Global Health

Plan II - Special
General Conditions & Special Conditions

global health
Foyer Group

Exclusively for Members of the International Flight Crew Association (Luxembourg) a.s.b.l

NAVIGATOR
Insurance Brokers Ltd.

Exclusively for Members of the IFCA- Interntaional Flight Crew Association (Luxembourg) a.s.b.l
Plan Effective January 1st, 2021

GENERAL CONDITIONS

Content

Policy documents

The mutual rights and obligations of the parties are governed by

- These General Conditions, which apply in common to all plans and the Special Conditions for each plan;
- The Definitions;
- The Particular Conditions and the medical appendices to the policy, which determine, in particular, the insured benefits and give an exact definition of the insured risk or risks.

The mutual rights and obligations of the parties derive from these policy conditions and any subsequent amendments.

1. Scope of Cover

The scope of cover and the individual cover limits are laid down in the General Conditions, the Special Conditions, the Particular Conditions (insurance policy) and their endorsements as well as the legal provisions of Luxembourg.

2. Policy Terms

2.1. Policy administration

2.1.1. Duty to declare when subscribing to a policy and during policy validity

2.1.1.1. When subscribing to a policy

The *policyholder* is obliged to answer all the insurer's questions truthfully and completely. The premium is set on this basis.

The policy will be null and void if the *insurer* is misled by intentionally omitted or inaccurate information relating to risk assessment. In such cases, the *insurer* has the right to retain any premiums already paid. The *insurer* has a recourse right for recovery of any amounts paid in settlement of claims, as well as for payment of all premiums due up to the date on which the *insurer* becomes aware of any omission or inaccuracy.

In the event of non-intentional omission or provision of false information, the *insurer* may, within one month from the date on which it becomes aware of this, propose an endorsement to the policy to take effect from that date.

If the *insurer*, however, proves that it would otherwise never have provided cover for the risk, then the *insurer* may cancel the policy within one month from the date it became aware of the breach of the duty to declare.

If the *policyholder* rejects the proposed amendment or if the proposal is not accepted after a period of one month from the date of receipt then the *insurer* may cancel the policy within two weeks.

In cases where the *policyholder* or the *insured* may be accused of non-fulfilment of the duty to declare and a claim occurs before the policy amendment or cancellation takes effect, then the *insurer* is only obliged to settle the claim pro rata to the amount of the premium actually paid and the premium that should have been paid if the risk had been correctly declared. If the *insurer* provides proof that the risk, whose true nature only came to light with the *claim*, would not otherwise have been insured then the *insurer*'s claim settlement shall be limited to a refund of the premiums or the premium instalments paid.

If several persons are covered by the insurance and the cancellation right for non-disclosure only relates to individual insured parties, then enforcement of the above rights may be limited to those individuals.

2.1.1.2. During policy validity

The *policyholder* or the *insured* person is obliged to disclose any change relating to the insurance policy that is likely to cause a significant and lasting increase in the risk insured.

2.1.1.3. More than one policy

If another health insurance policy exists in addition to this policy, then that other policy shall take precedence.

2.1.1.4. Right of withdrawal

If the contract is concluded via the *insurer*'s website the *policyholder* may withdraw from the contract within a delay of 14 calendar days without specifying a reason and without having to pay a fine.

The withdrawal period commences:
- On the day of the online completion,
- Or on the day that the *policyholder* receives the terms and conditions of the contract and information in case that point in time is later than the one aforementioned.

If the *policyholder* executes his right of withdrawal he informs the *insurer* before the end of the withdrawal period. The deadline is met if the information is sent before the expiry of the deadline in case where this information is in paper form (registered mail) or on another data carrier permanently accessible to the *insurer*.

2.1.2. Policy conclusion and effective date

Insurance cover takes effect on the date specified in the insurance policy, but not before completion of the insurance contract and not before the end of any waiting periods. The insurance contract shall be deemed to have been completed, as and when it has been signed by both contracting parties and the *policyholder* has paid the first premium or the first premium instalment.

No cover shall apply to claims that occurred before the insurance takes effect.

Medical expenses cover for new-born children begins immediately after the birth, without any waiting period and without risk assessment, provided that on the date of the birth of the child both parents have been *insured* with the *insurer* for medical expenses for at least three months and the request for insurance of the child is received not later than two months after the birth with retroactive effect to the first of the month in which the child was born. Insurance cover cannot be wider or more comprehensive

than that of the *insured* parents. New-born children may only be insured in insurance plans that are available for new policies.

2.1.3. Duration

The insurance policy begins on the date specified in the Particular Conditions (policy effective date). The insurance policy is valid for one year and is renewed on a tacit renewal basis for another period of one year unless cancellation notice has been served in time.

2.1.4. Premiums

2.1.4.1. Payment of premiums

Unless otherwise agreed, the legally permissible premiums, policy charges and taxes are payable in advance at the *insurer*'s registered office or at the offices of their duly authorised representative. Payment of premiums is an obligation falling on the *policyholder*.

If the policy covers more than one risk then the total premium is deemed to be one single amount.

The premium is an annual premium. It runs from inception of cover and is due at the beginning of each year of insurance. Other methods of payment are subject to the approval of the insurer.

The first premium is payable not later than the date of policy issue.

For newborn babies who are insured from birth, premiums are calculated as from the date of birth of the child.

2.1.4.2. Consequences of non-payment

In the event of non-payment of premiums or premium instalments, for whatever reason, within ten days after the due date, cover under the policy shall be suspended after a period of at least 30 days from the date of dispatch of a registered letter to the *policyholder* at his/her last known address. To ensure compliance with its duty to inform the *insurer* will also send the letter to the last known e-mail address. The registered letter contains the *insurer*'s demand for payment of the premiums due; it also stipulates the due date and the total amount of the premiums, as well as the consequences of non-payment on expiry of the period referred to above.

No notification of claim can be made on the *insurer* for any loss occurring during the time cover has been suspended.

The *insurer* has the right to cancel the policy ten days after the above-mentioned 30 day period.

If the policy has not been cancelled then cover shall resume at zero hour on the day following the date on which the *insurer* or its designated representative are paid the premiums due, or the instalments (if the annual premium is paid in instalments) that were the subject of the payment demand, as well as any premiums that had become due during the period of suspended cover and any legal or recovery costs.

Suspension of cover does not affect the rights of the *insurer* to lays claim to premiums that become due later, provided that the policyholder has been duly requested to pay. This right is, however, limited to two consecutive years' premiums.
Any policy that has remained suspended for non-payment of premium for an uninterrupted period of two years shall be cancelled automatically.

2.1.4.3. Modification of tariff or conditions

If the *insurer* intends modifying the terms and conditions of insurance and/or its tariffs, it can only do so in compliance with the provisions of the Insurance Contract Law* of 27 July 1997 and any subsequent amendments.

In certain cases, if the *insured* person reaches a certain age (for example transition from childhood to adulthood), the premium increases from the beginning of the calendar year, shall be that which corresponds to the higher age group. In this case the *insurer* is not obliged to inform the *insured* based on the provisions of the Insurance Contract Law* of 27 July 1997 and any subsequent amendments.

(**"Loi modifiee du 27 juillet 1997 sur le contrat d'assurance"*).

2.1.5. Benefits

2.1.5.1. Waiting periods

At the time of inception, there are waiting periods during which insurance cover shall only apply in the event of accident.

The waiting period for pregnancy (including any associated complications), childbirth, psychiatric services, psychotherapy and comprehensive dental care is ten months. The waiting period for fertility treatment is 24 months for both spouses or partners.

In the event of modification of the policy cover, these waiting periods shall apply to the newly applicable covers.

2.1.5.2. Declaration

The *policyholder* and/or the *insured* person(s) must declare any claim to the *insurer* as soon as possible and in any case within three years from the occurrence. If this is not possible due to unforeseen circumstances or "force majeure" then the *insurer* must be notified as soon as reasonably possible thereafter.

2.1.5.3. Obligations and formalities to be observed in the event of a claim

The *insured* has to take all necessary action without delay, in order to avoid a claim or to reduce the consequences of a claim.

The *policyholder* and/or the *insured* person(s) must immediately give the *insurer* all relevant information and answer all questions addressed to them, in order to determine the circumstances of the claim and make an assessment of its extent.

