HEALTHCARE PLAN

GENERAL TERMS AND CONDITIONS

Introduction

This policy is a contract between the POLICYHOLDER and the COMPANY.

The COMPANY agrees to give the insurance cover set out in this policy under the sections (and subsections) of cover that are shown as being included on the SCHEDULE. This policy, the SCHEDULE and all attached memoranda and endorsements detail the entire cover provided and the terms and conditions applying to it.

The COMPANY will only provide cover for those people who are shown as being insured on the SCHEDULE and/or have been enrolled on the platform of the MEDICAL PLAN ADMINISTRATOR, or any attached memoranda or endorsements for the period of insurance as long as the required premium has been paid and the COMPANY has accepted it.

The POLICYHOLDER should read this policy to make sure that they understand the cover provided and the limitations applying. If there are any elements of the cover that require clarification or do not meet the needs of the POLICYHOLDER, the POLICYHOLDER should in the first instance raise these with their insurance intermediary, where applicable.

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CHAPTER 1. GENERAL DEFINITIONS

The following definitions apply to the policy and have the same meaning wherever they are used in these general terms & conditions, policy SCHEDULE or endorsements.

1.1. ACCIDENT

Means a sudden, violent external event which results directly and immediately in INJURY to the INSURED PERSON, and which may or may not result in death, provided that the nature and location of the INJURY or the cause of death can be medically established.
ACCIDENT shall also be taken to mean:

a. Health disorders that are directly and solely due to an insured ACCIDENT;
b. INJURY resulting from lawful self-defense, or rescue or attempted rescue of endangered persons or goods;
c. Acute and unintentional ingestion of solid, liquid and/or gaseous substances that is injurious to a person's health;
d. Dislocations, sprains, muscle strains or ruptures caused by a sudden exertion;
e. Disorders due as a result of extreme weather conditions;
f. Drowning;
g. Rabies or tetanus as the result of an insured accident;
h. Death of the INSURED PERSON as a result of a traffic accident, due to cardiac arrest, myocardial infarct or cardiac artery rupture of the INSURED PERSON.

1.2. ACCUMULATION LIMIT

means the total maximum amount the COMPANY will pay in the aggregate under this and any other ACCIDENT insurance policy issued by the COMPANY for INJURIES suffered by all INSURED PERSONS in the same ACCIDENT or series of accidents contributed to, caused by or consequent upon the same original cause, event or circumstance

1.3. AIDS/HIV

Human immunodeficiency virus ("HIV") related illnesses including acquired immune deficiency syndrome ("AIDS"), AIDS related complex and/or any mutation, derivation, or variation thereof which occurs during the period of insurance of this policy or any subsequent renewal of this policy and manifests itself at any time after the EFFECTIVE DATE of this policy

1.4. AREA OF COVER

Means the geographical area as listed on the policy SCHEDULE:

1. Worldwide excluding USA
2. Worldwide including USA

1.5. ASSISTANCE CENTRE

means the organization that provides the assistance services described in this policy on behalf of the COMPANY.

1.6. BENEFICIARY

means the person who is designated as such in the policy; in the absence thereof:

- In the event of death: the spouse or PARTNER of the MAIN INSURED; in the absence of a spouse or PARTNER, the legal heirs with the exclusion of the sovereign state;
- In case of an under age INSURED PERSON: the insured parent(s);
- In all other cases: the INSURED PERSON.

1.7. BENEFIT PERIOD

means the period between the EFFECTIVE DATE and the termination of the coverage for the concerned INSURED PERSON.

1.8. CHILD

Any unmarried CHILD under 26 years of age who is economically dependent on the EXPATRIATED EMPLOYEE or the PARTNER of the EXPATRIATED EMPLOYEE.

1.9. COMPANY
The insurance company who provide benefits to the POLICYHOLDER, Generali Global Health is a division of Assicurazioni Generali S.p.A. UK Branch 100 Leman Street London E1 8AJ Company incorporated in Trieste in 1831. Registered office at Piazza Duca degli Abruzzi 2, Trieste, Italy. Authorised by Istituto per la Vigilanza sulle Assicurazioni (IVASS). Registered in the IVASS register of insurance and reinsurance companies under no. 1.00003. UK company registration no. BR1185.

1.10. COMPLEMENTARY MEDICINE
means consultation services and medication provided by a physiotherapist, chiropractor, acupuncturist, bonesetter, osteopath, homoeopath or Chinese medicine practitioner, who is fully trained, who is licensed by the competent medical authorities of the country in which treatment is provided, and who is practicing within the scope of his or her licensing and graduation.

1.11. COMPLICATIONS OF PREGNANCY are conditions whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy, such as: acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. They include ectopic pregnancy which is ended, spontaneous ending of pregnancy at a time when a viable birth is not possible, puerperal infection, eclampsia, and toxemia. They do not include complications or illness from IVF induced pregnancy, caesarean section, false labor, occasional spotting, PHYSICIAN prescribed rest during pregnancy, morning sickness, and similar conditions associated with the management of a difficult pregnancy but which are not medically distinct conditions.

1.12. CONGENITAL CONDITION means a physical or mental abnormality existing at time of birth or manifesting itself within six months of birth.

1.13. CO-PAYMENT means the share of the COVERED CHARGES the INSURED PERSON will pay, after application of DEDUCTIBLE if any. This is usually expressed as a percentage.

1.14. COSMETIC SURGERY means any treatment performed to reshape normal structures of the body in order to improve the physical appearance.

1.15. COVERED CHARGE means a reasonable and customary charge for a medical necessary service prescribed by a PHYSICIAN under the conditions of this policy.

1.16. DATE OF SERVICE means the date on which a medical service is rendered.

1.17. DEDUCTIBLE means an amount stipulated in the SCHEDULE which shall be deducted from any COVERED CHARGES, before application of the CO-PAYMENT, if any.

