# TRANSLATION OF INSURANCE TERMS AND CONDITIONS FOREIGNERS'COMPREHENSIVE MEDICAL INSURANCE EXCLUSIVE KZPCE 1/16

effective as of 1 January 2016

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## SECTION A

## JOINT PROVISIONS

Article 1

**Introductory Provisions**

1. The rights and responsibilities of parties to this **Foreigners' Comprehensive Medical Insurance EXCLUSIVE** (hereinafter in this section also merely as "Insurance") is governed by the laws of the Czech Republic, particularly by Act No. 89/2012 Coll., the Civil Code, as amended (hereinafter the "Code"), these Insurance terms and conditions, the provisions contained in the insurance policy and its annexes and in other documents which make up an integral part thereof.
2. Arrangements in the insurance policy that deviate from the Code or these Insurance terms and conditions shall prevail. Divergent provisions in the following sections of these Insurance terms and conditions shall prevail over the provisions of this section.
3. The contracting parties are on the one hand the Policyholder and on the other the Insurer.

Article 2

**Definition of Terms**

The following definitions of terms shall apply for the purposes of this insurance:

1. **Acute Healthcare** is care designed to prevent a serious deterioration in the state of health or to reduce the risk of a serious deterioration in the state of health so that the facts necessary for determining or changing the individual treatment process are ascertained in time or so that the Insured Person does not get into a state that would endanger him or his surroundings.
2. The **Current Premium** is the premium prescribed for the Insurance Period.
3. The **Qualifying Period** is the period in which the Insurer has no obligation to provide Insurance Benefits for events which would otherwise be Insured Events. The Qualifying Period is counted from the start of the agreed Term of Insurance.
4. The **Duration of the Insurance** is the actual period of time within the agreed Term of Insurance for which the personal Insurance was in effect.
5. **Hospitalisation** is understood to mean the state of the Insured Person caused by an Insured Peril, when he is provided with the necessary hospital diagnosis and curative care connected with his stay in bed.
6. **Chronic Illness** is a long-standing and developing illness (including post-traumatic states) that existed prior to the commencement of the insurance and was in a stable state during the previous 12 months and did not call for hospitalisation or a deteriorate or a change in the treatment procedures or medicine.
7. **One Hospitalisation Day** is every full 24 hours of continuous stay in hospital.
8. **One Insured Event** is an Insured Event arising from the Insurance of one person and from one and the same cause, at the same place and the same time, comprising all the facts and their consequences, amongst which there is a causal, territorial, chronological or other direct connection.
9. A **Lump Sum Premium** is a premium determined for the entire period for which the Insurance has been agreed.
10. A **Period** given in days is always understood to be the number of calendar days.
11. A **Random Event** is an event that is possible and in respect of which it is uncertain whether it will even occur within the Duration of the Insurance, or the time of its occurrence is unknown.
12. A **Sudden Illness** is understood to mean any sudden and unexpected health disorder which directly threatens the health or the life of the Insured Person, independent of his own will, and which requires acute and urgent healthcare.
13. An **Illness** for the purpose of this Insurance is the onset of a disorder which threatens the health or the life of the Insured Person and requires the provision of medical care. The onset of Illness is deemed to be the moment the onset of Illness is medically established.
14. **Urgent Healthcare** is care, the purpose of which is to prevent or reduce the occurrence of sudden conditions that are imminently life threatening or could lead to sudden death or serious endangerment to health, or cause sudden or intensive pain or sudden changes in the patient's behaviour, who endangers himself or his surroundings.
15. A **Newborn Baby** is understood for the purpose of this Insurance to be a child from the time of his/her birth to the end of the 3rd month of this child's age.
16. **Agreed Sum Insurance** is Insurance the purpose of which is obtain a sum, i.e. an agreed financial amount, as a consequence of an Insured Event in an amount that is independent of the occurrence or extent of the loss.
17. A **Beneficiary** is a party with a right to an Insurance Benefit as a result of an Insured Event.
18. An **Insurance Certificate** is a written confirmation that an insurance policy has been concluded, which the insurer issues to the policyholder.
19. The **Term of Insurance** is the period for which the personal Insurance was agreed. This period is not reduced by the premature expiration of the Insurance.
20. An **Insured Event** is an accidental state of affairs brought about by the Insured Peril, associated with the establishment of an obligation on the part of the Insurer to provide an Insurance Benefit.
21. An **Insured Peril** is the possible cause of an Insured Event (the "cause"). An Insured Peril does not cease due to the Insured Person's absence at the place of Insurance.
22. The **Insurance Period** is the period of time agreed in the insurance policy for which the premium was paid.
23. An **Insurance Risk** is a measure of the probability of the occurrence of the Insured Event caused by an Insured Peril.
24. The **Policyholder** is the party which has concluded the insurance policy with the Insurer.
25. The **Insurer** is a legal entity entitled to carry on insurance activity according to special legislation.
26. The **Insured Person** is a person in respect to whose life or health the insurance relates.
27. **Postnatal Care for a Newborn Baby** is healthcare for a Newborn immediately following upon its birth and without interruption to the continuity of hospitalisation.
28. **Professional Sporting Activity** is sporting activity performed under an employment or similar relationship which is the main source of the sportsperson's income.
29. The **Insured Person's Card** comprises written confirmation of the establishment and continuation of the medical insurance, which the Insurer issues always with the duration being limited to a period for which the premium was paid. The card serves the Insured Person for exercising the right to Insurance Benefits.
30. A **Contractual Healthcare Facility** is understood to mean a healthcare facility of such a healthcare provider with which the Insurer has concluded a contract for these purposes.
31. A **Loss Event** is an event resulting in damage which may constitute grounds for the establishment of a right to an Insurance Benefit.
32. **Loss Insurance** s insurance the purpose of which is to provide compensation for a loss arising from an Insured Event.
33. A **party to the Insurance** is understood to mean the Insurer and the Policyholder, as the contracting parties, as well as the Insured Person and every other person to whom a right or obligation arose under the private insurance.
34. An **Injury** is understood for the purpose of this Insurance to be the unexpected and sudden action of external forces or of one's own strength independent of the Insured Person's will, which resulted in damage to the Insured Person's health or his death. An Injury is deemed to occur the moment that the external forces or influences damaging the health or causing the death of the Insured Person came to bear. An Injury is also understood to benear-drowning, drowning and physical damage caused by high or low temperatures, lightening, radiation, electrical current, gases or vapours, toxic or corrosive substances, with the exception of the regularly repeating action of all of the above.
35. **Multiple Insurance** arises when two or more private insurance policies relate to the same insurance risk covered for the same period, if the sum of the Insurance Benefit limits exceeds the actual amount of the damage caused.
36. An **Interested Party** is a party interested in concluding an insurance policy with the Insurer.

Article 3

**Extent of Insurance**

1. The extent of the agreed Insurance is determined by the Insurance terms and conditions and electable parameters stipulated in the insurance policy. These parameters are elected by the Policyholder upon concluding the insurance policy based on knowledge of the insurable interest of the Insured Persons.
2. The following cover may be taken out as part of the **Foreigners' Comprehensive Medical Insurance Exclusive**:
   a) Medical Insurance,
   b) Hospitalisation Insurance,
   c) Medical Expenses Insurance in the Schengen Area.
3. The Policyholder shall elect which types of cover shall be taken out in respect of which persons and thein type, if required, and shall elect the Term of Insurance and the Insurance Period.
4. Insurance is effective only in the agreed place of Insurance, which is stipulated in the other sections for individual types of Insurance.