If the *policyholder* and/or the *insured* person(s) do not meet one of these obligations and this results in a loss for the *insurer*, then the *insurer* shall be entitled to reduce the claim settlement by the amount of the loss it has suffered. The *insurer* may refuse cover, if the *policyholder* and/or the *insured* person have wilfully not fulfilled their obligations.

For medical expenses cover, any hospital treatment must be notified within ten days of the start of such treatment. In the event of a breach of obligations the *insurer* may reduce the insurance benefits pro-rata to the loss it has suffered. The *insurer* may deny cover in the event of a wilful breach of obligations.

The requested information may also be provided to an authorised representative of the *insurer*. At the request of the *insurer*, the *insured* is obliged to submit to an examination by a doctor designated by the *insurer*.

2.1.5.4. Payment of benefits by the *insurer*

If benefits can also be claimed from a statutory health insurance fund, statutory or private personal accident insurance, statutory pension insurance fund or any other provider of benefits or institution, the *insured person* is obliged to assign all such rights to us.

The *insurer* is only liable to pay an insurance benefit when the voucher copy requested by it has been provided. This voucher copy becomes the property of the *insurer*.

The *insurer* reserves the right to store such evidence (voucher copy). When submitting cost records these must be the original documents, and must comply with the respective laws of the country which had issued the bill. In order to facilitate settlement and reimburse expenses as quickly as possible, the *insurer* will also accept cost records submitted by e-mail or fax, provided the quality of such evidence is acceptable. In case of legitimate interest, the *insurer* may request original supporting documents. If another health insurer or any other institution has participated in those expenses then copies of the supporting documents bearing their original stamp and acknowledgement of reimbursement will suffice. The insurer can also, with liberating effect, make a payment to the bearer or sender of proper original voucher copy.

Invoices must show: first name and surname, as well as the date of birth of the *insured* person(s), the doctor's exact description of the condition (diagnosis) or otherwise a precise description of the symptoms or coding under ICD-9 or 10 (International Classification of Diseases) plus each of the services provided with treatment date and itemised costs. For dental treatment a description of the teeth treated or replaced and the services provided must be given.

The prescription must show: first name and surname, as well as the date of birth of the *insured* person(s), the prescribed medication, the price and stamp attesting payment. Prescriptions must be submitted together with the associated medical bill or invoice for treatment or therapeutic aids or appliances.

In the case of not claiming a reimbursement, but the insured claims a flat daily hospital charge, then a certificate must be submitted confirming inpatient treatment, which clearly states the first and last name, as well as the date of birth of the person(s) treated, as well as a description of the medical condition, the date of admission and discharge and any days when the patient has been allowed to leave hospital.

The *insurer* has a right to insist that such voucher copy be provided on its own forms. These forms are to be completed by the *insured* and the doctor.

The *insurer* is entitled to pay out the benefits to the person who duly hands over or sends in the supporting documents. If there is a legitimate doubt as to the legality of this person, the *insurer* shall pay the amount of the refund to the *policyholder*.

Medical expenses in foreign currency are converted to Euros at the exchange rate on the day the supporting documents are provided to the *insurer*.

To ensure the processing of the documents can be done as quickly as possible (such as medical reports, invoices, and prescriptions), the *insurer* would ask the *policyholder/ insured* persons to provide

these in one of the following languages: French, German or English. In addition, the *insurer* recommends adding the supplement “Claims Form”.

Claims for insurance benefits can neither be assigned nor pledged.

2.1.5.5. Subrogation

Except where otherwise agreed, the *insurer* shall be subrogated to the rights and remedies of the *insured* up to the amount of the claims settlement paid.

If due to behaviour of the *insured* subrogation can no longer operate in favour of the *insurer* then the *insurer* can request refund of the compensation paid up to the amount of the loss sustained thereby.

An *insured* who has only received partial compensation may not be prejudiced by subrogation. In such cases the *insured* can assert a priority right against the *insurer* for payment of the remaining compensation.
Except in the case of malicious intent, the *insurer* has no recourse against the *insured*'s descendants, ancestors, spouse or relations by marriage in direct lineage nor against anyone living or a guest in his/her house nor against the *insured*'s domestic servants. However, the *insurer* may take recourse against these persons in so far as they have liability insurance under a valid policy.

2.1.5.6. Limitation of actions

The period of limitation for each claim on the insurance policy is three years. The period shall start to run from the date of the occurrence giving rise to the claim. If the person who is entitled to subrogation only becomes aware of this at a later date, then the limitation period shall start to run from that date only, but without exceeding five years from the date of the event, except in the case of malicious intent. The period of limitation shall not run against anyone who is unable to act in time due to "force majeure".

If the *insurance claim* is notified in due time, then the period of limitation shall be interrupted until the date on which the *insurer* announces its decision in writing to the other party. For the beneficiary of a claim, the period of limitation runs from the date on which he/she becomes aware both of the existence of the policy, their capacity as beneficiary as well as of the occurrence of the event giving rise to liability to pay the insurance benefits.

2.1.6. Termination

After the date of termination no benefits are payable, even for claim events that have already occurred and/or have already been notified.

2.2. Cancellation

2.2.1. Automatic cancellation

Any policy that has remained suspended for non-payment of premium for an uninterrupted period of two years shall be cancelled automatically.

In addition, cover shall end for any *insured* person who ceases to meet the insurability conditions set out in the tariff.

Policy cover shall cease on death of the *policyholder*. Nevertheless the *insured* persons have the right to continuity of cover by designating a new *policyholder*, provided this is done within two months of the death of the *policyholder*.

In cases of a granted divorce, the spouses are entitled to continue to enjoy policy cover as individual insured parties. The same applies to separated spouses.

2.2.2. Optional cancellation

If there are several cover items or insured risks then cancellation may apply either to the whole policy or to one or more cover items or risks.

2.2.2.1. Cancellation by the *policyholder*

The *policyholder* is entitled to cancel the insurance in total or for individual insured parties at the end of each policy year, but no sooner than the end of the agreed policy period. Cancellation notice must be sent no later than 30 days before the annual premium due date or else 30 days before the anniversary date of the effective date of the contract. The *policyholder* also has the right to cancel for a period of 30 days from the date of dispatch of the maturity notice by the insurer. Termination shall take effect on the second business day after serving cancellation notice, but at the earliest on the policy renewal date.

In the event of changes to the General Conditions the *policyholder is* entitled to cancel the insurance for the *insured* concerned within one month of receipt of notification of the changes. Cancellation shall take effect from the effective date of those changes.

If the premium is increased, then the *policyholder is* entitled to cancel the insurance for the *insured* concerned within 60 days from the date of dispatch of the maturity notice by the insurer. Termination shall take effect on the second business day after serving cancellation notice, but at the earliest on the policy renewal date.

If the *insurer* cancels cover under one or more of the *policyholder*'s policies or cancels another of the *policyholder*'s policies then the policyholder is entitled to cancel all his/her policies. Cancellation notice must be served within two weeks after the date of receipt of the *insurer's* declaration and will take effect at the end of the month in which such declaration is received.

If the *policyholde*r cancels policy cover in total or for individual insured parties then those insured parties have the right to continuity of cover by designating a new policyholder. Communication of this must be made within two months after the termination date. Cancellation shall only take effect when the *policyholder* provides evidence that the insured person(s) concerned are aware that cover is being cancelled.

2.2.2.2. Cancellation by the insurer

If one and the same benefit is wilfully insured under one or several insurance policies with too high a premium, then the policy is null and void. In this case, the *insurer* is entitled to retain the obtained premiums.

The *insurer* is entitled to terminate the insurance with immediate effect, if the policyholder, or an insured person fraudulently obtains or attempts to obtain an insurance benefit. The right to cancel comes to an end if it is not exercised within one month after the date on which the *insurer* has taken notice of the facts giving rise to the right to cancel.

If several person(s) are covered by the insurance and the cancellation right only relates to individual insured parties, then enforcement of the above rights may be limited to those individuals.

2.2.2.4. Bankruptcy of the policyholder

In the event of bankruptcy of the policyholder, insurance cover shall still apply to the general body of creditors who shall then be liable to the *insurer* for payment of any premium due after the declaration of bankruptcy. Nevertheless, the *insurer* and the curator are entitled to cancel the policy. The *insurer* may only cancel at least three months after the declaration of bankruptcy and such notice must be served within one month after expiry of that period. The curator may only cancel within the three months after the declaration of bankruptcy.