1.18. DENTAL PROSTHESIS
means crowns, inlays, onlays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment and repairs required.

1.19. DENTIST means a properly qualified medical practitioner who is licensed to render dental treatment by the competent medical authorities of the country in which treatment is provided, and who is practicing within the scope of his licensing and graduation.

1.20. DEPENDENT means an INSURED PERSON who is the adult PARTNER, dependent CHILD or CHILD under 26 years in full-time education of the EXPATRIATED EMPLOYEE, and who is residing with him in the HOST COUNTRY.

1.21. DISTURBED AREAS
Countries or regions that follow: Afghanistan, Chechnya, North-Korea, Iraq and Somalia.

1.22. EFFECTIVE DATE means the date on which the period of cover commences for the INSURED PERSON under this policy.

1.23. EMERGENCY means a sudden change in a person's health which requires urgent medical or surgical intervention to avoid permanent damage to life or health.

1.24. EYE SURGERY means ophthalmic surgery, such as laser eye surgery, cataract surgery, glaucoma surgery, canaloplasty, refractive surgery, corneal surgery, vitreo-retinal surgery, eye muscle surgery and oculoplastic surgery.

1.25. EXPATRIATED EMPLOYEE means an INSURED PERSON who is an employee of the POLICYHOLDER and who is on an expatriate assignment on behalf of the POLICYHOLDER.

1.26. HOME COUNTRY means the country of which the INSURED PERSON holds a passport and to which the INSURED PERSON would want to be repatriated. For an insured CHILD holding more than one passport, the HOME COUNTRY will be the HOME COUNTRY of an insured parent.

1.27. HOSPITAL means an establishment duly constituted and registered as a facility for the care and treatment of sick or injured persons as paying bed patients and which:
a. Has organized diagnostic and surgical facilities,
b. Provides 24 hour a day nursing services by REGISTERED NURSES,
c. Is supervised by a staff of PHYSICIANS, and
d. Is not a nursing home, rest home, convalescence home, place for custodial care, home for the aged, institution for mental or behavioral disorders, sanatorium, or a place for the treatment of alcoholics or drug addicts; even if located at the same place.

1.28. HOSPITALISATION means admission in a HOSPITAL as a registered bed patient for an OVERNIGHT stay upon the written advice from the PHYSICIAN and for which the HOSPITAL imposes a room and board charge.

1.29. HOST COUNTRY means the country where the INSURED PERSON is expatriated to.

1.30. ILLNESS means a physical condition marked by a pathological deviation from the normal healthy state, and which is not an INJURY.

1.31. INJURY means physical damage arising wholly and exclusively from a covered accident.

1.32. INSURED PERSON means every person designated as such in the policy SCHEDULE, who has applied for cover by this policy and for whom coverage has been confirmed in writing by the COMPANY or the MEDICAL PLAN ADMINISTRATOR.

1.33. PREMISES means the habitable premises where the INSURED PERSON resides in his HOST COUNTRY. It includes private approaches to such residence; and other premises and approaches used in connection with such residence, other than BUSINESS PROPERTY and farms.

1.34. INTOXICATION means situation in which the INSURED PERSON is under the influence of:
- alcohol;
- illegal narcotics;

And thereby violates the laws of the country in which the insured incident takes place.

1.35. LOSS OF HEARING means total and permanent loss of hearing

1.36. LOSS OF LIMB means:
In the case of a leg or lower limb:
a. loss by permanent physical severance at or above the ankle, or
b. permanent and total loss of use of a complete foot or leg. In the case of an arm or upper limb:

a. loss by permanent physical severance of the four fingers at or above the meta carpo phalangeal joints (where the fingers join the palm of the hand), or
b. permanent and total loss of use of a complete arm or hand.

1.37. LOSS OF SIGHT means permanent and total loss of sight in both eyes, or in one eye if the degree of sight remaining after correction is 3/60 or less on the Snellen Scale.

1.38. LOSS OF SPEECH means total and permanent loss of speech

1.39. MAJOR RESTORATIVE DENTAL TREATMENT
means removal of impacted, buried or unerupted teeth, removal of solid odontomes, and apicectomy

1.40. MEDICAL CONSULTANT means a PHYSICIAN advising the COMPANY, ASSISTANCE CENTRE or the MEDICAL PLAN ADMINISTRATOR.

1.41. MEDICALLY NECESSARY means for therapeutic services that the INSURED PERSON has a covered ILLNESS or INJURY and that the services are requested by the attending PHYSICIAN to prevent permanent damage to life or health.
For diagnostic services, MEDICALLY NECESSARY means that the INSURED PERSON has active symptoms of unknown cause and suggestive of a covered ILLNESS or INJURY, and that the services are requested by the attending PHYSICIAN to determine whether therapeutic services are required.

1.42. MEDICAL PLAN ADMINISTRATOR means the organization that provides the medical administration services described in this policy on behalf of the COMPANY. HENNER GMC International Administration, Avenida 5 de Outubro, n° 125, 2° piso, 1050-052 LISBOA - PORTUGAL

1.43. MEDICAL TREATMENT
All examinations or measures taken to restore health of the INSURED PERSON and prescribed and/or executed by a PHYSICIAN legally qualified to treat patients.

1.44. MEDICINES AND DRUGS are those for which a PHYSICIAN's prescription is required for purchase, which have been prescribed by a PHYSICIAN for treatment of a covered ILLNESS or INJURY, and which have been dispensed by a PHYSICIAN's office or by a licensed pharmacist.