Article 4

**Extent and Due Payment of the Insurance Benefit**

1. The amount and extent of the Insurance Benefit is determined by the Insurer in accordance with the Insurance terms and conditions.
2. The payment of an Insurance Benefit is conditional on the occurrence of an Insured Event and the meeting of all the conditions and obligations ensuing from the insurance policy and parts thereof, namely the payment of the premium.
3. Unless otherwise agreed by the contracting parties, the financial performance shall be payable in the currency of the Czech Republic and its territory and the Insurer shall pay it to the Beneficiary by transfer to this person's bank account or by postal order to his name and address.
4. If the Insured Person was entitled to receive financial performance that he did not receive whilst alive, this unpaid Insurance Benefit shall become the subject of inheritance proceedings.
5. In cases of the conversion of a foreign currency,t he Insurer shall use the exchange rate of the Czech National Bank valid at the time the Insured Event occurred.
6. An Insurance Benefit is payable within 15 days from the end of investigations of the notified event, with which the claim for the Insurance Benefit is connected. The investigations conclude upon there porting of its results to the person who exercised the claim to the Insurance Benefit.
7. If it is not possible to conclude the investigations necessary to ascertain the Insured Event, the extent of the Insurance Benefit or to ascertain the person entitled to receive the Insurance Benefitwithin three months ofthe notification date, the Insurer shall inform the notifier why the investigations cannot be concluded; if requested by the notifier, the Insurer shall inform the notifier of the reasons in writing. The Insurer shall provide the person who exercised the claim to theInsurance Benefit withan appropriate advance on the basis of this person's request; this shall not apply if there are reasonable grounds to deny the provision of such an advance.
8. Unless the law provides otherwise, the Insurer is entitled toreduce the Insurance Benefit:
   a) as a consequence of the compensation which the Beneficiary has already received in another manner,
   b) if a lower premium was agreed as a consequence of a breach of a duty of the Policyholder or the Insured Person when negotiating the conclusion of the policy or its amendment, the Insurer shall be entitled to reduce the Insurance Benefit by an amount equal to the ratio of the premium it received to the premium it ought to have received,
   c) if the breach of the duty of the Policyholder, Insured Person or another party entitled to the Insurance Benefit had a material effect on the occurrence of the Insured Event, its course, on increasing the extent of its consequences or on ascertaining or determining the amount of the Insurance Benefit, the Insurer shall be entitled to reduce the Insurance Benefit proportionally to the effect that this breach had on the extent of the Insurer's duty to render benefits,
   d) in the event of the thwarting of the passing of the right to the Insurer pursuant to Article 17,
   e) if it paid the Insurance Benefit in the unreduced amount

and has subsequently acquired a claim to reduce the Insurance Benefit. The Insurer is entitled to exercise a claim to the difference between the paid-out and the reduced Insured Benefit from the person in whose favour it was paid.

9. The Insurer may refuse to pay the Insurance Benefit if the Insured Event was caused by a fact
   a) of which it learned only after the occurrence of the Insured Event,
   b) which it was unable to as certain during the conclusion of the policy or its amendment as a consequence of the culpable breach of the obligation stipulated in paragraph 1 or 2 of Article 14 of this section,
   c) the awareness of which at the time of the conclusion of the insurance policy would result in it not concluding it or concluding it under different terms and conditions.
10. The Insurer may also refuse to pay the Insurance Benefit if, when exercising its right to benefits under the Insurance, the Beneficiary knowingly gave false or grossly distorted information pertaining to the extent of the Insured Event or withheld material information pertaining to this Insured Event.
11. The Insurance Benefit has an upper limit. The upper limit for the Insurance Benefit for individual types of Insurance is stipulated in the insurance policy:
12. A more detailed extent and manner of the Insurance Benefit for individual types of Insurance is stipulated in the other sections.

Article 5

**Insurable Interest**

1. Insurable interest is a legitimate need for protection from the consequences of the Insured Event.
2. The Policyholder has an insurable interest in his own life and health. It is understood that he Policyholder also has an insurable interest in the life and health of another person, if he demonstrates an interest conditional on his relationship to this person, whether resulting from a family relationship or being conditional on the benefit or advantage he gains from a continuation of this person's life or preservation of this person's health.
3. If the Insured Person consented to the Insurance it is understood that the Policyholder's insurable interest was demonstrated.
4. The insurance policy shall be invalid if the Interested Party did not have an insurable interest and the Insurer knew or ought to have known this when concluding the insurance policy.
5. The insurance policy shall be invalid if the Policyholder has knowingly insured a non-existent insurable interest, but the Insurer did not or could not have known this; however, the Insurer shall be entitled to remuneration corresponding to the premiums until the time it learned of the insurance policy being invalid.
6. The insurable interest does not terminate upon the absence of Insured Party at the place of Insurance, the taking up of similar private insurance or for reason of plain disinterest.
7. The termination of the insurable interest must always be proven to the Insurer.

Article 6

**Group Insurance**

1. Group Insurance is Insurance pertaining to a group of Insured Persons, as further defined in the insurance policy, whose identity need not be known at the time of the insurance policy being concluded.
2. If the Insurance applies to members of a certain group, the insurance policy need not specify the names of the Insured Persons, on the condition that the Insured Persons can be identified beyond doubt at least at the time of the Insured Event.
3. In the case of group insurance, a breach of the duty to give truthful and complete answers to the Insurer's questions only impacts the Insurance of those persons to whom a breach of this duty applies.

Article 7

**Conclusion of the Insurance Policy**

1. The insurance policy is concluded upon acceptance of the Insurer's Insurance offer. The offer is accepted upon its signing by the contracting parties, unless another manner of acceptance is expressly stated therein. If the Policyholder accepted the offer by the timely payment of the premium, it shall be deemed that the written form of the insurance policy has been duly observed.
2. The insurance policy is concluded for a definite time period.
3. An integral part of the insurance policy, apart from the Insurance terms and conditions, are also all agreements, supplements and annexes to the insurance policy and all documents defining the terms and conditions of the establishment, duration, alteration and expiration of the Insurance (e.g. applications, questionnaires, reports, medical examinations and checks, notices, records of the course of concluding the Insurance, the Insurer's information for the Interested Party on the conclusion of the insurance policy).

Article 8

**Commencement and Duration of the Insurance – Term of Insurance**

1. The Insurance is concluded for a fixed Term of Insurance from the commencement of the Term of Insurance to the end of the Term of Insurance. The Term of Insurance and the Insurance Period are agreed in the insurance policy.
2. The Insurance commences at 0:00 hours on the day agreed as the commencement of the Term of Insurance, but no earlier than on the day following the day on which Insurance premium is paid.
3. The Insurance lasts from its commencement until the actual expiration of the Insurance.
4. The Insurance cannot be suspended for reason of the non-payment of the premium.

