GlobalHealth

Journey

Special Conditions

Applicable to Plan Short

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1. Insurance cover

Special Conditions – Contractual basis

1.1 Scope of cover

Terms capitalized in this document, unless explicitly defined otherwise, will bear the meanings specified in the Glossaries outlined in the Special and the General Conditions of Insurance.

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

The Insurer offers cover for Diseases, Bodily Injuries, and other occurrences leading to insured events as outlined in the Insurance Policy.

Upon the occurrence of an insured event, the Insurer reimburses the expenses related to Medically necessary Treatment and other agreed Benefits, contingent upon the conditions set forth in the Insurance Policy and statutory regulations.

Under the current Special Conditions and within specified limits, the Insurer covers the medical expenses for each of the Insured Persons identified in the Insurance Policy.

Treatment abroad is excluded from Benefits if such Treatment was the sole reason or one of the reasons for travelling abroad.

1.2 Eligibility

The Insurance Policy is designed for individuals living, travelling or working outside of their Home Country on temporary basis. Anyone who stays abroad for at least 3 (three) months is eligible for insurance cover unless the Insurer agrees otherwise. Insurance cover is granted up to 3 (three), 6 (six) or 9 (nine) months with a maximum cumulative period of 9 (nine) months in total. All limits are per Insured Person, per Insurance Period. Benefit limits are provided on a "per Insurance Period" basis.

For change of residence, the Insurer will assess each case individually, determining whether to issue, modify, or terminate the insurance cover.

The Policyholder is responsible for ensuring compliance with local social security laws and regulations for all Insured Persons covered by the Insurance Policy. The Insurer reserves the right to terminate the entire Insurance Policy or the insurance cover for specific Insured Persons in the event of legal changes in a country that would result in a violation of laws or regulations.

1.3 Pre-Existing Conditions

The Insurer does not cover Pre-Existing Conditions including Congenital Conditions.

Pre-Existing Condition means any condition.

a) For which the Insured Person did have signs, symptoms or has received medical advice, Treatment, diagnosis, consultation or prescribed Drugs within 2 (two) years preceding the Effective Date of the Insurance Policy; or
b) For which medical advice or Treatment was recommended by a Doctor or Medical Practitioner within 2 (two) years preceding the Effective Date of the Policy.

1.4 Waiting Period

There are no Waiting Periods.

2. Geographical scope

2.1 Geographic Area

The insurance cover applies to insured events occurring in the following areas:

Geographical Area I: Worldwide including USA
Geographical Area II: Worldwide excluding USA

2.2 Temporary cover for Geographical Area I

If the Insurer has agreed to provide insurance cover under the Insurance Policy for 'Geographical Area II – Worldwide excluding USA', and the Insured Person is temporarily residing in the USA, the Insurer will still provide cover for medical emergencies, Accidents, and death occurring within Geographical Area I: Worldwide including USA, for trips lasting up to 3 (three) weeks.

Should an insured event occur within such 3 (three)-week period, and the Insured Person requires Emergency Treatment in the USA, there is no specific time limit on the Treatment itself. However, if a medical Emergency arises, the Insurer may relocate the Insured Person to another country for the Treatment if deemed medically appropriate and feasible.

The Insurance cover provided under the Insurance Policy will not extend to journeys undertaken solely for the purpose of obtaining Treatment in Geographical Area I.

If an Insured Person relocates to a Geographical Area different for the one agreed to be covered under the Insurance Policy for any duration, such relocation must be immediately notified to the Insurer, and this change will impact the premium due and any Benefits to be granted under the Insurance Policy.

2.3 Double Benefits for Geographical Area I

If the Insured Person is covered under Geographical Area I (worldwide including USA) the Insurer will double the maximum sums shown in 3.5, 3.6 and 3.7 (whether the Treatment takes place in the USA or not). If a Benefit is limited to a certain number of days or sessions, this limit will not change. If the Insurer has agreed to a Co-Payment, it will not change.

2.4 Policy Period

The Policy Period begins on the Effective Date and runs until the end date of insurance shown in the Insurance Certificate.

The Policy Period for Insured Persons who later join the Insurance Policy begins on the date indicated on their Insurance Certificate and runs until the end date of insurance (see also 2.6).

2.5 Extension of Policy Period

The Insurer may agree to extend the Policy Period, before the end date of the Policy Period. Only one (1) extension of Policy Period shall be allowed. The insurance cover is granted up to 3 (three), 6 (six) or 9 (nine) months with a maximum cumulative period of 9 (nine) months. The Insurer reserves the right to apply changes to the conditions of insurance of the Insurance Policy for the new Policy Period which follows the end date indicated in the Insurance Certificate.