1.45. MENTAL AND BEHAVIOURAL DISORDER means a psychiatric, psychological, affective, mental or behavioral disorder, irrespective of whether a physiologic cause is known or suspected. it includes any condition listed as MENTAL AND BEHAVIOURAL DISORDER in the International Classification of Diseases of the World Health Organization.

1.46. OPTICAL DEVICES
means MEDICALLY NECESSARY glasses, frames and contact lenses prescribed by an Ophthalmic PHYSICIAN

1.47. OUTPATIENT SURGERY means the surgery that does not require an OVERNIGHT HOSPITAL stay, but may require the use of a recovery facility for at least 4 hours. Surgery shall mean treatment by incisions or shockwaves or lasers, including endoscopic procedures requiring the professional services of a qualified PHYSICIAN or surgeon.

1.48. OVERNIGHT means an inpatient admission before 7pm with release no earlier than 8am the following morning.

1.49. PALLIATIVE CARE means the services prescribed by the attending PHYSICIAN, of an institution duly constituted and registered to provide a centralized program of palliative and supportive services to dying persons in the form of physical, psychological, social and spiritual care.

1.50. PARAPLEGIA means the permanent and total paralysis of the two lower limbs, bladder and rectum.

1.51. PARENTAL ACCOMMODATION means costs for an added bed in the same HOSPITAL room for a parent or legal guardian.

1.52. PARTICIPANT means person or corporate structure who are memberships of WCA.

1.53. PARTNER means person, who is not a CHILD, and with whom the EXPATRIATED EMPLOYEE forms a factual or legal union on the date of loss/ACCIDENT in question and with whom the INSURED PERSON lives at the same legal residence or domicile.

1.54. PHYSICIAN means a medical practitioner graduated from a recognized medical school listed in the directory of medical schools of the world health organization, who is licensed by the competent medical authorities of the country in which treatment is provided, and who is practicing within the scope of his licensing and graduation.

1.55. POLICYHOLDER means the person who has taken out this insurance with the COMPANY and who is named as such in the policy SCHEDULE, Worldwide Concept Association (WCA), 12 rue Michel Rodange, L-2430 Luxembourg. The benefits have been negotiated and are managed by WYCC, a trading name of ICS SA, Insurance Brokerage Company based in Luxembourg

1.56. POST-HOSPITALIZATION SERVICES means medical services immediately following a covered stay in a HOSPITAL, and that are provided by or ordered by the attending PHYSICIAN as a direct consequence of the covered ILLNESS or INJURY which necessitated such hospitalization.

1.57. PRECEDING POLICY means an expatriate healthcare policy covering ILLNESS and INJURY which terminates no earlier than the day prior to the EFFECTIVE DATE for the INSURED PERSON, and a copy of which has been provided to the COMPANY upon application.

1.58. PRE-HOSPITALIZATION SERVICES means medical services incurred within 30 days prior to and directly related to a covered stay in a HOSPITAL.

1.59. QUADRIPLEGIA means the permanent and total paralysis of the two upper limbs and two lower limbs.

1.60. REASONABLE AND CUSTOMARY EXPENSES means insured medical expenses which do not exceed the general level of fees for comparable services by similar healthcare providers in the same region for a similar ILLNESS or INJURY, irrespective of availability of insurance. In case of an unusual nature of service or supply, the MEDICAL PLAN ADMINISTRATOR will determine to what extent the charge is reasonable and customary, taking into account the complexity involved, the degree of professional skills required and other pertinent factors.

1.61. RECONSTRUCTIVE SURGERY means any treatment performed on abnormal structures of the body, whether caused by CONGENITAL CONDITIONS, developmental abnormalities, INJURY or ILLNESS, in order to improve function or approximate a normal appearance.

1.62. REGISTERED NURSE is a graduate trained nurse who has passed a state registration examination and has been licensed to practice nursing.

1.63. RELATIVE means spouse or PARTNER, father, mother, sister, brother, CHILD, grandchild, grandparent of the INSURED PERSON.

1.64. REPRESENTATIVE means a licensed attorney or similar professional who has been authorized to act on behalf of the INSURED PERSON in accordance with the conditions of this insurance policy.

1.65. RESIDENCE EMPLOYEE means an employee of an INSURED PERSON whose duties are incidental to the PREMISES or who covers duties elsewhere of a similar nature and not associated with the conduct of an INSURED PERSON's business.

1.66. ROUTINE DENTAL TREATMENT
means dental examinations, tooth extractions, tooth cleaning, normal compound filling, root canal treatment, paradental treatment, paradontosis treatment, gum treatment, and X-ray examinations.

1.67. SCHEDULE means the document showing details of the period of insurance, INSURED PERSONs, included policy sections and the sums insured, etc. which should be read with this policy

1.68. SOUND NATURAL TOOTH means a tooth with no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, that is not a dental implant and that functions normally in chewing and speech.

1.69. STANDARD PRIVATE ROOM is the lowest rated room with a single bed in that HOSPITAL.

1.70. THIRD-PARTY is any natural person or legal entity with the exception of the INSURED PERSON, DEPENDENT or RELATIVES.

1.71. VISION TREATMENT
means ophthalmic examinations and treatments, excluding any EYE SURGERY.

1.72. VENEREAL DISEASE means an ILLNESS which has been transmitted by sexual contact, or any of the following illnesses whether sexually transmitted or not: syphilis, gonorrhea, venereal warts including genital HPV (human papillomavirus), genital herpes, granuloma inguinale, chancroid, trichomona, pubic lice (phthirus pubis) infestation, and Chlamydia.

1.73. WAR means any activity arising out of military force or an attempt to participate in military force by a nation, and will include civil WAR, revolution, invasion and similar facts.

CHAPTER 2. GENERAL POLICY CONDITIONS

2.1. POLICY PERIOD

The policy commences on the date stipulated in the SCHEDULE and is valid for a period of one year. The policy is automatically renewed for successive periods of one year, unless stated otherwise in the SCHEDULE and except for cancellation on the terms stipulated in the current policy.