Article 9

**Amendments to and Termination of the Insurance Policy. Expiry of the Insurance**

1. All amendments to the insurance policy are made in writing upon the mutual agreement of the contracting parties.
2. The personal Insurance expires upon the lapsing of the Term of Insurance, i.e. at 24:00 hours on the day agreed as the date of the termination of the Term of Insurance.
3. The personal Insurance expires upon the termination of the insurable interest, on the date when the Insured Person dies, or on the date when the Insurer's notification of the refusal to pay the Insurance Benefit is received. If the personal Insurance expires upon the termination of the insurable interest, the Insurer shall be entitled to remuneration corresponding to the costs it incurred associated with taking out and administering the Insurance.
4. All personal insurance expire as at the date of the Insurer receiving notification by the Policyholder of the Insured Person passing to the public medical insurance of the Czech Republic within the Duration of the Insurance, on the condition that this notification includes a copy of the Insured Person's valid ID card that he/she is a participant of public medical insurance of the Czech Republic.
5. The Insurer or the Policyholder may terminate the Insurance in writing:
   a) within two months of the conclusion of the insurance policy. An eight day notice period shall commence running upon the serving of the termination, with the Insurance terminating upon the expiry of this period,
   b) within three months of the serving of the notification of the Insured Event. A one month notice period shall commence running upon the serving of the termination, with the Insurance terminating upon the expiry of this period.
   c) as at the end of the Insurance Period; however, if the termination is served to the other contracting party later than six weeks prior to the expiry of the Insurance Period, the Insurance shall terminate at the end of the subsequent Insurance Period.
6. The Policyholder may terminate the Insurance subject to an eight day notice period:
   a) within two months of learning that the Insurer applied a viewpoint contrary to the principle of equal treatment in determining the amount of the premium or for calculating the Insurance Benefit,
   b) within one month of receiving notification of the transfer of the insurance portfolio or part thereof or the transformation of the Insurer,
   c) within one month of the publishing of the notification that the licence enabling the Insurer to carry on its insurance business has been withdrawn.
7. If the Policyholder or the Insured Person breaches the duty stipulated in paragraph 1 or 2 of Article 14 of this section, either intentionally or through negligence, the Insurer shall be entitled to withdraw from the insurance policy if it can prove that it would not have concluded the insurance policy had the questions been answered truthfully and completely. The Policyholder shall be entitled to withdraw from the insurance policy if the Insurer breached the duty stipulated in paragraph 8 or 9 of Article 11 of this section. The right to withdraw from the insurance policy shall expire if not exercised by a party within two months of the day that it learned or ought to have learned of a breach of the duty stipulated in paragraph 1 or 2 of Article 14 or in paragraph 8 or 9 of Article 11 of this section.
8. If the insurance policy was concluded by means of a remote transaction, the Policyholder shall be entitled to withdraw from the policy, without giving any reason, within 14 days of its conclusion or of the date on which the terms and conditions were communicated to him, if such communication first occurs only upon his request after the conclusion of the policy.
9. The insurance policy may, in exceptional cases, be terminated by a written agreement of the contracting parties under the agreed conditions.
10. The insurance policy may be assigned only with the Insurer's consent.
11. If Insurance of another party's insurable risk is concluded, then the Insured Person shall take the place of the Policyholder on the date of the Policyholder's death or the date of it being wound up without a legal successor; however, if the Insured Person gives written notice to the Insurer within thirty days of the Policyholder's death or winding up that he is not interested in the Insurance, the Insurance shall expire on the date of the Policyholder's death or winding up. The effects of a delay shall not impact the Insured Person before the expiration of 15 days from the date that the Insured Person learned of his entry into the Insurance.
    However, if there is more than one Insured Person, the Insurance of all such parties shall terminate upon the expiry of the period in respect of which a premium was paid.
12. If the Insurer issues the Policyholder with a notice reminding it to pay the premium and instructs it in the reminder notice that the Insurance shall expire if the premium is not paid during the additional period, the Insurance shall expire upon the futile passing of this period.
13. The Insurance does not expire due to the termination of the Insured Person's residence in the place of Insurance prior to the expiry of the Term of Insurance.
14. The insurance policy terminates upon the expiry of the Insurance of all persons.

Article 10

**Premium**

1. The premium is the consideration for the Insurance cover provided. The amount of the premium is determined by the Insurer for the insurance policy. If the Insurance Period is identical to the Term of Insurance, a Lump Sum Premium is agreed. In other cases a Current Premium shall be agreed.
2. The Premium is always payable on the first day of the Insurance Period in the currency and the amount stated in the insurance policy.
3. The premium shall be considered as duly paid if demonstrably received by the Insurer's agent or credited to the Insurer's bank account.
4. The Insurer is entitled to the premium for the entire Duration of the Insurance. The Insurer acquires this right on the date on which the insurance policy is concluded.
5. If the Insurance is terminated as a consequence of the Policyholder's termination or as a consequence of a notification by the Policyholder of the Insured Person passing to the public medical insurance of the Czech Republic within the Duration of the Insurance, the Insurer shall return to the Policyholder, after calculating the total Insurance Benefit paid, but not later than 6 months from the date of the Insurance expiring, part of the premium corresponding to the unearned premium as at the expiry of the Insurance, after deducting:
   a) the costs associated with taking out and administering the Insurance and
   b) the costs associated with the Insurance Benefits.
6. If the Insurance is terminated as a consequence of an Insured Event, the Insurer shall be entitled to the premium up to the end of the Insurance Period during which the Insured Event occurred.
7. If the insurance policy is terminated by **agreement** before the date of the commencement of the Insurance, the Insurer shall return all received premiums to the Policyholder minus the costs associated with taking out and administering the Insurance, upon the return of the Insured Person's Card.
8. The Insurer is entitled to the premium until the time it learned of the expiry of the insurable interest.
9. If the Policyholder withdraws from the insurance policy, the Insurer shall return to the Policyholder the received premiums within 30 days of the date of the withdrawal taking effect less any Insurance Benefits it may have paid under the Insurance; if the Insurer withdraws from the insurance policy, it shall be entitled to also set off the costs associated with taking out and administering the Insurance. If the Insurer withdraws from the Insurance, the Policyholder, Insured Person or another party who had already received an Insurance Benefit shall reimburse the Insurer within this same time period the amount of the Insurance Benefit received that is surplus to the received premiums.
10. If the Policyholder withdraws from the insurance policy

according to Article 9(8) of this section, the Insurer shall return to the Policyholder the received premiums without undue delay, but not later than 30 days from the date of the withdrawal taking effect; in so doing, the Insurer shall be entitled to deduct any Insurance Benefit it had already paid under the Insurance. However, if the amount of Insurance Benefit paid exceeds the amount of premiums received, the Policyholder, or the Insured Person or the beneficiary in the event of the Insured Person's death, as the case may be, shall be obliged to pay the Insurer the amount of the Insurance Benefit paid that is surplus to the premiums received.

11. The Insurer will set off its outstanding premiums in the order in which they were created rather than in the order in which reminder letters were sent.

Article 11
**Rights and Obligations of the Insurer**

1. The Insurer is entitled to verify the submitted documents, to demand the submission of expert reports compiled by specialists or to consult complicated Loss Events with healthcare facilities or other competent entities, even abroad.
2. The Insurer shall issue the Insurance Certificate and the Insured Person's Card for every Insured Person to the Policyholder after the conclusion of the insurance policy and payment of the first premium. The validity of every Insured Person's Card shall always be for the period for which the premium was paid.
3. If the event of the loss, damage or destruction of a valid Insurance Certificate, the Insurer shall issue a duplicate thereof to the Policyholder at the Policyholder's request; the same applies to the issue of a copy of the insurance policy concluded in writing and the Insured Person's Card. The Insurer may make the issue of such a duplicate conditional on the payment of the costs it has incurred to do so.
4. The Insurer shall notify the Interested Party information about the Insurer and the Insurance taken out prior to the conclusion of the insurance policy.
5. The Insurer is also obliged to accept the payment of outstanding premiums and other outstanding receivables under the Insurance from the Policyholder's pledgee, from a Beneficiary or from the Insured Person.
6. Within the Duration of the Insurance, the Insurer shall provide information to the Policyholder at his address stipulated in the insurance policy or via the Insurer's web site. If the correspondence address is different from the address of the registered office or residential address, then it is designated as the correspondence address. The address may also be an address designated for electronic communication.
7. The Insurer shall not return originals of the documents. If the Insurer is not obliged to provide an Insurance Benefit, it shall return the originals of the documents upon request.
8. If the Insurer ought to be aware of the inconsistencies between the Insurance being offered and the Interested Party's requirements when concluding the insurance policy, it shall alert the Interested Party of them. In so doing, the circumstances and the manner in which the insurance policy is concluded, as well as whether the other contracting party is being assisted in the conclusion of the policy by an agent independent of the insurer shall be taken into account.
9. If the Insurer asks the Interested Party or the Policyholder in writing whilst negotiating the conclusion of the insurance policy about facts pertaining to the Insurance, the Insurer shall answer these questions truthfully and completely.
10. If the Policyholder asks the Insurer in writing to provide him with information that is material for rendering benefits under the policy, the Insurer shall provide such information in writing without undue delay.