The Insurer must be informed at least 4 (four) weeks prior to the end date of the initial Policy Period of any requests for the extension of the Policy Period and of any changes in the Insured Person's circumstances.

Any agreed changes in the insurance cover will apply from the beginning of the next Policy Period.

2.6 Ending of insurance cover

In addition to the reasons for termination of the Insurance Policy detailed in the General Conditions of Insurance, the insurance cover and the Insurance Policy shall cease upon reaching the maximum Policy Period of 9 (nine) months. The short-term cover offered under this Insurance Policy is not subject to automatic renewal.

2.7 Temporary cover for Home Country

If any Insured Person is temporarily away from the Country of Residence, the Insurer will grant insurance cover for medical Emergencies, as well as for the consequences of an Accident, also in the Home Country for trips up to a maximum accumulated 30 (thirty) days between two stays in the Insured Persons Country of residence.

The Insurer will not cover any medical expenses for the purpose of getting Treatment in the Home Country.

2.8 Permanent return to Home Country

When the Insured Person returns to the Home Country and thereby ending the stay abroad, the Insured Person shall notify the Insurer of the exact date of relocation to the Home Country, as soon as it becomes aware of it, latest however on the actual day of relocation. If the Insured Person fails to inform the Insurer of the relocation, the Insurer cannot guarantee cover and may have to terminate the Insurance Policy in line with the Terms and Conditions of Insurance. Insurance premiums already paid for the elapsed Policy Period are not refundable.

3. Benefits

3.1 General information

The Plan level, as selected by the Policyholder, is defined by the nature and extent of Benefits set out in the Special Conditions. Based on the selected Plan, the Insurer will reimburse expenses up to 100% of the Overall Limit per Policy Period specified in the scope of Benefits, unless expressly stated otherwise in the Terms and Conditions of Insurance.

3.2 Insured event

An insured event is characterized by the Medically necessary Treatment required for an illness, an Accident including the consequences of an Accident, or other events specified in the Special Conditions of Insurance (refer to 3.5-3.9 – scope of Benefits).

The commencement of the insured event is marked by the initiation of Treatment and concludes when medical findings indicate that further Treatment is not Medically necessary. In the event that the Insured Person requires Treatment for an illness, an Accident, or other occurrences detailed in the Special Conditions (refer to 3.5 to 3.9 – scope of Benefits) unrelated to the original insured event, it will be treated as a distinct new insured event.

3.3 Deductibles and Co-Payment

Deductibles

There are no Deductibles.

Co-Payment

Co-Payment is the percentage of Treatment costs that the Insured Person must contribute. The Insurer has established a fixed 20% Co-Payment for Outpatient Treatment.

Co-Payments apply on Policy Period basis for each Insured Person. Expenses are allocated to the Policy Period during which the Doctor or Therapist was consulted and when Drugs and/or Dressings were provided.

3.4 Criteria for obtaining Benefits

Insured Persons have the flexibility to select any licensed Doctors, or Therapists within the country where they need Treatment, and this choice extends to other healthcare Practitioners.

The Insurer will reimburse expenses solely for Medically necessary Treatments within the scope of medical practice. Reimbursement for such Treatments and services from other Therapists is subject to reasonable fees aligned with Usual, Customary and Reasonable rates. These rates refer to expenses associated with approved and covered medical services or supplies, not exceeding the standard fees charged by other providers of similar standing in the same Geographical Area, offering comparable Treatment for a similar illness and/or injury.

Additionally, the Insurer may reimburse expenses that surpass the maximum fees based on Usual, Customary and Reasonable rates if they are incurred due to difficulties arising from the illness or medical findings, provided the expenses are reasonably determined.

For services by other Therapists, such as masseurs (where there may not be a separate Customary and Reasonable rate in the country of Treatment), reimbursement will be based on comparable fees for Doctors and customary prices in the country where the Treatment occurs.

Dental procedures like dentures, Implants, dental surgery, and orthodontic Treatment, even when performed by a Doctor in a Hospital, are not considered part of inpatient or Outpatient Treatment and are not covered via this Insurance Policy.