2.2. ELIGIBILITY

The POLICYHOLDER will cover their members: MAIN INSURED and their DEPENDENTs while on foreign expatriate assignment outside their HOME COUNTRY or frequent travelers. The age limit for enrolment of an INSURED PERSON is 70 years.

The individual cover commences the day immediately following the acceptance by the COMPANY and/or the MEDICAL PLAN ADMINISTRATOR or on THE EFFECTIVE DATE of the policy mentioned in the policy SCHEDULE, whatever comes the latest.

The EFFECTIVE DATE for a new-born CHILD of an INSURED PERSON is the moment of birth, provided notification was given to the COMPANY within 4 weeks of the date of birth and the mother or father was insured for at least 10 continuous months immediately prior to the date of birth.

The medical formalities are:

- In case of compulsory affiliation by the employer of a group:

No medical questionnaire will, in principle, be required for the core plan.
For the optional benefits however, the completion of a medical questionnaire might be required in accordance with the law on Insurances. The MEDICAL CONSULTANT can at his discretion define partial or total exclusion of cover or propose additional premium to waive exclusions.

- In all other cases:

A medical questionnaire has to be completed by each INSURED PERSON and has to be submitted to the MEDICAL CONSULTANT of the COMPANY in accordance with article 61 of the law on Insurances the MEDICAL CONSULTANT can at his discretion define partial or total exclusion of cover or propose an additional premium to waive exclusions.

In case of compulsory affiliation by the employer of a group:
If the INSURED PERSON is afflicted with an ILLNESS or physical INJURY after ACCIDENT prior to the EFFECTIVE DATE of this policy and if the INSURED PERSON was covered under a PRECEDING POLICY for which benefits would have been available had it remained in force, the INSURED PERSON will be covered for the existing ILLNESS or physical INJURY after ACCIDENT under this policy, as far as these costs incur after the EFFECTIVE DATE.

2.3. AREA OF COVER

The policy covers the INSURED PERSON within his AREA OF COVER as mentioned in the policy SCHEDULE.

Cover outside the INSURED PERSON'S AREA OF COVER is limited to EMERGENCIES in case of TRAVEL, taking place during the BENEFIT PERIOD and lasting no longer than 90 consecutive days, and excluding any TRAVEL if the purpose of the trip is to obtain MEDICAL TREATMENT or medical advice or in case the INSURED PERSON is travelling against the advice of a PHYSICIAN.

2.4. TERMINATION OF BENEFITS

The benefits for the INSURED PERSON under this policy terminate on the earliest of the following moments:
2.4.1 At midnight on the last day of the BENEFIT PERIOD;
2.4.2 On the next annual policy renewal date following the 75th birthday of the INSURED PERSON or as defined in the SCHEDULE;

2.5. PAYMENT OF PREMIUMS

The premium shall be paid in advance. The premium is due and payable in the place of residence of the POLICYHOLDER upon presentation of the receipt or upon notification of the premium due date. Legally imposed taxes and contributions are in addition to this premium.

In case of non-payment of the premium, the policy will be terminated in accordance with the law of on Insurances.

2.6. INCREASE IN RISK

The POLICYHOLDER, PARTICIPANT and/or INSURED PERSON shall inform the COMPANY immediately of any change in circumstances or conditions that may increase the risk. This includes but is not limited to changes in business activities, change of HOME COUNTRY, or change of HOST COUNTRY.

In case of an increase in risk, the law on Insurances applies.

2.7. CHANGE OF PREMIUM RATES AND/OR CONDITIONS

The premiums of the core plan and the optional benefit DENTAL & VISION care may be adjusted on the annual renewal date, based on the attained age of each INSURED PERSON on the renewal date or on the increase of medical expenses.
This adjustment gives no right to cancel the policy.

The COMPANY can also change the premium and/or the conditions of certain insurance covers per category for all similar covers, with effect on the annual renewal date.

In case of a change of premium rates and/or a change of conditions, the COMPANY will provide a written notice to the POLICYHOLDER at least 4 months prior to the EFFECTIVE DATE of the change. The POLICYHOLDER is deemed to have accepted the change, unless it cancels the policy within three months of the notification of the change.

2.8. CLAIMS NOTIFICATION

2.8.1 The POLICYHOLDER, PARTICIPANT, INSURED PERSON or BENEFICIARY shall respect the claim procedures mentioned under the title “claims procedure” of the concerned benefit, or in any event notify the COMPANY as soon as it is aware of the potential occurrence of an insured event/loss.

2.8.2 The POLICYHOLDER, PARTICIPANT, INSURED PERSON or BENEFICIARY shall provide at their own expense all reasonable and necessary documents to substantiate the claim. They shall cooperate in medical or other examinations or enquiries related to the claim, held in accordance with article 61 of the law of 4 April 2014 on Insurances if the COMPANY, ASSISTANCE CENTRE or the MEDICAL PLAN ADMINISTRATOR deems this necessary.

2.8.3 The INSURED PERSON and/or the PARTICIPANT shall take all reasonable measures to prevent and limit the consequences of the insured event/loss.

2.8.4 If the INSURED PERSON and/or POLICYHOLDER, PARTICIPANT do not comply with one of the obligations stated under 2.8.1, 2.8.2 and 2.8.3 to the detriment of the COMPANY, the COMPANY may claim a reduction of the benefit equivalent to the loss it has suffered.

2.8.5 The COMPANY may refuse cover if the INSURED PERSON and/or POLICYHOLDER, PARTICIPANT did not comply with the obligations set out under 2.8.1, 2.8.2 and 2.8.3 with fraudulent intent.