2.2.3. Cancellation notice

Cancellation notice may either be sent by registered mail or served by a bailiff or by handing over a cancellation letter against a receipt.

2.2.4. Refund of premium in the event of cancellation

Regardless of the grounds for termination, the premium relating to the period after the effective date of cancellation shall be refunded within 30 days of the effective date of termination. After expiry of this period the amount shall, as of right, attract interest at the statutory rate.

2.2.5. End of the Insurance

Insurance cover ends - even for outstanding claims - with termination of the insurance relationship.

In the interest of all involved parties the insurer complies with international regulation. The *insurer* is not obliged to provide insurance cover or to cover claims or other benefits under this insurance contract, if the benefits of such an insurance cover, the payment of such claims or the provision of such benefit will expose the *insurer* to a sanction, a ban or a limitation under a resolution of the United Nations, under commercial or economic sanctions, under laws or provisions of the European Union or of the United States of America.

2.3. Miscellaneous

2.3.1. Several policyholders

In the case of several *policyholders* these shall be jointly and severally liable for policy obligations.

In the event of partial cancellation or any other reduction of insurance cover then the provisions of the foregoing paragraph shall apply only for this reduction and in accordance with that which is stipulated.

The *policyholder,* acting both in his/her own name and in the name and for the account of other insured parties, hereby allows the *insurer* to process medical or sensitive data, relating both to him/her and to other insured parties, to the extent this is necessary for the purpose of this insurance policy.

2.3.2. Notifications

All *insurer* notifications to the *policyholder* may validly be addressed to his/her last known place of residence. In cases where there are several *policyholders* then each notification of the insurer to any one of them shall be legally binding on all of them. All notifications to the *insurer* must be sent to the *insurer*'s registered office.

2.3.3. Complains

In any dispute related to the insurance policy, the *policyholder* may address a written complaint

- either to the insurer's general management;
- or to the Insurance Ombudsman (c/o: Association des Compagnies d'Assurances, 12, rue Erasme, B.P. 448, L-2014 Luxembourg, or to the Luxembourg consumer association: Union Luxembourgeoise des Consommateurs: 55, rue des Bruyères, L-1274 Howald);
- or to the Insurance Supervisory Authority: Commissariat aux Assurances (7, Boulevard Joseph II, L-1840 Luxembourg),

without prejudice to the policyholder's right to take legal action.

2.3.4. Applicable law and place of jurisdiction

The policy is governed by Luxembourg law. For any dispute arising from the insurance policy, solely the courts of the Grand Duchy of Luxembourg shall have jurisdiction, without prejudice to the application of international treaties or agreements.

2.3.5. Local laws

In certain countries insurance cover is subject to local laws for health insurance providers, especially for local residents. The *policyholder* and the *insured* person(s) are responsible for making sure that their health insurance corresponds to the legal requirements. The insurance cover provided by Foyer Santé is not a substitute for a national statutory health insurance.

3. Insurability

Insurable are all persons who temporarily reside abroad for at least 3 months.

Excluded from insurance cover are all persons who permanently reside in the USA.

If the *insured* person respectively his/ her co-insured persons permanently take(s) up residence in the USA the insurer will terminate the insurance relationship. For any changes of place of residence in all other countries the insurer may review while the insurance relationship is ongoing if the insurance relationship is conform to the local laws. According to the outcome of this review the insurer may decide whether the insurance cover can continue to be granted or if it has to be modified or terminated.

4. Definitions

Incapacity to work	The *insured person* is temporarily and absolutely incapable of undertaking his/her usual professional activities or other gainful activity. *Incapacity for work* must be attested by a medical *authority*.
Medication	Any substance or compilation that has healing properties in terms of a disease.
Medical authority	A person, who is authorised to practice medicine by virtue of having graduated from Medical School. This person is entitled to pronounce a diagnosis of a disease and/or bodily injury following an accident.
Start of treatment	*Treatment* begins with the determination of the need for care as a result of a deterioration of health, or an accident.
Hospital	Any public or private healthcare institution, which is constantly under medical supervision, keeps medical records, and is intended for use by persons whose state of health requires a stay in the institution for continuous medical treatment and/or diagnosis, observation or monitoring that only the institution can provide. The following are not deemed to be hospitals: closed psychiatric institutions, medical teaching facilities, convalescent homes, approved recreation and nursing homes, spas and sanatoriums.
Disease	A deterioration of physical or mental health, for which the cause and symptoms can be objectively identified therefore making diagnosis possible and treatment a necessity. Such deterioration may not be due to an accident causing bodily injury.
Benefit	Reimbursement of medical expenses or payment of daily benefits to the insured following a claim admissible under the policy.
Accident involving personal injury	A sudden event, occurring against the will of the *insured*, which causes bodily injury for which the cause and symptoms lie outside the victim's body and can be objectively identified therefore making diagnosis possible and treatment a necessity.
Insurer	The term "insurer" shall mean Foyer Santé S.A. 12, rue Léon Laval L−3372 Leudelange, being the insurance company issuing this policy.
Insured	The person(s) named in the insurance policy.
Claim	The medically necessary treatment of an insured person, as a result of illness or accident. A claim begins with the *treatment*; it ends after a medical examination confirms treatment is no longer required. If the treatment has to be extended to a disease or the consequences of an accident, not in direct connection with the ongoing treatment, then this is deemed to be a new claim. As regards daily benefits, the claim must involve permanent *incapacity for work*. The claim ends when *incapacity for work no longer applies and* the treatment is no longer required. If incapacity for work is caused by several illnesses or accidents, daily benefits will only be paid once.
Policyholder	The person who concludes the insurance policy and is responsible for premium payment, or else any person who as a result of an agreement between the parties acts on their behalf, or the dependants of the *policyholder* on his/her death.

I. SPECIAL CONDITIONS
Foyer Global Health
Special

Contents

1. Scope of cover

The insurer provided benefits for the *diseases*, accidents, and other events stipulated in the policy.

In the event of a claim the insurer provides reimbursement of the cost of treatment and other agreed services.

Within the monetary limits of this policy the insurer pays for the medical expenses of each of the insured persons set out in the policy schedule and who have taken out cover under the terms of this policy.

2. Geographic scope

The insurance is valid for the following regions:

- *Region 1:* Worldwide
- *Region 2:* Worldwide excluding the United States

The insurance is valid for the region that the insured person's future country of residence is located in.

If insurance cover relates to region 2 insurance cover shall only apply for medical emergencies, accidents and death in the event of temporary travel (i.e. for a maximum of six weeks) to region 1.

Travel for the purpose of treatment in a non-agreed region is not insured.

Any change in the country of residence of the insured person must be notified immediately, since this change affects the premium.

3. Insurability

All persons who are temporarily abroad for at least 3 months are insurable.

People who are permanently resident in the United States are excluded from insurance cover.

If an insured person takes up permanent resident in the United States then the *insurer* will terminate the insurance relationship. In the event of moving to any other country, the *insurer* may on a case-by-case basis, even during an ongoing insurance relationship, check that this policy complies with national law and according to the results, decide whether insurance cover can be maintained or else needs to be modified or terminated.

The *insurer* can terminate any individual insurance, if the law regarding insurance cover for nationals, residents or impatriates in a country changes with the effect that the insurance cover provided by us is in breach of national law.

3.1 Inclusion of pre-existing conditions or waiting period

On proposal for insurance the insured may opt for the inclusion of pre-existing conditions on the basis of a health risk assessment with a waiting period.

3.1.1 Pre-existing conditions

In order to decide on the inclusion of pre-existing conditions from the beginning of the policy, the health questions in the proposal form must be answered truthfully to the best of the *insured person(s)* knowledge. In such cases the applicant must undergo a medical examination. Depending on the result of the medical examination the *insurer* can extend the policy by adding further terms and conditions, charge an additional premium or refuse the proposal for that person. Any illness that arises in the period between proposal and acceptance of that proposal by the *insurer* will be considered to be a pre-existing condition.

3.1.2 Waiting period clause

Instead of applying for a comprehensive medical risk assessment, the *insured person* can - if he/she is 55 or younger - opt for a "waiting period". In this case, insurance cover will be granted for any condition suffered by the person to be insured in the five years prior to inception of the insurance cover after a continuous waiting period of two years without medical treatment, symptoms, advice or medication for that pre-existing condition. If the insured person during the first two years of insurance cover receives medical treatment, advice or medication for that pre-existing condition then a waiting period of two years (without medical treatment, advice or medication) for that condition begins again. Services for new illnesses not linked to that condition will be immediately reimbursed.