Article 12
**Obligations of the Policyholder**

The Policyholder has the following obligations:

1. To pay the Insurance premium to the Insurer.
2. To inform all Insured Persons, in a timely manner, of the contents of the insurance policy, including all annexes and parts thereof, and provide them with all materials and information which it has received on their behalf from the Insurer.
3. To inform every Insurer without undue delay in the event of Multiple Insurance occurring, providing details of the other insurers and the insured amounts or the Insurance Benefit limits agreed in the other insurance policies.
4. To inform the Insurer without undue delay of a change in correspondence address.
5. Always return the Insured Person's Card to the Insurer within five calendar days of the expiration of the Insurance, if the Insurance expires before the end of the agreed Insurance Period.
6. If the Policyholder is also the Insured Person, all the obligations of the Insured Person shall apply to the Policyholder as well.

Article 13
**Obligations of the Insured Person**

The Insured Person has the following obligations:

1. To do everything to avert the occurrence of an Insured Event and to reduce the extent of their consequences,
2. To release the healthcare provider in writing, at the request of the Insurer, from its obligation to maintain confidentiality and provide the Insurer with written authorisation to obtain information from healthcare staff which is subject to the obligation to maintain confidentiality and which is required for the Insurer's investigations if any Loss Event has occurred,
3. To always follow the instructions of the attending doctor,
4. To abide by the safety measures for the Duration of the Insurance,
5. To use suitable protective aids and equipment required for the maximum safe performance of all activities performed,
6. To have the appropriate valid licence for the performance of all activities carried out at the place of Insurance,
7. To arrange for proper supervision or escort, should this be usual for the performed activity,
8. To refrain from standing in places designated as inappropriate by the organiser,
9. To comply with the legislation in force at the place of his stay,
10. To seek out medical treatment, should the need arise,
11. To comply with the obligations prescribed in the other sections for the types of Insurance taken out.

Article 14
**Other Rights and Obligations of the Parties to the Insurance**

1. If the Insurer asks the Interested Party in writing whilst negotiating the conclusion of the insurance policy or asks the Policyholder in writing whilst negotiating the amendment of the insurance policy about facts that are relevant to the Insurer's decision on evaluating the insurance risk, whether it will insure them and under what conditions, the Interested Party or the Policyholder shall answer these questions truthfully and completely. The duty shall be deemed to have been duly met if nothing material had been concealed as part of the answer.
2. The provisions contained in paragraph 1 of this article regarding to the duty of the Policyholder shall also apply to the Insured Person.
3. Should an event occur with which the person who considers himself to be a Beneficiary links his claim to an Insurance Benefit, he shall notify this fact to the Insurer without undue delay, give the Insurer a truthful explanation of the cause, the origin and the extent of the consequences of such an event, the rights of third parties and any Multiple Insurance; at the same time, he shall also submit to the Insurer the required documents and proceed in the manner agreed in the insurance policy. If this person is not simultaneously the Policyholder or the Insured Person, the Policyholder and the Insured Person shall also have the duties.
4. The same notification may be made by any person with a legal interest in the Insurance Benefit.
5. The notification under paragraph 3 and 4of this article shall be deemed received after the Insurer:
   - I.) was notified of the event on the Insurer's form that has been duly completed,
   - II.) was handed originals (unless stated otherwise hereinafter) of all the required documents or documents requested by the Insurer.

   The required documents are:

   - A) documents demonstrating:
     - a) the cause, time, place and circumstances of the occurrence of the Insured Event, its extent and the direct connection of the Insured Event with the Insured Person, at least detailing the first name, surname and date of birth of the Insured Person,
     - b) a detailed specification of the subject of compensation (e.g. a medical report with the diagnosis, description and date of the procedures performed and the medicine administered, and a detailed medical release report in the event of an Insured Event under Hospitalisation Insurance),
     - c) the subject of the requested payment (e.g. bills or invoices issued by a doctor or bills issued by a pharmacy on the basis of a prescription issued by the attending doctor) and detailing the date and amount of the payment (e.g. receipts on a cash payment, account statements),
   - B) in the case of Insurance Benefits for Out-patient Medicine prescribed by a doctor, also copies of the prescriptions made out in the name of the Insured Person, specifying the date of issue, the quantity and description of the medicine and healthcare aids, and the signature and stamp of the issuer,
   - C) for an Insured Event investigated by the police, also a police report or confirmation of the investigation of an accident,
   - D) in the case of the death of the Insured Person, also a copy of an official death certificate and medical certification of the cause of death.

   All documents must be made out in the name of the Insured Person and must contain the date of issue and also the signature and stamp of the issuer, if prescribed on the document.
6. The Insurer shall commence investigations necessary to ascertain the existence and extent of its duty to perform without undue delay of the receipt of the notification under paragraph 5 of this article. The investigations shall be deemed as duly concluded upon the reporting of their outcome to the person who exercised the claim to the Insurance Benefit; at the request of this person, the Insurer shall justify the amount of the Insurance Benefit in writing, or the reason for this claim being refused, as the case may be.
7. If the notification contains knowingly false or grossly distorted material information pertaining to the extent of the notified event, or if information pertaining to this event has been knowingly concealed therein, the Insurer shall be entitled to compensation for the costs it purposefully incurred in investigating the facts in regards to which this information was given to or concealed from him. It is understood that the demonstrable costs of the Insurer were incurred purposefully.
8. If the Policyholder, the Insured Person or another party exercising a claim to the Insurance Benefit causes investigation costs or an increase therein by breaching a duty, the Insurer shall be entitled to claim reasonable compensation from such a person.
9. The Policyholder and the Insured Person are obliged:
   - a) to notify the Insurer in writing at any time within the Duration of the Insurance of a change of any and all particulars made in the insurance policy,
   - b) to enable the Insurer to conduct investigations into the causes of the Loss Event and the extent of their consequences and to co-operate with the Insurer as required,
   - c) to notify the Insurer the details of all insurance policies valid at the time of the Loss Event occurring, the subject of which is insurance of the same Insured Peril.

Article 15
**Delivery of Documents**

1. Documents designated for the parties to the Insurance (hereinafter the "addressee") shall be delivered by the holder of a postal licence (hereinafter the "Post Office"), by ordinary or registered mail to the residential address or registered office stated in the insurance policy. Should the addressee give an address that is different to his residential address or registered office (hereinafter the "correspondence address"),delivery shall be made to this address, with the addressee not being able to claim that his actual his residential address or registered office is in another place.
2. Correspondence sent by mail is deemed to be delivered on the third business day following dispatch. Correspondence sent to an addressee by registered mail with a delivery slip is deemed to be delivered on the date of receipt stated on the delivery slip.
3. Correspondence sent to an email address is deemed to be delivered on the date that it was delivered to the email box of the addressee; in the event of doubts, it shall be understood that it was delivered on the date that it was sent by the sender.
4. Correspondence sent to a data mailbox is deemed to be delivered the moment that this data mailbox is logged on by the person who, in view of the extent of his/her authority, has access to the correspondence.
5. Documents of the parties to the Insurance may also be delivered via an employee of the Insurer or by other parties authorised by the Insurer; in these cases the document is deemed to be delivered on the date it is accepted.
6. If the addressee deliberately thwarts the delivery of a document, it shall be deemed to have been duly delivered on the day that its receipt was thwarted by the addressee.
7. If the addressee thwarts the receipt of correspondence in another manner, e.g. by failing to take delivery of this correspondence or by failing to mark his/her/its letter box by his/her first name and surname or company name, it shall be deemed to have been duly delivered on the date on which it was returned to the insurer.
8. The Insurer's or Policyholder's place of delivery is the address stated in the insurance policy.