2.9. INDEMNITY

Indemnities shall be based on the medical and factual data available to the COMPANY and/or the MEDICAL PLAN ADMINISTRATOR.

All indemnities shall be payable without interest after acceptance by the INSURED PERSON, POLICYHOLDER,
PARTICIPANT and/or beneficiary/beneficiaries.

Any claim for an indemnity upon refusal by the COMPANY shall become prescribed three years after the refusal is notified to the INSURED PERSON and/or the BENEFICIARY/BENEFICIARIES.

2.10. SUBROGATION

By payment of the indemnity the COMPANY shall be subrogated, up to the amount of the indemnity, to the rights and legal claims of the INSURED PERSON or the BENEFICIARY/ BENEFICIARIES against a THIRD PARTY/PARTIES in accordance with the law on Insurances.

2.11. WAIVER OF RECOURSE

The COMPANY will waive any right of recourse against the liable THIRD- PARTY / PARTIES for payments related to the benefits Accidental Death and Permanent Invalidity following an ACCIDENT.

2.12. OTHER INSURANCE AND SUBROGATION

If the liability, loss or damage that is covered under this policy is also covered by a National Health Service, or would have been covered under these, had this insurance not been underwritten, this insurance shall only provide cover in excess of what would have been covered by the National Health Service. The amounts paid under this insurance shall not exceed, when combined with the amounts paid by the National Health Service the maximum limits as mentioned on the policy SCHEDULE.

In the event of INJURY, loss or damage involving the actions or negligence of a THIRD PARTY, the POLICYHOLDER, PARTICIPANT, INSURED PERSON or BENEFICIARY shall use their best endeavours to claim from such THIRD PARTY for the full amount of the loss. The POLICYHOLDER, PARTICIPANT, INSURED PERSON and BENEFICIARY shall not negotiate, settle, compromise, release, or otherwise discharge any claim against such a party without the COMPANY'S express written consent. The COMPANY has full rights of subrogation and may take proceedings in its own name, but at the COMPANY'S expense, to recover the amount of any payment made under the policy including but not limited to the cost of such proceedings.

2.13. CANCELLATION

2.13.1. The COMPANY may cancel the policy:

2.13.1.1. On every annual renewal date of the policy, by giving prior notice by registered letter, bailiff service or delivery of a cancellation letter against receipt at least three months before the renewal date;

2.13.1.2. In case of an unintentional omission or inaccuracy in the declarations or questionnaires of the POLICYHOLDER when concluding the policy, or in case of an increase in risk, if the proposal of the COMPANY to amend the policy is refused by the POLICYHOLDER within the period of one month after receipt of this proposal, the COMPANY may cancel the policy within fifteen calendar days as from the refusal (in accordance with the law on Insurances);

2.13.1.3. In the case of non-payment of the premium (in accordance with the law on Insurances);

2.13.1.4. After each claims notification, but no later than one month after the payment or the refusal of payment of the indemnity;

2.13.1.5. In case of bankruptcy of the POLICYHOLDER but no earlier than three months after the declaration of bankruptcy.

2.13.2. The POLICYHOLDER or the PARTICIPANT may cancel the policy:

2.13.2.1. On every annual renewal date of the policy by giving prior written notice by registered letter, bailiff service or delivery of a cancellation letter against receipt at least 3 months before the renewal date;

2.13.2.2. in the case of changes in the insurance conditions or the rate except for the disposition of article 2.7.;

2.13.2.3. If the COMPANY and the POLICYHOLDER or the PARTICIPANT cannot reach an agreement in case of a change in risk;

2.13.2.4. After each claims notification, but no later than one month after the payment or the refusal of payment of the indemnity.

2.13.3. The cancellation of the policy shall be effected by registered letter, bailiff service or delivery of a cancellation letter against receipt. Unless stipulated otherwise in these conditions, cancellation of the policy shall take effect on expiry of a period of one month from the day following the service or the date of receipt, or in case of a registered letter, the day of delivery.

2.13.4. Cancellation of the policy by the COMPANY pursuant to a claims notification shall take effect on expiry of a period of three months from the day following the service or the date of receipt, or in case of a registered letter, the day of delivery.

However, cancellation of the policy shall take effect on expiry of a period of one month from the day following the service or the date of receipt, or in case of a registered letter, the day of delivery, if the POLICYHOLDER, the PARTICIPANT, the INSURED PERSON or the BENEFICIARY fails to fulfil any of the obligations arising from the occurrence of the loss with the intention to mislead the COMPANY, provided that the COMPANY filed a civil claim for damages with an examining magistrate against any of these persons, or has commenced criminal proceedings against any of these persons.

2.13.5. In the event that the policy is cancelled for any reason whatsoever, premiums paid for the insurance period after cancellation takes effect, shall be reimbursed. In case of a partial cancellation or any other reduction in the insurance benefits, the aforementioned only applies to the part of the premiums corresponding to such reduction and in proportion thereto.

2.14. FRAUD – INTENTIONNEL OMMISSION OR INACCURACY

Notwithstanding any agreement to the contrary, the COMPANY shall not be required to provide a benefit to the POLICYHOLDER, PARTICIPANT, INSURED PERSON, DEPENDANTS or BENEFICIARY who intentionally caused the insured event/loss

If an intentional omission or inaccuracy in the declaration misleads the COMPANY in the assessment of the risk, the policy shall be void.

In such case the POLICYHOLDER, PARTICIPANT, INSURED PERSON or BENEFICIARY will lose all the benefits under the policy. The POLICYHOLDER, INSURED PERSON or BENEFICIARY will reimburse any benefit already paid by the COMPANY and compensate the COMPANY for the loss or damage incurred due to the fraud or the intentional omission or inaccuracy.

