon Laval
L-3372 Leudelange
Luxembourg
Telephone: +352 270 444 3100
E-mail: feedback@globalhealth.insurance
Internet: <https://globalhealth.insurance>

- b) or to the Insurance Ombudsman, in care of the Association des Compagnies d'Assurances et de Réassurances du Grand-Duché de Luxembourg (Luxembourg Insurance and Reinsurance Association), 12 rue Erasme, L-1468 Luxembourg,

- c) or to the Consumer Ombudsman, Union Luxembourgeoise des Consommateurs (Luxembourg Consumer Protection Association), 55 rue des Bruyères, L-1274 Howald,

- d) or to the National Consumer Ombudsman Service, Service National du Médiateur de la Consommation, 6 rue du Palais de Justice L-1841 Luxembourg,

- e) or to the Luxembourg Insurance Commission, Commissariat aux Assurances, 11 Rue Robert Stumper, L-2557 Gasperich Luxembourg. The opening of the complaint procedure with the Commissariat aux Assurances is subject to the condition that the complaint has been previously dealt with by the Insurer.

This is in addition to the Policyholder's right to pursue legal action in court. For further details on the out-of-court complaint resolution procedure, please refer to the procedure available on the Insurer's website at: <https://globalhealth.insurance>.

5.7 Applicable law and competent court

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

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

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

5.8 Local legislation

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

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

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

5.9 Language and communications

The Policyholder and the Insured Person expressly require that the Terms and Conditions of Insurance and, more generally, the Insurance Policy and all supporting documents and information be submitted to the Policyholder and the Insured Person in English, German, French or Spanish.

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

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

5.10 Solvency and financial condition report

The solvency and financial condition report published from time to time by the Insurer is available on the Insurer's website under the following address: <https://globalhealth.insurance>.

5.11 Guarantee Fund

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

5.12 Force majeure

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

5.13 Change of data

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

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

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

6. Glossary

Accident

An Accident is a sudden and unexpected event acting on the body externally and which damages health.

Application Form

The application for health insurance which contains the insurance proposal within the meaning of the applicable legislation, signed by the Policyholder and, as the case may be, the Insured Person(s).

Benefit

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

Bodily Injury

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

Claim

Treatment of an Insured Person following a Disease or Bodily Injury prescribed and administered by a Medical Authority. The Claim begins on the date of the Start of Treatment and ends when a medical examination performed by a Medical Authority confirms that the Treatment is no longer necessary.

If the Treatment must be extended for a Disease or due to consequences of a Bodily Injury not directly related to such Treatment, a new Claim is deemed to have arisen.

Country of Residence

The country in which the Insured Person has its current habitual residence or its current temporary residence.

Disease

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

Distance Insurance Contract

Any insurance contract concluded between an Insurer and a Policyholder under an organized distance sales or service-provision scheme run by the Insurer, who, for the purpose of the contract, makes exclusive use of one or more means of distance communication up to and including the moment at which the insurance contract is concluded.

Doctor

Physician (general Practitioner or specialist) holding a medical diploma, which is recognized by law in the country in which the Treatment is provided, who is authorized to provide medical care.

For the purposes of this Insurance Policy, the term shall also include Dentists, alternative Practitioners, Therapists licensed and/or recognized as such in the country of Treatment.

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

Dressings

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

Drugs

Active substances which are used, alone or mixed with other substances, in the diagnosis or Treatment of Disease, ailment, Bodily Injury or pathological complaint. Food, cosmetics and toiletries are not considered to be Drugs. Drugs must be prescribed by a Doctor and must be delivered by a pharmacy. Drugs are commonly referred to as: "medicines"; "pharmaceuticals".

Effective Date

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

Emergency

A sudden, acute illness or the acute deterioration of some aspect of health directly putting the Insured Person's general state of health at risk.

General Conditions of Insurance

The terms and conditions governing the risks insured by the Insurer (this document).

Glossary

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

Glossaries

The Glossary and the Glossary included at the end of the Special Conditions, which all form an integral part of the Terms and Conditions of Insurance.

Hospital

An institution for inpatient and sometimes Outpatient Treatment which is approved and licensed in the country in which it operates. The Insurer will only pay Benefits if the Hospital is under constant medical management, has adequate diagnostic and therapeutic facilities and keeps medical records.

The Insurer does not consider convalescent and nursing homes, health centres, health resorts and spas, Hospices as well as sanatoriums as Hospitals.