Article 16
**Rescue Costs**

1. If the Policyholder purposefully incurs costs in averting he immediate threat of an Insured Event or to mitigate the consequences of an Insured Event that has already occurred, it shall be entitled to compensation for these costs from the Insurer, as well as compensation for the loss suffered by the Policyholder in connection with this activity.
2. Compensation for rescue costs incurred in order to save lives or the health of persons is limited to 30% of the agreed insured amount or Insurance Benefit limit.
   The amount of compensation for rescue costs for the Period of Validity of the insurance policy is limited to CZK 100,000, with the exception of costs incurred by the Policyholder with the Insurer's consent.
3. Compensation for rescue costs is in excess of the framework of the agreed Insurance Benefit limit.
4. If the Insured Person or another person incurred rescue costs in excess of the framework of duties stipulated by law, they shall have the same right to compensation against the Insurer as the Policyholder.

Article 17
**Assignment of Rights to the Insurer**

1. If a person entitled to the Insurance Benefit, the Insured or a person incurring rescue costs, became entitled to compensation from another party for a loss or another similar right in connection with an Insured Event which is imminent or has already occurred, this claim, including appurtenances, security and other rights connected therewith, shall pass to the Insurer upon the payment of the Insurance Benefit, up to the amount of the benefits rendered by the Insurer to the Beneficiary. The above shall not apply if this person became entitled to this right against someone with whom he lives in a joint household or is dependent on him, unless he caused the Insured Event intentionally.
2. The person whose right passed to the Insurer shall release the required documents to the Insurer and disclose it all that is necessary in order to exercise the claim. Should this person thwart the passing of this right to the Insurer, the Insurer shall be entitled to reduce the benefits under the Insurance by the amount it could otherwise have received. If the Insurer has already rendered benefits, it shall be entitled to compensation up to this amount.
3. The Beneficiary is obliged to take measures to ensure that the right to compensation which pass to the Insurer under the law do not expire or become stature-barred.
4. The Beneficiary must not enter into an agreement with a third party to relinquish a claim for compensation against this third party if such claims pass to the Insurer.
5. The Beneficiary is obliged to confirm the assignment of rights to the Insurer in writing upon the Insurer's request.
6. If, in connection with the exercise of the claim, the Insurer incurs additional costs due to the fault of the Beneficiary, then the Insurer is entitled to require the Beneficiary to pay such costs.

Article 18
**Final Provisions**

1. Representations and notifications with respect to the Insurer are only valid if submitted in writing.
2. The language of communication is Czech.
3. Persons with restricted legal capacity shall be represented by their guardian. It is understood that persons who have yet to attain full legal capacity act with the consent of their statutory representative or that this statutory representative acts on their behalf.
4. If payment is made in cash, the date of payment is the date the sum is deposited in favour of the recipient. If the payment is not made in cash, the date of payment is the date the sum is credited to the account of the recipient.
5. The Insurer's costs associated with taking out and administering the Insurance come to 20% of the unearned premium.
6. All disputes arising out of or in connection with this Insurance which are not resolved by agreement or out-of-court settlement shall be dealt with by any court having jurisdiction in the Czech Republic in compliance with Czech law.

**SECTION B**

## MEDICAL INSURANCE

Aside from the Joint Provisions of Section A, the medical insurance (hereinafter in this section merely as "Insurance"") is also governed by the provisions of this section.

Article 1
**Purpose and Subject of the Insurance**

1. The Insurer shall, in the event of the occurrence of an Insured Event, provide the Beneficiary with an Insurance Benefit to the extent of the loss affecting the subject of the Insurance up to the agreed amount.
2. The Beneficiary is the Insured Person.
3. The subject of the Insurance is the health of the Insured Person. Supplementary insurance can also be taken out to cover the health of the insured mother's Newborn Baby.
4. The Insurance is concluded as Loss Insurance.

Article 2
**Insured Event**

An Insured Event is drawing by the Insured Person of medical services within the Duration of the Insurance and after the expiry of the Qualifying Period at the place of Insurance and to the extent and under the conditions stipulated in the provisions of this section.

Article 3
**Extent and Place of Insurance**

1. Insurance is effective only in the agreed place of Insurance, which is the territory of the **Czech Republic**.
2. The Qualifying Period applied in cases of healthcare services for reason of:
   - pregnancy is **three months**,
   - childbirth is **eight months**.

   The Qualifying Period is **not applied** in the event of the conclusion of "Newborn Baby" cover.
3. The Policyholder shall elect the upper limit for the Insurance Benefit and the type of Insurance in the following extent:
   In the event of the:
   "**Standard**" cover being concluded, the Insurance does not apply to events for which the Insurance Benefit is conditional on the conclusion of "Newborn Baby" cover,
   "**Newborn Baby**" cover being concluded, the Insurance shall also apply to events set out under Article 4(6)(d) of this section.

Article 4
**Extent of the Insurance Benefit**

1. The right to Insurance Benefit by way of drawing on healthcare services provided by the Insurer is conditional on the presentation at all times of a valid Insured Person's Card to the provider of these services prior to drawing on these services. This obligation may also be fulfilled by another person.
2. Unless stipulated below that the Insurer realises the Insurance Benefit via the provision of services without direct payment by the Insured Person, the Insurer shall reimburse the Beneficiary the costs of the damage that had actually been incurred.
3. Insurance Benefits for healthcare services drawn in connection with pregnancy or childbirth shall be rendered by the Insurer only after the expiry of the Qualifying Period, if agreed.
4. The Insurer shall not render Insurance Benefits for services drawn outsider of the Duration of the Insurance.
5. The Insurance Benefit has an upper limit.
6. The Insurer renders Insurance Benefits up to the limits pursuant to paragraph 9. of this article to the extent of:
   a) healthcare services reimbursed to the insured persons of public medical insurance of the Czech Republic (hereinafter merely as "healthcare"). This healthcare shall be rendered by the Insurer only at contractual healthcare facilities.
      Only in the event of a sudden deterioration in the state of health of the Insured Person, where a delay may result in serious damage to health or a threat to life, shall the Insurer render his healthcare in a non-contractual healthcare facility on the territory of the Czech Republic. Necessary and reasonable costs demonstrably incurred for healthcare services shall be defrayed, but only until such time as it was possible to arrange health services by the Insurer's contractual healthcare facility.
      Bedcare at the Insurer's contractual healthcare facilities is rendered without direct payment to the provider by the Insured Person.
   b) repatriation of a sick Insured Personon medical grounds with the approval of the attending doctor and the Insurer, by a medical transportation service organisation approved by the Insurer or by the Insurer's assistance service provider, to the state whose passport the Insured Person holds or to another state in which the Insured Person has been permitted residence. The Insurer may, upon prior approval, also cover the transportation costs of another person required to accompany the Insured Person in justified cases. The Insurer renders these services via its contractual provider without direct payment to the provider by the Insured Person,
   c) transportation of the physical remains of the Insured Person to the state whose passport the Insured Person holds or to another state in which the Insured Person has been permitted residence, performed by a specialist organisation approved by the Insurer or the Insurer's assistance service provider. The Insurer may, upon prior approval, also cover other related costs in justified cases. The Insurer renders these services via its contractual provider without direct payment to the provider by the Insured Person
   d) if, at the time of the occurrence of the Insured Event, the "**Newborn Baby**" cover is in effect, the Insurer shall provide an Insurance Benefit even in the case of the Postnatal Care of a Newborn Baby of an insured mother born within the Duration of the Insurance. Bed care at the Insurer's contractual healthcare facilities is rendered without direct payment to the provider by the Insured Person,
   e) assistance services to the extent of Article 6 of this section. The Insurer renders these services via its contractual provider without direct payment to the provider by the Insured Person.
7. The costs detailed in paragraph 6 of this article shall be paid by the Insurer directly or via the assistance service provider to the healthcare facility or another party that has demonstrably incurred these costs.
8. Direct defrayment of a loss:
   If the Insured Person directly defrayed a loss constituting an Insured Event and the Insurer does not provide this service without the direct payment by the Insured Person, the Insurer shall subsequently settle the reasonable costs upon receipt of the originals of the required documents, i.e. it shall render financial performance. If an original document has been submitted for payment to a party other than the Insurer, a copy will suffice if it records and confirms payments made by this party.
9. The upper limit for the Insurance Benefit is determined by the benefit limits specified in the insurance policy:
   a) The benefit limit for costs under letters a) to c) of paragraph 16 of this article (Healthcare services, including repatriation and transportation) applies to the Insurance Benefit for every single Insured Event.
   b) The individual limit detailed under letter a) of this paragraph is the benefit limit for costs under letter d) of paragraph 6 of this article (Postnatal care of a newborn baby), which further applies to the Insurance Benefit for the sum of all Insured Events occurring within the Duration of the Insurance.