4. Benefits

4.1. General information

The *insurer* will provide a 100% refund of eligible expenses, as described and to the extent set out in the following benefit overviews, unless otherwise agreed in the policy conditions or policy definitions.

4.2. Deductibles

Depending on the insurance plan taken out the *insurer* will provide 100% refund of eligible expenses up to the maximum annual limit specified in the following benefit overviews, unless otherwise agreed in those benefit overviews, the general information, the policy conditions or policy definitions.

4.2.1 Deductibles

The Global Health Special plan has the following deductible variants:

- EUR 0
- EUR 250
- EUR 500
- EUR 1,000

The deductible applies per insurance year and per insured person and only for outpatient treatments.

If the insured person has agreed a deductible with the *insurer*, the *insurer* will refund 100% of eligible expenses for outpatient treatment less the agreed deductible.

Expenses are allocated to the policy year in which the doctor or medical practitioner has been consulted and the medication, dressings and medical aids were provided.

4.2.2 Increased benefits for region 1

If the policyholder has taken out insurance cover for region 1 (= worldwide) then the limits and maximum amounts set out in 4.3.2, 4.3.3 and 4.3.4 will be doubled (irrespective as to whether the medical treatment takes place in the United States or not).

If a benefit is limited to a certain number of days or sessions then this limit applies unchanged. If a deductible has been agreed, this will remain unchanged.

4.3. Benefits

4.3.1. General

The insured person is free to choose between the established and recognised doctors and dentists in the country in which the treatment is to be provided. As far as is provided for in the tariff, the services provided by other people, who offer medical treatment may be acceptable for cover.

Medical and dental services, as well as the services provided by other medical practitioners are eligible for cover, in so far as their charges are calculated on the basis of scales of charges that are typical in that country. Cover may also apply to charges that exceed those scales if these are justified and reasonable in view of the illness and any diagnosis-related complications. In the case of practitioners such as masseurs, midwives or naturopaths, for which no separate scale of charges exists in the foreign country, The *insurer* will use the comparable remuneration for doctors or else the usual prices in that country.

In cases of reimbursement of dental technical laboratory work and materials the *insurer* will use the average prices in that country. Dental prostheses, dental implant services and orthodontics when these services are performed by a doctor will also to be regarded as services by a dental practitioner. They are not the subject of outpatient or inpatient treatment. The *insurer* provides cover within the policy scope for examinations or treatment methods and medications that are recognised by orthodox medicine. The *insurer* also provides cover for methods and medicines that have been seen to be effective in practice or are used because no orthodox medical protocol exists. The *insurer* may however reduce the benefits payable to the level that would have applied if available orthodox medical protocols and medicines had been used.

4.3.2. Inpatient treatment

Overview

Inpatient treatment benefit overview
General hospital treatment and accommodation and care in a single or twin-bed room
Medical services (including pathology, radiology, computed tomography, magnetic resonance imaging, positron emission tomography and palliative care)
Hospital costs, including operating room, intensive care and laboratory
Surgery and anaesthesia
Operations performed as an outpatient instead of inpatient
Drugs and dressings
Therapeutic aids and appliances
Therapies, including occupational therapy, light therapy, hydrotherapy, inhalations, packs, medical baths, cold and/or heat treatment, electrotherapy
Medical aids
Services for pregnancy and childbirth, services of a midwife or attendant in the hospital
Pregnancy and childbirth complications
Newborn Care
Congenital conditions
Cancer therapy, oncology medicines and medical treatment, including reconstructive surgery after breast cancer
Bone marrow or organ transplantation (costs for both donors and recipients)
Psychiatric services
Inpatient Psychotherapy
Refund of parent's costs when accompanying a child under 18 for inpatient treatment
Home nursing care instead of a hospital stay
Daily hospital allowance for inpatient treatment, for which no cost refund is claimed from the *insurer*
Inpatient rehabilitation
Hospice
Day hospital (partly inpatient) treatment
Transport to the next available suitable hospital for primary care after an accident or in an emergency

Detailed benefit descriptions

General hospital treatment and accommodation and care in a single or twin-bed room

When medically treatment becomes necessary in a hospital environment then the insured person can choose freely between hospitals in the country where treatment is to take place. Treatment in a hospital means any treatment, in which the person to be treated is admitted to a hospital for at least 24 hours to be treated medically and receive care.

When medically necessary treatment is carried out in hospitals that also provide cures or sanatorium or convalescence treatment, cover is only provided for those benefits set out in the policy and where the *insurer* has approved these in writing before the start of treatment.

The *insurer* provides cover for the duration of inpatient treatment without any time limit.

Medical services (including pathology, radiology, computed tomography, magnetic resonance imaging, positron emission tomography and palliative care)

Cover shall apply to the expenses incurred for the necessary medical treatment as an inpatient for examinations, diagnostics and therapy.

Hospital costs, including operating room, critical care and laboratory work

This refers to other costs for the use of specialised facilities such as operating theatres, intensive care units and the laboratories.

Surgery and anaesthesia

This refers to costs incurred for the necessary services, such as for example medical services, anaesthesia and the use of specialised facilities. Expenses for outpatient surgery are also eligible in so far as these replace an inpatient stay.

Operations performed as an outpatient instead of inpatient

Outpatient treatment, which can be performed in a doctor's surgery or in a hospital, but does not require to be followed by a stay overnight or a hospital stay.

Drugs and dressings

Drugs, dressings, treatment and medical aids must have been prescribed by a competent medical authority in the hospital during an inpatient stay. In addition, the drugs must have been obtained from a pharmacy or by another source that is approved by the authorities.

Classic homoeopathy medicines are also considered as fully-fledged medicines.

Nutritional food, tonics, mineral water, cosmetics, products for personal hygiene as well as bath salts are not considered to be drugs.

Physiotherapy, including massage

Physiotherapy and massages must have been prescribed by a hospital doctor as part of inpatient medical treatment. In addition, they must be performed by a doctor or a certified therapist. The prescription must be issued before the start of treatment and mention the diagnosis and the type and number of sessions.

Therapies, including occupational therapy, light therapy, hydrotherapy, inhalations, packs, medical baths, cold and/or heat treatment, electrotherapy

These physio-medical services must have been prescribed by a hospital doctor as part of inpatient medical treatment. In addition, they must be performed by a doctor or a certified therapist. The prescription must be issued before the start of treatment and mention the diagnosis and the type and number of sessions.

Therapeutic aids and appliances

Cover applies to costs incurred for those therapeutic aids and appliances that serve as a life-saving measure or directly mitigate or compensate for physical disabilities, such as cardiac pacemakers and artificial limbs/prostheses (except dentures). These must be adjusted during the inpatient stay and

remain in or on the body. Expenses for the repair of such medical aids are eligible for reimbursement under the above terms and conditions.

Services for pregnancy and childbirth, services of a midwife or attendant in the hospital

The *insurer* will cover eligible expenses up to EUR 5,000* for childbirth in a hospital, a maternity or a comparable institution, as well as the expenses for nursing care at home or domestic help, that is necessary due to the pregnancy or pregnancy-related illness, as well as for the services of a midwife or attendant.

A waiting period of 10 months applies.

Pregnancy and childbirth complications

The *insurer* will cover eligible expenses in connection with premature birth, miscarriage, abortion, stillbirth, ectopic pregnancy, molar pregnancy, caesarean birth, post-partum haemorrhaging, placenta retention and complications from these conditions.

A waiting period of 10 months applies.

Newborn Care

Medical expenses cover for newborn children begins immediately after the birth, without any waiting period and without risk assessment, provided that on the date of the birth of the child both parents have been insured with the *insurer* for medical expenses for at least three months and the request for insurance of the child is received not later than two months after the birth with retroactive effect to the first of the month in which the child was born. Insurance cover cannot be wider or more comprehensive than that of the insured parents. New-born children may only be insured in insurance plans that are available for new policies.

If the biological mother is still within the waiting period for pregnancy and childbirth cover then medical expenses will not reimbursed for this. However, there is insurance cover for newborn care as long as the above conditions are met.