ICD Codes

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

Insurance Certificate

The Insurance Certificate issued to the attention of the Policyholder and the Insured Person that confirms the scope, and the Effective Date of the insurance cover provided under the Insurance Policy.

Insurance Policy

The contractual framework for health insurance constituted by the General Conditions of Insurance, together with the Application Form, the Special Conditions, the Particular Conditions, the Glossaries, the Insurance Certificate, and any subsequent written agreements between the Insurer, the Policyholder and, where relevant, the Insured Person.

Insurance Year

Period of 12 months that starts either on the Effective Date or the date of the renewal of the Insurance Policy, as the case may be.

Insured Person

The person designated in the Application Form as the person whose health is insured under the Insurance Policy.

By signing the Application Form, the Insured Persons are deemed to also accept to be bound by the terms of the Insurance Policy and any rights and obligations deriving therefrom.

Any Insured Person shall receive a Service Card.

Insurer

The Insurer underwriting the Insurance Policy is Foyer Global Health S.A., a health insurance company established in Luxembourg under the form of a public limited liability company (société anonyme) having its registered office at 12, Rue Léon Laval L-3372 Leudelange, registered under no. B134.471 in the Luxembourg Trade and Companies Register, supervised by the Commissariat aux Assurances (11, rue Robert Stumper, L-2557 Luxembourg; +352226911-1; caa@caa.lu).

Medical Authority

A person authorised to practice medicine in the country where the Treatment is delivered, on the basis of a recognised and official medical degree. He/she can make a diagnosis related to a Disease and/or a Bodily Injury.

Medically Necessary

Medically Necessary are all appropriate medical measures, based on internationally approved medical standards at the respective time and location, which are used to diagnose, treat, heal or relieve the Disease condition, illness or injury and are recognized as appropriate by the Insurer.

These measures must be:

- a) Carried out in a health care facility that is duly authorized and licensed by the authorities in the country of Treatment.
- b) The most appropriate considering both patient safety and cost effectiveness and are consistent with the generally accepted standards of medical practice.
- c) Consistent with the diagnosis, symptoms or Treatment of the underlying condition.
- d) Clinically appropriate, in terms of type, frequency, extent, site, and duration, and

considered effective for the patient's illness, injury, or Disease.

- e) Not required purely for comfort or convenience of the patient, medical providers, Therapists or Doctors.
- f) Not for clinical trial, experimental, investigational, or cosmetic purposes.
- g) Not for screening and preventive care purposes.

Medication

Any substance or composition with curative properties relating to a Disease.

Particular Conditions

The terms and conditions specific to each individual Insurance Policy.

Plan

The Plan chosen by the Policyholder for the Insured Person(s), which defines the extent of the insurance cover provided under the Insurance Policy.

Policyholder

The natural or legal person who enters into the Insurance Policy with the Insurer.

Service Card

The document issued by the Insurer to the Insured Person in accordance with the Insurance Policy, which includes data relevant for contacting the Insurer and which should be used in all communications with the Insurer.

Service Centre

The Service Centre on the ground that offers direct access to local specialists, seamless service and first-class support. The Insured Person can access help services in line with the Plan level chosen whenever an insured event or Emergency happens. On the reverse of the Service Card the number is indicated to contact the Service Centre – 24 hours a day, 7 days a week. The "Insurance No." indicated on the front side of the Service Card should always be at hand.

The Service Centres are familiar with the healthcare system and the local structures of the Country of Residence. They will recommend Doctors and Hospitals, make appointments or procure Medication.

The Service Centre can issue a guarantee for payment or ensure for the quick and straightforward reimbursement of costs.

Special Conditions

The document specifying the exact scope of the insurance cover and the Benefits provided for under the Insurance Policy.

Start of Treatment

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

Terms and Conditions of Insurance

The General Conditions of Insurance, the Special Conditions of Insurance, and, where applicable, the Particular Conditions of Insurance, are collectively being referred to as the Terms and Conditions of Insurance.

Treatment

The diagnostic and therapeutic measures classified as medical services, including medical advice, aids and interventions as well as Drugs and Dressings, which serve to recognize or alleviate and cure a Disease or Bodily Injury and which are deemed Medically Necessary on the basis of objective medical findings and scientific knowledge at the time of Treatment.

Waiting Period

Period after the Effective Date during which no cover and no Benefits are granted under the Insurance Policy for the risks subject to the Waiting Period.

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E-mail: policy@globalhealth.insurance

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