Article 5
**Obligations of the Insured Person**

Besides the obligations contained in Section A, the Insured Person has the following obligations:

1. To **turn to the** Insurer's **assistance service provider** in a Loss Event, **always and without delay**, if his state of health permits, and follow its instructions. This obligation may also be fulfilled by another person.
2. To always identify himself by showing a valid Insured Person's Card to the healthcare provider. This obligation may also be fulfilled by another person.
3. To undergo treatment or necessary medical examinations by a doctor designated by the Insurer or by the Insurer's assistance service provider.
4. In the event that he is required to participate directly in the settlement of the loss that is the Insured Event:
   a) pay reasonable and demonstrable costs to the authorised recipient,
   b) collect the originals of the required documents and to store them safely until their submission to the Insurer,
   c) submit the required documents to the Insurer without undue delay.

Article 6
**Assistance Services**

1. The assistance services are services provided to the Insured Person in connection with the Medical Insurance taken out and are arranged for by the Insurer's contractual organisation. Assistance services are provided 24 hours a day. Contact details for the provider of the assistance services are contained in the Insured Person's Card.
2. The assistance services are provided to the following extent:
   - recommendation of a contractual healthcare facility,
   - arranging admission at a contractual doctor for treatment during office hours,
   - arranging for the admittance of the Insured Person into the care of the Insurer's pediatrician or general practitioner,
   - recommendation of an appropriate procedure n the case of a Loss Event,

- monitoring developments in the medical condition during the course of hospitalisation,
- provision of a liquidity guarantee to the contractual healthcare facility in the event of a claim for an Insurance Benefit,
- arranging for the repatriation of a client in a medically justified event,
- arranging for a professional companion as part of the repatriation,
- arranging for the transportation of the physical remains in the event of death.

**SECTION C**

## HOSPITALISATION INSURANCE

If hospitalisation insurance (hereinafter in this section merely as "Insurance") is concluded as part of the insurance policy, the Insurance shall, besides the Joint Provisions of Section A, also be governed by the provisions of this section.

Article 1
**Purpose and Subject of the Insurance**

1. In the event of the occurrence of an Insured Event the Insurer shall provide the Beneficiary with a lump-sum Insurance Benefit to the extent according to the provision of this section.
2. The Beneficiary is the Insured Person.
3. The subject of the Insurance is the health of the Insured Person.
4. The Insurance is concluded as Agreed Sum Insurance.

Article 2
**Insured Event**

With the exception of the agreed exclusions, an Insured Event is the hospitalisation of the Insured Person in a healthcare facility at the place of Insurance commenced within the Duration of the Insurance due to Insured Perils occurring within the Duration of the Insurance and during the Insured Person's stay at the place of Insurance Insured Perils are:

a) Injury,
b) Illness,
c) Pregnancy,
d) Childbirth.

Article 3
**Extent and Place of Insurance**

1. Insurance is effective only in the agreed place of Insurance, which is the **territory of the states of the Schengen Area**, including the Czech Republic.
2. The Qualifying Period in the case of hospitalisation for reason of:
   - Illness is applied for a period of **three months**,
   - Pregnancy or childbirth is applied for a period of **eight months**,
   - Injury s not applied.

Article 4
**Extent of the Insurance Benefit**

1. The Insurer shall, in the event of the occurrence of an Insured Event, provide the Beneficiary with a lump-sum Insurance Benefit in an amount corresponding to the product of the insured amount stipulated in the insurance policy for this Insurance and the number of days of hospitalisation. The number of days of hospitalisation is limited to the maximum hospitalisation period.
2. Insurance Benefits for events arising in connection with illness, pregnancy or childbirth shall be rendered by the Insurer only after the expiry of the agreed Qualifying Period.
3. The Insurance Benefit has an upper limit. The upper limit for the Insurance Benefit is the insured amount stipulated in the insurance policy.
4. The hospitalisation period:
   a) in the case of pregnancy is 30 days for one year within the Duration of the Insurance,
   b) in the case of childbirth is 10 days for one year within the Duration of the Insurance,
   c) in other cases is 365 days for one Insured Event.
5. The hospitalisation period is always counted from the first day of hospitalisation.
6. The first and last day of hospitalisation is counted as one day.
7. The Insurer does not provide an Insurance Benefit for hospitalisation lasting less than 24 hours.
8. The Insurer is entitled to deduct from the Insurance Benefit any outstanding premiums or other outstanding receivables under the Insurance.
9. If there is an increase in the insured amount within the Duration of the Insurance, this increased insured amount can only be applied for Insured Events occurring after the expiry of the agreed Qualifying Period, which is newly counted from the moment that of the amendment in the Insurance takes force.
10. Investigations of an event may be concluded not earlier than the end of hospitalisation or the expiry of the maximum hospitalisation period.