If an under-age child is adopted then an individual medical risk assessment shall be carried out for insurance purposes. For technical reasons a surcharge of up to 500% of the tariff rate may be applied after the risk assessment

Congenital conditions

The *insurer* provide cover for eligible expenses up to a maximum amount of EUR 150,000 for the entire lifetime for all disorders or diseases found at birth, anomalies, birth defects and malformations, errors during birth, prematurity and malformations including related illnesses.

Cancer therapy, oncology medicines and medical treatment, including reconstructive surgery after breast cancer

As part of inpatient hospital care the *insurer* assume the eligible expenses for medical services, diagnostic tests, radiation therapy, cancer therapy, drugs and hospital costs.

* The quoted amounts apply – if not otherwise specified – per person and insurance year

Bone marrow or organ transplantation (costs for both donors and recipients)

In cases of bone marrow or organ transplantation (for example heart, kidney, liver, pancreas) the *insurer* assumes the eligible expenses for both the patient as well as the donor up to a total amount of 200.000 EUR over the entire lifetime. Recoverable costs are those associated with organ procurement from an organ donor, the costs for organ transportation to where the patient is located as well as the expenses for possible inpatient stay for the donor, but not the costs for searching for an organ or a suitable donor.

Psychiatric services

The *insurer* will refund the expenses for psychiatric services as part of inpatient treatment, provided the *insurer* have given prior written approval before the beginning of the treatment.

A waiting period of 10 months applies.

Inpatient Psychotherapy

A prerequisite for refund is that treatment is given by a psychiatrist, a psychotherapist or a doctor further trained in the specialist field of psychiatry, psychotherapy or psychoanalysis. For inpatient psychotherapy the *insurer* provide cover only if and to the extent that the *insurer* have given prior written approval before the beginning of the treatment

A waiting period of 10 months applies.

Refund of parent's costs when accompanying a child under 18 for inpatient treatment

The *insurer* will refund the additional expenditure for the prescribed presence of a parent at the bedside of a child under 18 admitted for inpatient treatment.

Home nursing care

The *insurer* will assume the eligible expenses for prescribed home nursing care and domestic help by appropriate, trained persons as a substitute for a medically recommended hospital stay or to shorten such a stay. Home nursing care is in addition to medical treatment and is refundable in addition to this. The *insurer* will refund this for a maximum of 60 days per hospital stay subject to prior written approval.

Daily hospital allowance for inpatient treatment where no claim has been made on the insurer

The *insurer* will pay a daily hospital allowance of €150* for inpatient treatment where no claim has been made on the *insurer*.

Inpatient rehabilitation

Costs are refundable for inpatient rehabilitation in continuation of medically necessary inpatient hospital treatment, for example, after bypass surgery, a heart attack, organ transplantation, as well as operations on large bones or joints, provided and to the extent that the *insurer* have given prior written approval. Inpatient rehabilitation must in principle begin within 2 weeks after discharge from the hospital. Cures and stays in cure establishments, spas, sanatoriums and convalescent homes as well as in nursing homes are not insured. The *insurer* will refund inpatient rehabilitation for a maximum of 28 days per hospital stay subject to prior written approval.

Hospice

* The quoted amounts apply – if not otherwise specified – per person and insurance year

If no non-hospital care for the insured persons can be provided in their own or a family member's home, and under the condition that the hospice works with experienced palliative medicine nurses and doctors as well as being under the technical responsibility of a nurse or other qualified person, who has several years' experience in palliative care or has appropriate training and can prove training for a responsible positions in palliative care, the *insurer* will reimburse expenses for accommodation, food, care and support depending on the condition.

A prerequisite for the granting of benefits for full or semi-inpatient hospice treatment is that the insured person must be suffering from an illness

- that it is progressive, meaning that it is progressively getting worse, and has already reached a very advanced stage and
- Recovery is not possible so that inpatient palliative care is necessary and only a limited life expectancy of weeks or a few months can be expected.

Hospice benefits will be granted amongst others for the following conditions:

- Advanced cancer
- Full-blown state of the infectious disease Aids
- Disease of the nervous system with inexorable progressive paralysis
- Final state of chronic kidney, liver, heart, digestive tract or lung disease.

Hospice expenses will be refunded for a stay of up to 7 weeks for the duration of the contract.

Day hospital (partly inpatient) treatment

Day hospital treatment shall mean treatment in a hospital without overnight stay. The length of the stay in hospital is between eight and 24 hours.

Transport to the next available suitable hospital for primary care after an accident or in an emergency

The *insurer* will reimburse the reasonable transport costs to the nearest suitable hospital or to the nearest suitable medical facility.

4.3.3. Outpatient treatment

Overview

Outpatient treatment
Medical services (including pathology, radiology, computed tomography, magnetic resonance imaging, positron emission tomography and palliative care)
Cancer therapy, medicines, and oncology medical services
Health check-ups
Services for pregnancy and childbirth, services of a midwife or attendant
Pregnancy and childbirth complications
Congenital conditions
Acupuncture, homoeopathy, osteopathy and chiropractic, including medicines and dressings
Speech Therapy
Psychiatric services
Outpatient Psychotherapy
Drugs and dressings
Over-the-counter medicines
Physiotherapy, including massage
Therapies, including occupational therapy, light therapy, hydrotherapy, inhalation, packs, Medical baths, cold and/or heat treatment, electrotherapy
Therapeutic aids and appliances
Vaccinations and immunizations
Visual aids, including Eye Test
Transport to the nearest suitable doctor or hospital for primary care after an accident or emergency by rescue services recognized using transportation means that are appropriate in the situation
Fertility Treatment

Detailed benefit descriptions

Medical services (including pathology, radiology, computed tomography, magnetic resonance imaging, positron emission tomography and palliative care)

Cover shall apply to the expenses incurred for the necessary medical treatment as an inpatient for examinations, diagnostics and therapy.

Eligible expenses are, inter alia, costs for pathology, radiology, computed tomography, magnetic resonance imaging, positron emission tomography, chemotherapy and other oncology (cancer) medical services as well as for vaccination and prophylactic measures.

Cancer therapy, medicines, and oncology medical services

Outpatient services are refunded in connection with chemotherapy and oncology medical services.

Health check-ups

Routine health checks are examinations or screening tests carried out, without the presence of clinical symptoms.

These tests, which are carried out depending on age for the purpose of detecting anomalies or illnesses, include the following examinations:

- Vital parameters (blood pressure, cholesterol, pulse, breathing, temperature, etc.)
- Cardiovascular examination
- Neurological examination
- Cancer screening
- Paediatric screening
- Diabetes screening
- HIV and AIDS screening
- Gynaecological screening.

The *insurer* will reimburse these services up to an amount of EUR 250* per year of insurance.

Services for pregnancy and childbirth, services of a midwife or attendant

The *insurer* will cover eligible expenses up to EUR 5,000* resulting from pregnancy, or a pregnancy disease, including (routine) screening, childbirth and the services of a midwife or attendant. For women over 35 this includes amniocentesis and nuchal translucency measurement.

There is a waiting period of 10 months.

Pregnancy and childbirth complications

The *insurer* will cover eligible expenses in connection with premature birth, miscarriage, abortion, stillbirth, ectopic pregnancy, molar pregnancy, caesarean birth, post-partum haemorrhaging, placenta retention and complications from these conditions.

There is a waiting period of 10 months.

Congenital conditions

The *insurer* provides cover for eligible expenses up to a maximum amount of EUR 150,000 for the entire lifetime for all disorders or diseases found at birth, anomalies, birth defects and malformations, errors during birth, prematurity and malformations including related illnesses.

Acupuncture, homoeopathy, osteopathy and chiropractic, including medicines and dressings

The *insurer* will only cover eligible expenses if the above treatment is carried out by doctors or other practitioners, who can prove they have certified appropriate training in the country where the treatment is given and that they are approved or authorised there to dispense such treatment.

The medicines and dressings prescribed by those doctors or physicians in the course of the treatment are also eligible for reimbursement.

The *insurer* will reimburse these services up to an amount of EUR 2,500* per year of insurance.

Speech Therapy

In speech and voice disorders the *insurer* will cover eligible expenses for prescribed practice sessions, provided that these are conducted by a doctor or speech therapist the *insurer* provides cover for this only if, and to the extent that the *insurer* has given a written undertaking before the start of the treatment

Psychiatric services

The *insurer* will refund the expenses for psychiatric services up to EUR 5,000*, provided the *insurer* has agreed to reimbursement of these costs in writing before the beginning of the treatment.