Premiums due up to the moment when the COMPANY had knowledge of the intentional omission or inaccuracy shall be payable to the COMPANY.

2.15. TRANSFER

The policy cannot be transferred unless otherwise agreed upon in writing with the COMPANY.

2.16. DOMICILE

For the purpose of this policy, the COMPANY 'S sole domicile is its registered office in Brussels. Notifications to the POLICYHOLDER shall be validly sent to his/her most recent address, as communicated in writing to the COMPANY. The POLICYHOLDER must check the most recent address of the PARTICIPANT

2.17. PERSONAL DATA

How we handle personal data

In order for us to provide quotes, insurance policies or deal with any claims in connection with the insurance arrangements that your employer has put in place with us, we need to collect and process personal data about you, including:

- individual details, such as name, address and date of birth;

- risk details, which is information we need to collect in order to assess the risk to be insured and provide a quote. This may include data relating to your health and details of your job, including your salary;
- current and past claims details, which may also include data relating to your health.

We might collect your personal data from various sources, including your employer, your employer's insurance broker and medical experts appointed to treat you in the event of a claim.

We will keep your personal data only for so long as is necessary and for the purpose for which it was originally collected.

The provision of insurance involves the sharing of personal data between different insurance market participants, including brokers, insurers and reinsurers, and third parties who provide services in connection with the insurance, such as medical experts, each of whom may be located outside of your country of residence.

If you have any questions in relation to our use of your or your dependant's personal data, please visit generaliglobalhealth.com/Info/privacy-information

When we need your consent
In order to provide insurance cover and deal with insurance claims, we may need to process categories of personal data which have additional protection under data protection law, such as your health data.

Your consent to this processing may be necessary for us to achieve this.

Your consent may be withdrawn at any time. However, if consent is withdrawn this will impact our ability to provide insurance or pay claims.

2.18. GOVERNING LAW AND SETTLEMENT OF DISPUTES

Applicable law: The provisions of the present contract are governed by the England and Wales law on Insurances and by all its extensions, modifications and executory decisions.

Regulatory Information: We are an Italian public company incorporated with limited liability. We were established in 1831 and have our Head Office in Trieste, Italy. We are registered on the Italian register of insurance and reinsurance companies in Section 1 under No.1.00003.

We are authorised to transact insurance business by the Italian regulator (Istitutio per la Vigilanza sulle Assicurazioni Private e di Interesse Collettivo). As the policy is issued by the UK Branch of our company we are also subject to limited regulation by the Financial Conduct Authority. Details about the extent of our regulation by the Financial Conduct Authority are available upon the request. We have been operating in the UK since 1963 and our UK Branch is registered with Companies House under number BR1185.

Complaints
The most important thing for us is to help resolve your concerns as quickly as possible. Upon receipt of your complaint, we will do all we can to resolve your complaint within the first 3 days. However, if we can't do this, we will contact you to acknowledge your complaint and explain the next steps. Letting us know when you are unhappy with our service gives us the opportunity to put things right for you and improve our service for everybody. If despite the efforts of the COMPANY, the INSURED PERSON is not satisfied, it can address a complaint:

- by e-mail: UG65@henner.com
- by phone: +351 218 290 397
- by ordinary mail: Henner Portugal – International Administration, Avenida 5 de Outubro, nº 125, 2º piso, 1050-052 Lisbon, Portugal
- Website : www.henner.com

To help us resolve your complaint, please supply the following information:

- your name and membership details (policy number and/or claim file number)
- a contact telephone number
- a description of your complaint and, if available, the name of the contact person within the COMPANY
- any relevant information relating to your complaint that we may not have already seen

The Financial Ombudsman Service
We will generally issue our final response within eight weeks from when you originally contact us. However, we will respond sooner than this if we are able.

If it looks as though our review of your complaint will take longer than this, we will let you know the reasons for the delay and will keep you informed and updated. If we cannot respond fully to your complaint within eight weeks, or you are unhappy with our final response, you can refer your complaint to the Financial Ombudsman Service for an independent review. The Financial Ombudsman Service will only consider your complaint once we have issued a final response, or if eight weeks have passed since you first notified us of your complaint.

How to contact the Financial Ombudsman Service:

- by e-mail: complaint.info@financial-ombudsman.org.uk
- by phone: +44 (0) 800 023 4567; from abroad: +44 (0) 207 964 0500
- by ordinary mail: The Financial Ombudsman Service, Exchange Tower, London, E14 9SR

Jurisdiction
Any dispute between parties will be subject to the exclusive competence of the England and Wales courts.

2.19. GENERAL EXCLUSION – SANCTIONS

This policy will not cover any loss, injury, damage or legal liability sustained directly or indirectly by any individual or entity identified on any applicable government watch list as a supporter of terrorism, narcotics or human trafficking, piracy, proliferation of weapons of mass destruction, organized crime, malicious cyber activity, or human rights abuses.

The COMPANY shall not be deemed to provide cover and the COMPANY 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 COMPANY, its parent COMPANY or its ultimate controlling entity to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, or United States of America.

CHAPTER 3. MEDICAL EXPENSES

3.1. MEDICAL EXPENSE BENEFITS

This policy shall provide cover:

- for the actual REASONABLE AND CUSTOMARY MEDICAL EXPENSES incurred by the INSURED PERSON;
- within the limitations stated in the general conditions and the policy SCHEDULE;
- for the treatment and services listed below;
- that directly relate to a covered INJURY or ILLNESS;
- that have a DATE OF SERVICE during the BENEFIT PERIOD;
- that are prescribed or executed by a PHYSICIAN and certified MEDICALLY NECESSARY by the attending PHYSICIAN;
- that are generally accepted and scientifically recognised medical services, excluding any experimental or pioneering services;

Insured services in case of:

3.1.1. HOSPITALIZATION & OUTPATIENT SURGERY:

3.1.1.1. HOSPITAL accommodation costs in a STANDARD PRIVATE ROOM;
3.1.1.2. PARENTAL ACCOMMODATION during HOSPITALIZATION of an INSURED PERSON under 18;
3.1.1.3. Expenses related to the operating room, intensive care, medical imaging, diagnostic and laboratory tests, prescribed MEDICINES AND DRUGS, blood and plasma, surgical appliances, rental of medical aids.
3.1.1.4. Fees of PHYSICIANS, including general nursing care.