Article 5
**Exclusions from the Insurance**

An Insured Event does not include:

1. events, the cause or symptoms of which arose outside the Duration of the Insurance or outside of the agreed place of Insurance,
2. events associated with:
   a) performances and diagnostic methods that are not medically recognised or performed by a qualified healthcare professional, including hospitalisation provided in such facilities,
   b) cosmetic measures,
   c) spa and convalescent treatment and stays, treatment at specialist treatment facilities (including long-term care facilities, sanatoria and hospices) and at facilities for subsequent ward treatment care,
   d) examinations and treatment of venereal and sexually transmitted diseases and AIDS,
   e) artificial fertilisation and infertility treatment,
3. the examination and treatment of psychiatric disorders, psychological tests and psychotherapy,
4. homeopathy and acupuncture,
5. hospitalisation solely related to the need for caretaker and guardian services,
6. complications that arise in connection with the provision of healthcare for illnesses, states or injuries to which the Insurance does not apply,
7. events which the Policyholder, Insured Person or Beneficiary could foresee or which they knew of at the time the insurance policy was taken out,
8. events which the Insured Person brought about intentionally (including suicide or attempted suicide) or which were caused by the intentional conduct of the Policyholder or the Beneficiary,
9. events which were caused to the Insured Person by another person at the instigation of the Insured Person, the Policyholder or the Beneficiary,
10. events arising in connection with a riot which the Insured Person provoked, or in connection with criminal activity which the Insured Person committed or attempted to commit,
11. events which have occurred as a result of or in connection with the usage of, or the consequences of the usage of, alcohol, drugs, narcotics or other psychotropic or addictive substances by the Insured Person, even in the case of the voluntarily as well as proven treatment of additions to alcohol, addictive substances or gambling addiction, including stay in a detoxication facility or in a treatment facility for the other said addictions,
12. events which have occurred during test trials of Transport Means,
13. events which have occurred during stunt activities,
14. events which have occurred whilst performing Professional Sporting Activity,
15. events associated with driving a motor vehicle, when the Insured Person refuses to undergo a test to determine the content of alcohol, toxic or narcotic substances in his blood,
16. events which have occurred whilst working at heights, underground and underwater (e.g. whilst working as a scaffolder, roofer, chimneysweeper, diver, speleologist, miner),
17. events which the Insurer Person failed to document by providing proof of their duration, or failed to provide documentation that the Insurer requested or demanded of him in the course of the investigation of the Insured Event,
18. events whereby the Insured Person failed to comply with the legislation in force at the place of Insurance,
19. events which have occurred as a result of or in connection with the:
   - the effects of released nuclear energy, chemical or biological weapons,
   - wartime events and civil war,
   - acts of violence (including civil disturbances and terrorist activity), in which the Insured Person has participated,
   - the handling of a firearm or explosive by the Insured Person,
20. that part of hospitalisation surpassing the maximum hospitalisation period.

**SECTION D**

## MEDICAL EXPENSES INSURANCE IN THE SCHENGEN AREA

If medical expenses insurance in the Schengen Area (hereinafter in this section merely as "Insurance") is concluded as part of the insurance policy, the Insurance shall, besides the Joint Provisions of Section A, also be governed by the provisions of this section.

Article 1
**Purpose and Subject of the Insurance**

1. The Insurer shall, in the event of the occurrence of an Insured Event, provide the Beneficiary with an Insurance Benefit to the extent of the loss affecting the subject of the Insurance up to the agreed amount.
2. The Beneficiary is the Insured Person.
3. The subject of the Insurance is the health of the Insured Person.
4. The Insurance is concluded as Loss Insurance.

Article 2
**Insured Event**

With the exception of the agreed exclusions, an Insured Event is a change in the medical condition (including sudden changes in Chronic Illness) of the Insured Person caused by Sudden Illness or Injury, which occurred within the Duration of the Insurance and at the place of Insurance and which requires the subsequent provision of Acute and Urgent Healthcare at the place of Insurance.

Article 3
**Extent and Place of Insurance**

Insurance is effective only in the agreed place of Insurance, which is the territory of the states of the Schengen area, with the exception of the territory of the Czech Republic.
The territory of the states is understood to also include the Exclusive Economic Zone (EEZ).
The Policyholder shall elect the type of trip in the following extent:
**Type of trip**
Insurance is only effective for the performance of the activities involved in the agreed type of trip.
If the following type of trip is agreed:

a) "**Tourist**", applies to recreational Trips and stays while performing ordinary recreational and leisure activities, e.g. aerobics, animation programmes, athletics, badminton, baseball, basketball, bowling, skating (with the exception of competitive figure skating and speed skating), curling, cycle tourism, fitness, floor ball, football, golf, handball, street hockey, roller skating, animal riding (e.g. horse, camel, elephant), canoeing on calm water, fitness exercise in physical fitness organisations, corfball, billiards, bowling, lacrosse, indoor climbing, archery, curling, modern gymnastics, orienteering and cross-country running, swimming, beach and water recreational activities, city stays not limited by altitude, field hockey, arm wrestling, recreational fishing, skateboarding, softball, squash, table tennis, chess, fencing (sport, historic, scenic, etc.), with the exception of the use of sharp weapons, darts, snorkelling, dancing, tennis, tourism in non-demanding terrain of up to 3000 metres above sea level, rowing, water skiing and wakeboarding, water polo, volleyball, windsurfing, winter sports on groomed and public tracks (skiing with the exception of speed skiing, snowboarding; bobsleigh, ski bobbing and sledding – not competitive), study trips and other activities of a comparable risk, with the exclusion of activities detailed in item b) of this paragraph.
b) "**Working**", applies to Insurance for activities normally performed for a gain(e.g. au-pair), performed for the benefit of another person and to in order to gain practical experience. This Insurance also applies to the activities detailed in item a) of this paragraph.

Article 4
**Extent of the Insurance Benefit**

1. Unless stipulated below that the Insurer realises the Insurance Benefit via the provision of services without direct payment by the Insured Person, the Insurer shall reimburse the Beneficiary the costs of the damage that had actually been incurred. A loss is represented by necessary and reasonable expenses demonstrably incurred on healthcare for the Insured Person at the place of Insurance.
2. The Insurance Benefit up to the limits set out in paragraph 5 of this article to the following extent:
   a) Acute and Urgent Healthcare of the Insured Person including:
      - the essential examination required in order to determine the diagnosis and the medical procedure to be taken,

- the essential standard treatment,
- the essential hospitalisation for the patient in a multi-bed hospital room with standard equipment,
- a necessary operation with associated necessary expenses,
- the essential medicine and healthcare aids prescribed by the doctor of the quantity required until the patient returns to the Czech Republic,
- transportation necessary from a healthcare standpoint from the location where the Insured Event took place to the nearest medical first aid facility or hospital and back,

b) repatriation of a sick Insured Person, which is necessary from a medical standpoint and is carried out, upon the assessment and approval of the Insurer's supervising doctor and with the consent of the attending doctor, by a medical transport organisation approved by the Insurer or by the Insurer's assistance service provider, to a healthcare facility in the Czech Republic designated in the same manner, or to the place of residence of the Insured Person in the Czech Republic. The Insurer renders these services via its contractual provider without direct payment to the provider by the Insured Person,

c) the Insurer may, upon prior approval and in justified cases, also cover the costs of another person required to accompany the Insured Person,

d) transportation of the bodily remains of the Insured Person to his place of residence in the Czech Republic performed by a specialist organization approved by the Insurer or the Insurer's assistance service provider. Upon prior approval and in justified cases the insurer may also cover additional associated costs. The Insurer renders these services via its contractual provider without direct payment to the provider by the Insured Person,

e) urgent dental care of the Insured Person to alleviate sudden pain with the exception of the production and repair of dentures, fixed dentures and orthodontic aids,

f) assistance services to the extent of Article 7 of this section. The Insurer renders these services via its contractual provider without direct payment to the provider by the Insured Person.