There is a waiting period of 10 months.

Outpatient Psychotherapy

A prerequisite for refund is that treatment is given by a psychiatrist, a psychotherapist or a doctor further trained in the specialist field of psychiatry, psychotherapy or psychoanalysis. The *insurer* will refund the expenses for outpatient psychiatric services provided the *insurer* has agreed to reimbursement of these costs in writing before the beginning of the treatment.

Medicines and dressings

Medicines and dressings must be prescribed by a medical doctor or dentist or a person working under their authority. Such medicines must come from a pharmacy or other officially approved supplier. Nutritional food, tonics, mineral water, cosmetics, products for personal hygiene as well as bath salts are not considered to be medicines.

Over-the-counter medicines

The insured person(s) may buy non-prescription medicines without a prescription; usually they are for the treatment of symptoms of common diseases for which the insured person(s) do(es) not necessarily have to visit a doctor.

The *insurer* will reimburse these up to an amount of EUR 75* per year of insurance.

Physiotherapy, including massage

This means physio-medical services (physiotherapy and exercise therapy, massages), that are available on prescription. In addition, they must be performed by a doctor or a certified therapist. The prescription must be issued before the start of treatment and mention the diagnosis and the type and number of sessions.

The *insurer* will reimburse up to 20 sessions per person per year of insurance.

Therapies, including occupational therapy, light therapy, hydrotherapy, inhalations, packs, medical baths, cold and/or heat treatment, electrotherapy

These are physio-medical services (occupational therapy, light therapy, hydrotherapy, inhalations, packs, medical baths, cold and/or heat treatment, electrotherapy and exercise therapy) for which a prescription is required. In addition these must be provided by a doctor or certified therapist and must have been prescribed by the doctor as part of outpatient medical treatment. The prescription must be issued before the start of treatment and mention the diagnosis and the type and number of sessions.

The *insurer* will reimburse up to 10 sessions per person per year of insurance.

Medical aids

Costs eligible for refund are those incurred for the purpose of outpatient treatment for orthopaedic and prosthetic appliances, as well as other material up to EUR 1,000*, which are used to prevent physical disabilities or directly to mitigate or compensate for this. Medical aids must be prescribed by a doctor and must not be considered as general consumer goods.

Medical aids for the purpose of outpatient treatment shall mean: Bandages, trusses or shoe inlays, crutches, hearing aids, compression stockings, artificial limbs/ prostheses (excluding dental prostheses), lounger and seat pans, orthopaedic body, arm and leg support devices and speech equipment (electronic larynx).

The following medical aids are eligible only after prior written agreement by the insurer: Wheelchairs, cardiac and respiratory monitoring devices, infusion pumps, inhalation devices, oxygen equipment and surveillance monitors for babies. Other aids are not considered as medical aids.

Expenses for the repair of such medical aids are eligible for reimbursement under the above terms and conditions. Expenses for sanitary supplies such as pads and massage devices for example, as well as for use and maintenance of such aids are not eligible for refund.

Vaccinations and immunizations

Cover is for the costs incurred for preventive vaccination and prophylactic measures up to EUR 250*, in so far as they are recommended for the particular country, including the medical costs for the administration of the vaccine and the cost of the vaccine itself.

Visual aids, including Eye Test

Costs incurred for spectacle frames and lenses, as well as contact lenses and refraction measurement up to EUR 150 * per year of insurance.

Transport to the next available suitable hospital for primary care after an accident or in an emergency

Cover shall apply to the expenses of transportation to the nearest suitable hospital for primary care after an accident or in an emergency.

Fertility Treatment

With the *insurer's* prior written agreement stipulating that the *insurer* will bear the costs in the terms and conditions of the agreed scope of cover, the *insurer* can cover for example the following recognized treatments:

- In-vitro fertilisation (IVF)
- Intracytoplasmic sperm injection (ICSI)

Costs will be assumed under the condition that

- at the time of treatment (first stimulation day of each cycle or else the first cycle day if insemination without hormonal stimulation) the woman has not reached the age of 40 and the man 50.
- there is organic-related infertility of the insured persons that can be overcome by means of assisted reproductive techniques alone
- medical assessment has ascertained a significant possibility of success of over 15 % for the selected
- method and that the man and the woman have international insurance with us.

The *insurer* will refund 50% of the costs incurred in connection with undergoing fertility treatment, including diagnosis and treatment, up to a maximum of EUR 7,500 for the whole duration of policy cover.

There is a waiting period of 24 months for both spouses or partners.

4.3.4. Dental treatment

Overview

Benefits overview: Dental treatment
General dental care
Two preventive dental check-ups per year of insurance
X-ray examination
Tartar removal and polishing
Treatment for oral mucosa and gum disease
Simple fillings
Surgical treatment, extractions, root canal work
Night splint
Dental care after an accident
Comprehensive dental care
Dental care after an accident
Dental Prostheses (e.g. prostheses, bridges and crowns, inlays)
Implant treatment
Orthodontic services
Dental laboratory work and materials
Drawing up treatment plan and estimate of costs
Dental care after an accident

Detailed benefit descriptions

General dental care

- Two preventive dental check-ups per year of insurance
- X-ray examination
- Tartar removal and polishing
- Treatment of mouth and gum disorders
- All simple fillings - either amalgam (silver) or plastic (white)
- Root canal work
- Anaesthetist costs
- Surgery
- Extractions
- Night splint
- Dental care after an accident

Comprehensive dental care

Comprehensive dental services include the following types of more complex measures and curative care. The *insurer* will refund the following services up to EUR 2,000* per year of insurance.

- Dental Prostheses (e.g. prostheses, bridges and crowns)
- Inlays (gold, porcelain), including dental laboratory work and materials
- Onlays

- Implants
- Orthodontic treatment in children under the age of 18, including metal braces and retainers, as well as drawing up treatment plan and cost estimate
- Dental laboratory work and materials
- Drawing up treatment plan and estimate of costs
- Dental care after an accident

There is a waiting period of 10 months.

Dental care after an accident

If dental treatment is necessary as a result of an accident, no policy limits will apply to this. The accident must be proven to us by a doctor or police report.

4.4. Cover limitations

Cover does not extend to *diseases*, including their consequences, as well as for death and the consequences of accidents due to military operations, military service, riot and civil commotion, not expressly included in the insurance.

There is no cover for illnesses, treatment and accidents caused wilfully nor their consequences or for treatment or stays in an institution for drug withdrawal.

Unless otherwise laid down in the tariffs, there is no cover for *cures* and treatments as well as for rehabilitation in a sanatorium.

There is no liability to provide cover for treatment provided by spouses, parents or children. Proven material expenses will be reimbursed.

There is no cover for cosmetic measures of all types and their consequences.

There is no cover for attempted suicide.

For treatment provided by doctors, dentists, naturopaths and in *hospitals*, for which the insurer has refused refunds for serious reasons, no benefit is payable if the insured event occurs after the policyholder has been notified of the exclusion. If at the time of claims notification treatment has not yet finished, there is no obligation to refund costs incurred more than three months after said notification.

There is no cover for accommodation due to dependency (long-term care) or minding.

There is no cover for medical reports, treatment and expense summaries that the policyholder or insured person are bound to supply.

There is no cover for the insured person's loss of autonomy or when the insured person needs to be constantly looked after. Staying at home and/or receiving non-medical care at home or in a convalescence home or similar or in a psychiatric home or similar shall give rise to no cover.

If medical care or other treatment delivered shall exceed that which is medically necessary then the insurer may reduce its benefits accordingly. In addition, the *insurer* shall be entitled to such a reduction, if excessive sums are charged for such medically necessary treatment or for any other service.

For claims arising before inception of policy cover, that part of the claim falling before inception or during the waiting period shall be excluded.

The *insurer* does not provide cover for the operational and hormonal approximation of the biological sexual characteristics of the other sex.

The *insurer* does not provide cover for treatment or surgery to correct the *insured person's* vision, for example by laser, refractive keratotomy (RK) and photo refractive keratotomy (PRK). Cover does apply to the correction of the *insured person's* vision when this is necessary due a disorder, illness or injury (e.g. cataract or detached retina).