3.1.2. HOSPITAL Cash:

3.1.2.1. Benefit per consecutive night for the INSURED PERSON that stays as inpatient for more than 48 hours in a HOSPITAL. The benefit is limited to 30 nights per policy year.
3.1.2.2. The benefit per night according to the dispositions of article 3.1.2.1 will be doubled in case of a coma;

3.1.3. Outpatient Benefit:

3.1.3.1. Fees of PHYSICIANS;
3.1.3.2. Prescribed MEDICINES AND DRUGS that cannot be purchased without prescription;
3.1.3.3. Medical imaging, diagnostic and laboratory tests, and surgical appliances;
3.1.3.4. Medical aids
3.1.3.5. Non-experimental preventive care and examinations;
3.1.3.6. COMPLEMENTARY MEDICINE.

3.1.4. Local Ambulance:

3.1.4.1. Local EMERGENCY medical transport.

3.1.5. Private Nursing:

3.1.5.1. Inpatient in HOSPITAL or nursing home;
3.1.5.2. Home nursing costs by a REGISTERED NURSE, up to 60 days per policy year;
3.1.5.3. PALLIATIVE CARE.

3.1.6. Maternity and Childbirth:

Expenses covered under the points 3.1.1 to 3.1.5 above that are related to:
3.1.6.1. Pregnancy, prenatal childbirth and post-natal treatment;
3.1.6.2. COMPLICATIONS OF PREGNANCY;
3.1.6.3. CONGENITAL CONDITIONS.
These benefits are limited to costs resulting from pregnancy and childbirth after a waiting period of 10 months following the effective date of the cover for the mother or the father, unless the waiting period was waived by the COMPANY because of a PRECEDING POLICY.

3.1.7. Cancer treatment:
Expenses covered under the points 3.1.1 to 3.1.5 above that are related to cancer inpatient and outpatient treatment, including specialist fees, medical imaging, diagnostic and laboratory tests, radiotherapy, chemotherapy and HOSPITAL charges.

3.1.8. Organ transplant:
Expenses covered under the points 3.1.1 to 3.1.5 above that are related to operations, treatments and testing involved with the transplantation of organs from a human donor.
The policy does not cover the costs of acquisition of the organ or expenses incurred by the donor, except for direct costs of surgery to remove such organ for transplantation but not to exceed 30% of the total treatment costs.

3.1.9. MENTAL AND BEHAVIOURAL DISORDERS:
Expenses covered under the points 3.1.1 to 3.1.5 above that are related to the treatments of MENTAL AND BEHAVIOURAL DISORDERS.
The inpatient treatment is limited to MENTAL AND BEHAVIOURAL DISORDERS that begin more than 10 months after
THE EFFECTIVE DATE of the cover, unless the waiting period was waived by the COMPANY because of a PRECEDING POLICY.
The outpatient treatment is limited to MENTAL AND BEHAVIOURAL DISORDERS that begin more than 18 months after the EFFECTIVE DATE of the cover, unless the waiting period was waived by the COMPANY because of a PRECEDING POLICY.

3.1.10. AIDS/HIV:
Expenses covered under the points 3.1.1 to 3.1.5 above that are related to the treatment of human immunodeficiency virus (“HIV”) related illnesses including acquired immune deficiency syndrome (“AIDS”), AIDS related complex (“ARC”) and/or any mutation, derivation, or variation thereof which manifests itself for the first time after the EFFECTIVE DATE of the cover.

3.1.11. EMERGENCY dental:
Expenses covered under the points 3.1.1 to 3.1.5 above that are related to EMERGENCY dental treatment required for accidental damage to SOUND NATURAL TEETH.

3.1.12. EMERGENCY vision:
Expenses covered under the points 3.1.1 to 3.1.5 above that are related to EMERGENCY vision treatment required for accidental damage to an eye.

3.2. CLAIMS PROCEDURE Contact information:
The MEDICAL PLAN ADMINISTRATOR
HENNER GMC
International Administration
Avenida 5 de Outubro, n° 125, 2° piso
1050-052 LISBOA - PORTUGAL

24/365 telephone number: +351 218 290 397
Email: ug65@henner.com
Website: www.henner.com. An ID will be communicated to the INSURED PERSON with the welcome package.

Non-emergency HOSPITALIZATION and OUTPATIENT SURGERY need pre-certification from the MEDICAL PLAN ADMINISTRATOR. The MEDICAL PLAN ADMINISTRATOR will guarantee the care of medical expenses to the HOSPITAL.

The INSURED PERSON must pay other expenses to the provider and submit a claim for reimbursement in writing to the MEDICAL PLAN ADMINISTRATOR within 90 days of the DATE OF SERVICE.

Claim notification forms can be obtained by contacting the 24/365 telephone number or can be found on the website. The claim form must be completed and sent to the MEDICAL PLAN ADMINISTRATOR together with the original documentation, invoices and receipts (photocopies or scans are not accepted).

In case the INSURED PERSON can claim from the National Health Service or any other insurance policy, he should first request reimbursement from that organization. The INSURED PERSON shall afterwards forward the original settlement confirmation from that organization with photocopy of the submitted documentation, invoices and receipts to the MEDICAL PLAN ADMINISTRATOR. The MEDICAL PLAN ADMINISTRATOR shall deduct the amounts that are or could have been received from that organization.