3. Direct defrayment of a loss:
If the Insured Person directly defrayed a loss constituting an Insured Event, the Insurer shall subsequently settle the reasonable costs upon receipt of the originals of the required documents, i.e. it shall render financial performance. Originals of these documents remain with the Insurer and are not returned. If an original document has been submitted for payment to a party other than the Insurer, a copy will suffice if it records and confirms payments made by this party.
4. If an Insured Event occurred and the continuous hospitalisation of the Insured Person exceeds the Duration of the Insurance, the Insurer shall decide on the subsequent procedure as follows:
   a) if the state of health of the Insured Person does not allow for his repatriation, the Insured Person shall be treated in a healthcare facility designated by the Insurer until such time as his state of health improves to such an extent as to allow for his repatriation,
   b) if the state of health of the Insured Person allows for his repatriation, the repatriation can proceed after the consent of the attending doctor is obtained and also, if necessary, final treatment in a healthcare facility in the Czech Republic designated by the Insurer.
5. The upper limit for the Insurance Benefit is determined by these limits:
   a) The agreed benefit limit for expenses pursuant to items a) to e) of paragraph 2 of this article (Healthcare, including repatriation and transportation) is specified in the insurance policy and limits the Insurance Benefit for one and all of the Insured Person's Insured Events.
   b) The partial limit detailed pursuant to letter a) of this paragraph is the benefit limit for costs pursuant to letter e) of paragraph 2 of this article (Urgent dental treatment) is stipulated in the insurance policy and limits the Insurance Benefit for one and all of the Insured Person's Insured Events.
6. The Insurer is entitled to deduct from the Insurance Benefit outstanding premiums or other insurance claims.

Article 5

**Exclusions from the Insurance**

Besides the exclusions stipulated in Section A, Insured Events are not deemed to be:

1. events, the cause or symptoms of which arose outside the Duration of the Insurance or outside of the agreed place of Insurance
2. childbirth, including premature and puerperium, abortion, artificial fertilisation, infertility treatment and tests or tests (including laboratory and ultrasound) to ascertain and monitor pregnancy, tests involving contraception and payment of contraception,
3. cases of travel abroad for the purposes of utilizing healthcare,
4. dental treatment and associated services, with the exception of the treatment of the consequences of an injury and urgent simple dental treatment to eliminate sudden pain,
5. preventative examinations, vaccination, medical tests and treatment not associated with the sudden onset of Illness or Injury,
6. rehabilitation, physical therapy, chiropractic operations, exercise therapy and self-reliance training,
7. organ transplants, haemophilia treatment, interferon treatment, insulin therapy except during the provision of first aid, chronic haemodialysis,
8. replacements for spectacles, contact lenses and hearing aids and the production and repair of orthopaedic prostheses,
9. examination and treatment of psychiatric disorders not associated with any other sudden onset of illness or injury, psychological tests and psychotherapy,
10. procedures and diagnostic methods that are not medically recognised or performed by a qualified healthcare professional, including hospitalisation provided at such facilities,
11. cosmetic measures,
12. spa and convalescent treatment and stays, treatment at specialist facilities (including long-term care facilities, sanatoria and hospices) and at facilities for subsequent ward treatment care,
13. acupuncture and homeopathy,
14. complications that may arise during the treatment of illnesses, conditions or injuries not covered by the Insurance,
15. examinations and treatment of venereal and sexually transmitted diseases and AIDS from the determination of a diagnosis,
16. coverage of medicine and healthcare aids not prescribed by a doctor, i.e. freely available without a doctor's prescription or medicine whose administration started before the commencement of the Insurance,
17. treatment of illnesses and states of health where healthcare is appropriate, useful and necessary, but may be postponed and need not be provided until one returns to the Czech Republic,
18. events after the Insured Person refuses to undergo repatriation, treatment or necessary medical examinations by a doctor assigned by the Insurer or the Insurer's assistance service provider,
19. transportation, searching, probing and rescue operations, if an Insured Event has not occurred at the same time impacting on the health of the Insured Person,
20. events which the Policyholder, Insured Person or Beneficiary could foresee or which they knew of at the time the insurance policy was taken out,
21. events arising during the preparations for and performance of activities for which the appropriate insurance under Article 5 has not been taken out,
22. events which the Insured Person brought about intentionally (including suicide or attempted suicide) or which were caused by the intentional conduct of the Policyholder or the Beneficiary,
23. events which were caused to the Insured Person by another person at the instigation of the Insured Person, the Policyholder or the Beneficiary,
24. events arising in connection with a riot which the Insured Person provoked, or in connection with criminal activity which the Insured Person committed or attempted to commit,
25. events which have occurred as a result of or in connection with the usage of, or the consequences of the usage of, alcohol, drugs, narcotics or other psychotropic or addictive substances by the Insured Person,
26. events which have occurred during test trials of Transport Means,
27. events which have occurred during stunt activities and the taming of beasts of prey,
28. events which have occurred during activities at locations not designated for that purpose,
29. events which have occurred in an area that a state administration body has designated as a war zone or as an area that is otherwise dangerous to life and health, or has not recommended for travel or a stay in this area if the journey or the stay commenced or the insurance policy was taken out after this declaration was made,
30. events which have occurred as a consequence of or in connection with:
    a) the effects of released nuclear energy, or of chemical or biological weapons,
    b) wartime events or civil war,
    c) acts of violence (including civil disturbances and terrorist activities), in which the Insured Person took an active part,
    d) handling of a firearm or explosive by the Insured Person.
31. events occurring and healthcare services provided on the territory of the Czech Republic,
32. events occurring during the preparation and conducting of Professional Sporting Activity,
33. events occurring in connection with any sporting activity in excess of the frame work of the tourist trip specified in Article 3 of this section.

Article 6

**Obligations of the Insured Person**

Besides the obligations contained in Section A, the Insured Person has the following obligations:

1. To **contact the Insurer's assistance service provider** in a Loss Event, **always and without delay**, if his state of health permits, and follow its instructions. This obligation may also be fulfilled by another person.
2. To always identify himself by showing a valid Insured Person's Card to the healthcare provider. This obligation may also be fulfilled by another person,
3. Undergo treatment r necessary medical examinations by a doctor designated by the Insurer or by the Insurer's assistance service provider,
4. In the event that he is required, on rare occasions, to participate directly in the settlement of the loss that is the Insured Event:
   a) pay reasonable and demonstrable costs to the authorised recipient,
   b) collect the originals of the required documents and to store them safely until their submission to the Insurer,
   c) submit the required documents to the Insurer without undue delay.
5. If the state of health of the Insured Person permits, undergo repatriation at the proposal of the Insurer or the Insurer's assistance service provider.

Article 7

**Assistance Services**

Assistance services are provided to the Insured Person in connection with the Medical Expenses Insurance taken out and are arranged for by the Insurer's contractual organisation:

**AXA ASSISTANCE CZ**, s.r.o., City Point, Hvězdova 1689/2a, Post Code 140 62, PRAGUE 4 – Pankrác
Tel.: **+420 272 101 010**, SMS: **+420 606 601 755**,
Fax: **+420 272 101 001**, **e-mail: info@axa-assistance.cz**

Assistance services are provided 24 hours a day to the extent of:

- the provision of a liquidity guarantee to the contractual healthcare facility in the event of a claim for an Insurance Benefit,
- medical assistance in the event of out-patient healthcare,
- medical assistance in the event of hospitalisation,
- arranging for the repatriation of a client in a medically justified event,
- arranging for a professional companion as part of the repatriation,
- arranging for the transportation of the physical remains in the event of death,
- accompaniment by a family member.

Article 8

**Duration of the Insurance**

Should a situation occur within the Duration of the Insurance where the Insured Person cannot, independently of his own will, return to the Czech Republic prior to the expiry of the Term of Insurance agreed in the insurance policy, the Term of Insurance shall be automatically extended, without an increase in the premium, for the time until the reasons stated hereinafter pass, but no more than seven days immediately following the initial Term of Insurance. The reasons for an extension are objective facts, which may be forces of nature (e.g. earthquakes, volcanic eruptions, floods and spates, storms), transport strikes, technical defect in a means of transport or terrorist acts preventing the Insured Person from returning to the Czech Republic.