5. Tariff

The premium shall be set at the time of taking out cover on the basis of the country in which the *insured person(s)* is/are staying. If there is any change of residency during policy validity to region 2 then the premium will be adjusted accordingly at the beginning of the next policy year. If there is a change of residency during policy validity to region 1 then the premium will be adjusted immediately

If after a birthday the insured person moves into another age category then the premium will be adjusted to the new age.

II. Medical Assistance Services and Additional Services

In association with a health insurance product from Foyer Global Health

Contents

1. Object of the Medical Assistance Services and Additional Services

The insurer provides the medical assistance services and additional services within the scope of medically necessary treatments for illnesses, accidents, in particular emergencies, and other events.

2. Geographical coverage

The medical assistance services and additional services are effective worldwide.

3. Services

3.1. General information

The type and scope of the medical assistance services and additional services provided by the insurer are in accordance with the following service overviews, unless otherwise stated in these service overviews, our general remarks in the general conditions, or in the definitions.

3.2. Medical Assistance Services

The medical assistance services and the additional services can only be concluded in conjunction with a health insurance product from Foyer Global Health.

Medical assistance overview

24-hour telephone and email service with experienced advisers, doctors and consultants
Medically necessary ambulance service and return transport
Information on the medical infrastructure/care with due consideration for the required language
Support and information (second opinion, monitoring the course of the illness)
Guaranteed payment of costs, particularly in preparation for the stay in hospital
Payment of an advance
Support and information on the type, possible causes and treatment options/forms of therapy for the illness and information about specialist medical terms
Support in organising a "doctor-to-doctor" discussion
Assistance in choosing the prescribed medication, comparable preparations and their side effects
Medical support and advice prior to travelling (vaccinations, putting together a first-aid kit)

24-hour telephone and email service with experienced advisers, doctors and consultants

Medical assistance is available 24 hours a day, 7 days a week and 365 days a year by calling the medical assistance hotline.

Ambulance service and return transport

This service covers a medically justified and necessary ambulance service and return transport, both in the country of residence or to a cross-border location. The costs of medically justified and necessary accompaniment during transport are also included in the service provided.

- The ambulance service and return transport may also be carried out due to inadequate medical care and inadequate standards of hygiene in the hospital providing the treatment.
- The ambulance service and return transport must be ordered by the doctor in charge, and there must be a prior approval from the insurer to cover the cost.
- The ambulance service and return transport to a hospital suitable to provide further treatment will occur after this has been agreed between the doctor in charge and the insurer.
- Subject to agreement with the insurer, return transport can also be to the insured's current place of residence or last permanent place of residence in the insured's home country or country of origin, if the insured event occurred outside the country of residence.

Information on the medical infrastructure/medical care with due consideration for the required language

- Designation of doctors, hospital consultants, hospitals and specialist hospitals in the surrounding area of the insured party, particularly with regard to the required language
- Advice and support in the selection of a treatment location in the case of a medically necessary transfer/change of care provider

Support and information (second opinion, monitoring the course of the illness)

- Support and organisation of a second medical opinion (medical findings) from a specialist in the relevant medical field in the event of life-threatening and serious illnesses and health disorders
- Support in selecting a specialist and hospital, and in the organisation of admittance and discharge
- Organisation and support in monitoring the course of the illness/ recovery by doctors and the insurer's contacts

Guaranteed payment of costs, particularly in preparation for the stay in hospital

- Submission of a cost payment guarantee, e.g. in the event of planned inpatient treatment
- Direct settlement of costs with the doctor/ hospital in charge is possible

Payment of an advance

Payment of an advance to the insured person(s) if the care provider and/or hospital only accepts cash payments

Support and information on the type, possible causes and treatment options/forms of therapy for the illness and information on specialist medical terms

Advice, clarification and explanation of medical matters in the event of the insured person becoming ill, particularly with regard to causes and treatment options/forms of therapy for an illness and explanation of specialist medical terms

Support in organising a "doctor-to-doctor" discussion

In the event of illness and a deterioration in health, e.g. in the case of chronic ailments, the insurer will help to organise a "doctor-to-doctor" discussion, e.g. between the patient's doctor in the country of departure/ origin and in the country of residence

Assistance in choosing the prescribed medication, comparable preparations and their side effects

- Information on drugs and their side effects and interactions with other preparations and pre-existing medical conditions.
- Information on comparable and identical preparations

Medical support and advice prior to travel (vaccinations, putting together a first-aid kit)

- Medical information on standards of hygiene in the country of residence
- Advice and information on recommended vaccinations for the country of residence, especially in the event of pre-existing medical conditions
- Support in putting together a first-aid kit with due consideration for the standards of hygiene and weather conditions in the country of residence.
- Advice and information can be obtained from the insurer by telephone and email

3.3. Additional Services

There will be an entitlement to receive "additional services" if the insurance service is agreed for the insured party in accordance with the certificate of insurance (CP).

Overview of additional services

Return transport to the country of residence
Organisation of patient visits for relatives
Delaying the return journey
Procurement and dispatch of essential drugs
Organisation of return transport or childcare
Transfer of the mortal remains and organisational support in the event of death
Help with any psychological problems arising from the stay abroad
Document storage (storage and obtaining replacements in the event of loss)
Arrangement of legal assistance in the event of legal difficulties
Arrangement of a relocation service
Arrangement of intercultural training (information on the local culture)

Return transport to the country of residence

When it is agreed by the insurer, and it is medically necessary to transport the insured party for treatment, the insurer will reimburse the transportation costs (first class rail ticket, Economy Class flight) for the insured party's return trip to the country of residence, subject to prior agreement, up to a value of EUR 3,000.

Organisation of patient visits for relatives

In the event of inpatient treatment due to an emergency, the insurer will organise the visit of one family member to the place of treatment and back home, and will pay the travel costs up to a total of €3,000*, if the inpatient treatment lasts at least 7 days and the insurer's cost payment guarantee is available. (The costs of a first class rail ticket and Economy Class flight will be paid)

Delaying the return journey

If the return journey from the country where the patient is staying has to be delayed (when travelling back to the country of origin/home country or to a new country) due to a medical emergency affecting an insured party, resulting in the inability to travel, the insurer will reimburse the costs to change/cancel the hotel and flight bookings up to €3,000*.

Procurement and dispatch of essential drugs

If an insured person takes essential drugs that are not available in the country where the insured person is staying, the insurer will endeavour to obtain these drugs as quickly as possible. This is provided that the drug is legally approved in the country where the insured person is staying and its import does not contravene any legal regulations

Organisation of return transport or childcare

- In the event of both parents being required to stay in hospital because of a medical emergency, the insurer will organise childcare by a suitable service provider, and will pay the costs for this, for the duration of the inpatient treatment but no longer
- If both parents are treated as inpatients in hospital during a holiday because of a medical emergency, the insurer will reimburse the costs for the children (up to 18 years of age) to travel to their current place of residence in their country of residence

Transfer of the mortal remains and organisational support in the event of death

- Completion of the necessary formalities to transfer or cremate the mortal remains, in particular obtaining the death certificate, the accident report, establishing contact with the authorities/consulate and establishing which relatives are entitled to authorise transfer or cremation
- Reimbursement of the costs for the transfer of the mortal remains to the country of departure or home country and the costs for the formalities associated with the transfer up to an amount of €10,000*
- Transfer of the urn to the country of departure or home country in the event of cremation
- Funeral costs are not insured

* The quoted amounts apply – if not otherwise specified – per person and insurance year

Help with any psychological problems arising from the stay abroad

- The insurer will offer counselling in the event of a psychologically stressful situation
- The insured person(s) will receive psychologically therapeutic support by telephone from experienced doctors, and advice on the course of action to take, up to a maximum of 5 conversations

Document storage (storage and obtaining replacements in the event of loss)

- The insurer offers a storage facility for important documents (e.g. passport, visa, driving licence, vaccination certificate, and other important documents).
- If the original document is lost, a copy will be sent by email, fax or courier, and support will be provided in obtaining a replacement.

Arrangement of legal assistance in the event of legal difficulties

If required, the insurer will provide selected English-, German-, French- or Spanish-speaking lawyers/experts in the country of residence.

Arrangement of a relocation service

If required, the insurer will arrange special service providers to organise relocation and provide support in looking for accommodation if necessary.

Arrangement of intercultural training (information on the local culture)

If required, the insurer will arrange country-specific and intercultural training on living and working abroad in preparation for the stay abroad.

4. Tariff

The insurance premium is indicated in the certificate of insurance (CP).