3.3. MEDICAL SERVICE PROVIDER REFERRAL

The MEDICAL PLAN ADMINISTRATOR can refer the INSURED PERSON, upon request, to a suitable HOSPITAL. The information can be obtained by contacting the 24/365 telephone number or can be found on the website.

While the MEDICAL PLAN ADMINISTRATOR exercises care and diligence in selecting the medical service providers, the COMPANY or the MEDICAL PLAN ADMINISTRATOR cannot guarantee and is not responsible for the service obtained from the medical service providers.

3.4. EXCLUSIONS

The COMPANY shall not pay any indemnity when the expenses are caused by or are directly or indirectly contributed to by:

3.4.1. Intentional self-inflicted, suicide or a suicide attempt;

3.4.2. WAR in the HOME COUNTRY or HOST COUNTRY or in DISTURBED AREAS; however, the INSURED PERSON will continue to be entitled to the benefit for 14 calendar days from the start of the hostilities in case he/she is surprised by such events in all countries except those of DISTURBED AREAS;

3.4.3. ACCIDENTS occurred during the preparation of or participation in crimes or criminal offences;

3.4.4. Intent and/or incitement, and/or an intentional reckless act from the INSURED PERSON, the POLICYHOLDER, PARTICIPANT or a BENEFICIARY, unless it concerns a justified attempt to save people and/or animals and/or goods in danger

3.4.5. Disabilities while serving in any branch of the military or armed forces of any country, or international authority while on duty, or participation in WAR, civil WAR, invasion, insurrection, revolution, use of military power, usurpation of government or military power, or participation in an actual or attempted riot or any loss directly or indirectly caused by or attributable to any criminal or intentional illegal act or the INSURED PERSON, PARTICIPANT or POLICYHOLDER breaking any government laws and regulations or any known or suspected terrorist act.

The COMPANY shall not pay any benefit if related to:

3.4.6. Nutritional and dietary supplements, baby food;

3.4.7. COSMETIC SURGERY;

3.4.8. MENTAL AND BEHAVIOURAL DISORDERS listed as F10 till F19, F45, F52, F55, F59 or F99 in the International Classification of diseases of the World Health Organization;

3.4.9. Expenses incurred where an INSURED PERSON has not followed the medical advice of the PHYSICIAN;

3.4.10. Products that can be obtained without a PHYSICIAN'S prescription;

3.4.11. Sex change or gender reassignment;

3.4.12. Cure centre, bath centre, spa, health resort and recovery centre, even if the stay is medically prescribed;

3.4.13. Dental and Vision Treatment, except the EMERGENCY dental benefit and the EMERGENCY vision benefit as mentioned in the articles 3.1.11 and 3.1.12;

3.4.14. Batteries, electricity, maintenance expenses and recharging of appliances or medical aids (including hearing and visual aids);

3.4.15. Transfer, transport or travel expenses, except those for local EMERGENCY medical transport or after prior approval of the ASSISTANCE CENTRE.

CHAPTER 4. DENTAL & VISION CARE

The option dental & vision care can only be taken by all the INSURED PERSONS who are covered by the core plan.

4.1 DENTAL CARE

This policy shall provide cover:

- Within the limitations stated in the policy and the policy SCHEDULE;
- Based on REASONABLE AND CUSTOMARY MEDICAL EXPENSES
- For the services listed below;
- That are prescribed and certified MEDICALLY NECESSARY by a DENTIST or dental PHYSICIAN;
- That are general accepted and scientifically recognized medical services, excluding any experimental or pioneering services;
- that have a DATE OF SERVICE during the BENEFIT PERIOD.

The insured services, within sums insured as listed on the policy SCHEDULE are:

- ROUTINE DENTAL TREATMENT;
- MAJOR RESTORATIVE DENTAL TREATMENT;
- DENTAL PROSTHESIS;
- Orthodontic treatment.

The reimbursement of the expenses is reduced or refused to the extent that the INSURED PERSONS teeth are deemed by a DENTIST or dental PHYSICIAN to be in a considerably worse condition than the teeth of persons of the same age who have at least annual dental checks and receive the recommended dental treatment, or if the cause of the worse condition of the INSURED PERSONS teeth is prior to the BENEFIT PERIOD.

Indemnity for MAJOR RESTORATIVE DENTAL TREATMENT, DENTAL PROSTHESIS and orthodontic treatment is limited to treatments that begin more than 6 months after the EFFECTIVE DATE of the cover for the INSURED PERSON, unless the waiting period was waived by the COMPANY because of a PRECEDING POLICY.
Orthodontic treatment is only covered if started before age 16.

4.2 VISION CARE

This policy shall provide cover:

- Within the limitations stated in the policy and the policy SCHEDULE;
- Based on REASONABLE AND CUSTOMARY MEDICAL EXPENSES
- For the services listed below;
- That are prescribed and certified MEDICALLY NECESSARY by a ophthalmic PHYSICIAN;
- That are generally accepted and scientifically recognized medical services, excluding any experimental or pioneering services;
- That have a DATE OF SERVICE during the BENEFIT PERIOD.

The insured services, within sums insured as listed on the policy SCHEDULE are:

- VISION TREATMENT;
- EYE SURGERY;
- OPTICAL DEVICES.

4.3 CLAIMS PROCEDURE

As described in article 3.2 above.

4.4 EXCLUSIONS

The COMPANY shall not pay any indemnity when the expenses are caused by or are/were directly or indirectly contributed to by:

- one of the events mentioned in articles 3.4.1 to 3.4.8 above;
- Learning difficulties or developmental disorders.