III. Definitions

Accident	Accident is a sudden unexpected external event that affects the body and damages health
Acupuncture.	Acupuncture is a method in ancient Chinese traditional medicine that cures illnesses or reduces pain with the help of fine needles placed into the body. Orthodox medicine recognises this primarily as a method for pain relief.
Assistance company	An assistance company is specialised in providing insured persons with advice and help in emergency situations or for hospital treatment. Additional services that may facilitate the insured person's stay abroad, as well as the reimbursement of certain costs, for example repatriation costs will be provided through the assistance partner. The complete range of services can be found in the enclosed Assistance conditions.
Cancer	Cancer is the general term for all malignant diseases caused by a proliferation of modified cells (tumour, carcinoma). These cells can destroy the surrounding tissue and produce secondary tumours (metastases).
Chiropractic	A Chiropractic is also known as manual therapist. Displaced or distorted vertebrae are "put back" again or other joints "reset" using special techniques.
Conservation treatment	Conservation treatment is treatment for the conservation of teeth (e.g. fillings, root canal work).
Conventional Medicine	Conventional Medicine is the university based, scientific and therefore generally accepted and applied form of medicine.
Conversion	Conversion is the alteration of policy cover with the insurer, e.g. change of deductible or amount of the deductible whereby the policyholder and the insured persons retain the guarantees and rights the policyholder has acquired out of policy cover that has remained uninterrupted with the insurer.
Country of Origin	The country of origin is the country in which the insured person was permanently living in before relocating to another country abroad.
Country of residence	The country of residence is the country in which the insured person will be living in after the beginning of the stay abroad.
Daily hospital allowance	If the policyholder does not claim reimbursement from the insurer for an insured person in respect of medically necessary inpatient treatment then the insurer will pay depending on the plan level, a daily hospital allowance per prescribed day in hospital occurs.
Deductible	A deductible causes the insured persons to retain a certain portion of the costs themselves. A deductible is the self retention of the policyholder and/or the insured person in the insurer’s reimbursement payments. If a deductible has been agreed this will be documented in the policy schedule
Dentist	A practitioner who focuses on diseases of the teeth and mouth.
Doctor	A doctor is a physician (general practitioner or specialist) or holder of a medical diploma, which is recognized by law in the country in which the treatment is provided and who is authorised to provide medical care (see treatment). The insured persons are free to choose a doctor, who meets these criteria.
Domestic help	Domestic help is a part of home nursing care. It includes assistance for normal regularly recurring chores of domestic daily life, such as grocery shopping, cooking, cleaning the home, washing up, changing and washing clothes and ensuring comfort of the home is maintained.
Dressings	Dressings are material applied as a bandage

Drugs	Drugs are active substances which are used, alone or in a mixture with other substances in the diagnosis or treatment of disease, suffering, bodily injury or pathological complaints. Food, cosmetics and toiletries are not considered to be drugs. Drugs must be prescribed by a physician and must be delivered by a pharmacy. Commonly stated as: Medicines, pharmaceuticals.
Emergency	An emergency is understood to be the sudden occurrence of an acute illness or acute deterioration in health, which is a direct threat to the state of health of the insured person.
Functional therapeutic and functional analytical services	An investigation and treatment method for diagnosing disorders and diseases of the entire mouth area that is associated to dental treatments.
Home Country	The home country is the country of which the insured person is a national, or to which he/she is to be transferred to in the event of death
Homoeopathy	Homoeopathy is based on three pillars: the similarity rule, the remedy picture and the potentiality of the substances. A specialist in homoeopathy assumes that a disease that manifests itself in specific symptoms can be cured by a substance that causes similar symptoms in healthy people.
Hospice	An institution that exclusively serves the purpose of providing patients with a life expectancy of only a few months with care and alleviating the life-threatening symptoms by palliative medical care
Hydrotherapy	Hydrotherapy is the targeted treatment by external application of water.
ICD codes	ICD stands for International Classification of Diseases. It is an international system for coding and classification of all known diagnoses.
Implant treatment	Implant dentistry services are understood to be the inserting of dental implants (metal or ceramic) as root substitutes or in toothless gums.
Inpatient rehabilitation	Inpatient rehabilitation is a medical procedure to restore a person back to their previous physical condition after a serious illness/operation, for example, after bypass surgery, heart attack, transplantation of organs, as well as operation on large bones or joints, or a serious accident.
Insurance proposal	The application for insurance is made by a person/ policyholder and/or the insured persons by means of a proposal form provided by the insurer.
Insured	The person(s) named in the insurance policy.
Insurer	The term "insurer" shall mean Foyer Santé S.A. 12, rue Léon Laval L 3372 Leudelange, being the insurance company issuing this policy.
Magnetic resonance imaging (MRI)	This is understood as a diagnostic technique for visualisation of the internal organs and tissues with the help of magnetic fields and radio waves.
Medical treatment	Medical treatment is understood to be the diagnostic and therapeutic measures classified as medical services which serve to recognise or alleviate and cure health problems, disease or injury. Treatment is deemed to medically necessary on the basis of objective medical findings and scientific knowledge at the time of treatment, it is seen as reasonable and therefore medically necessary.
Medically necessary	Medically necessary are all actions that are suitable for healing or alleviating a disease/ an illness
Oncology	Oncology is a branch of internal medicine, which is concerned with the development, diagnosis, and treatment of tumours and tumour-related diseases.
Operations performed as an outpatient instead of inpatient	Operations that can be performed on an outpatient basis at the doctor's surgery or in the hospital but do not require an overnight or longer stay in the hospital.

Osteopathy	The osteopathic approach to medicine includes comprehensive manual diagnostics and therapy of the malfunctioning of the body's musculoskeletal framework, internal organs and the nervous system. It is mainly used in chronic pain of the vertebral column and the peripheral joints.
Palliative Care	Palliative therapy is the extensive and active treatment of patients with a limited life expectancy for which curative therapy is no longer possible in their condition. This type of treatment provides the best possible quality of life for the patient and his/her family.
Partly inpatient treatment	Partly inpatient treatment means a stay in a day or night clinic or hospital, in which the patient is in the hospital during the day or at night but for which a full-day (24-hour) inpatient basis is no longer required.
Policyholder	The person who takes out the insurance policy and is responsible for premium payment, or else any person who as a result of an agreement between the parties acts on their behalf, or the dependants of the policyholder on his/her death.
Policy schedule	The insurance cover that has been agreed for the insured persons as well as the premium due are documented in the schedule.
Positron emission tomography (PET)	Positron emission tomography (PET) is a non-invasive imagery process based on the detection and imagery of a substance with positron emitters spread inside the patient's body. The concentration of these "markers" in a tumour can then be quantified, the substance is injected intravenously, and the radiation is detected with external detectors. With the help of PET important biological processes can be visualised in tumours
Practitioner	Practitioners can be a person(s) who besides doctors also have recognised and well-founded training in their area of treatment and are authorised for treatment in that speciality in the country in which the treatment is to be provided. The following are understood to be practitioners: Naturopaths, speech therapists and midwives as well as independent practitioners practising in state approved medical ancillary professions (for example massage therapists and medical attendants, physiotherapists). The insured persons are free to choose a practitioner who meets these criteria.
Pre-existing conditions	Pre-existing conditions are conditions and their consequences, or the results of an accident, of which the policyholder or the insured persons were aware or had treatment for before policy inception. By special agreement with the insured person these can in principle be included. Pre-existing conditions that were not disclosed on proposing for insurance are not insured.
Prophylactic Measures	Prophylactic measures are a part of preventive medicine. These are individual and general measures to prevent imminent diseases (e.g. vaccination, passive immunisation, precautionary medication at the point of entry in areas at risk, accident prevention etc.).
Region	Insurance cover is valid for the following regions: • Region 1: Worldwide • Region 2: Worldwide excluding the United States
Scale of charges	A scale of charges is the foundation on which the calculation of medical or dental services is based. These may differ from country to country.
Second Opinion	Second opinion or medical opinion is medical advice by another doctor, who has so far not been involved, as to a life threatening and severe condition or permanent health problem.
Service Card	The insured person(s) receive a personalised service card with the main phone numbers of the assistance company. The personalised service card serves as proof of insurance when dealing with all service providers.
Spa and sanatorium treatment	A cure or sanatorium treatment serves to consolidate a person's state of health

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