Under the Insurance Policy, the Insurer will reimburse expenses for examinations, Treatment methods, and Drugs widely accepted in Conventional Medicine. Additionally, costs for methods and Drugs proven in practice or used due to the unavailability of conventional alternatives are eligible for reimbursement. However, Benefits may be limited to amounts equivalent to what would have been paid if Conventional Medicine had been accessible.

3.5 Overall Limit per Policy Period

	Short
Benefits	
Overall Limit per Policy Period	EUR 500,000 / USD 650,000 / GBP 420,000 / CHF 465,000

3.6 Scope of Benefits: Inpatient Benefits

	Short
Inpatient Benefits	
Accommodation in a private or semi-private room	✓
Consultations and diagnostic services, including pathology, radiology, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) and Palliative Medicine	✓
Hospital charges, including operating theatres, anaesthesia, intensive care wards and laboratories	✓
Surgery and anaesthetics	✓
Outpatient surgery instead of inpatient Treatment	✓
Drugs and Dressings	✓
Physiotherapy, including massages	✓
Therapies, including occupational therapy, light therapy, Hydrotherapy, inhalation, packs, medical baths, cryotherapy, thermotherapy, electrotherapy	✓
Therapeutic aids and appliances	✓ only if needed as a life-saving measure, such as cardiac pacemakers
Cancer Treatment, oncological Drugs and Treatment, including reconstructive surgery for breast Cancer	✓
Parent accommodation during inpatient Treatment of a minor child	✓
Inpatient Follow-Up Rehabilitation	✓ Up to 14 days after written pre-approval
Daycare	✓
Transport to the nearest suitable Hospital for initial Treatment following an Accident or an Emergency	✓

The specified maximum sums and maximum periods apply per Insured Person and per Policy Period.

3.7 Scope of Benefits: Outpatient Benefits

	Short
Outpatient Benefits	
Maximum Outpatient Limit	EUR 2,000 / USD 2,600 / GBP 1,680 / CHF 1,860
Consultations and diagnostic services, including pathology, radiology, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET) and Palliative Medicine	✓ 80%*
Chemotherapy, oncological Drugs and Treatment (e.g. for Cancer patients)	✓ Up to EUR 10,000 / USD 13,000 / GBP 8,400 / CHF 9,300
Drugs and Dressings	✓ 80%*
Transport to the nearest suitable Doctor or Hospital for initial Treatment following an Accident or an Emergency	✓

The specified maximum sums and maximum periods apply per Insured Person and per Policy Period.
*max. outpatient limit applies

3.8 Scope of Benefits: Medical Assistance Benefits

	Short
Medical Assistance Benefits	
24-hour phone and e-mail service with experienced counsellors, own Doctors and specialists	✓
Medical evacuation and Repatriation	✓
Information on medical infrastructure (local medical care and names and addresses of multilingual Doctors)	✓
Support and information by our medical service (Second Opinion, monitoring of the course of the illness)	✓
Guarantee of payment (GOP) (preparing for a stay in Hospital)	✓
Return of mortal remains	✓ Up to EUR 2,500 / USD 3,250 / GBP 2,100 / CHF 2,325
Additional appropriate medical support (information on the nature, possible causes and possible Treatment of an illness)	✓
Online services	✓

The specified maximum sums and maximum periods apply per Insured Person and per Policy Period.

3.9 Scope of Benefits: Additional Assistance Benefits

	Short
Additional Assistance Benefits	
Telemedicine	✓

4. Description of Benefits

4.1 Inpatient Benefits

The Insurance Policy provides cover for the inpatient Benefits described below:

Accommodation in a private or semi-private room

The Insured Person has the flexibility to select the Hospital for receiving Medical Treatment. Medical Treatment in a Hospital encompasses any Treatment, during which the Insured Person is admitted to a Hospital in the country where it is undergoing Treatment, for a minimum duration of 24 (twenty-four) hours.

In cases where the Treatment is conducted in Hospitals offering Sanatorium Treatment, the Insurance Policy exclusively covers Treatments meeting the criteria for Conventional Medicine/Medically necessary Treatment, unless alternative Treatments have been explicitly approved in writing by the Insurer prior to the Start of Treatment. Accommodation is restricted to standard private or semi-private rooms, as specified in the scope of Benefits. A standard private room is defined as a basic single occupancy room with an adjoining private bath or shower room in a Hospital. **It explicitly excludes rooms with upgraded amenities, including but not limited to deluxe rooms, executive rooms, or suites that may have additional facilities such as kitchens, dining areas, or sitting rooms.**

The Insurance Policy covers the entire inpatient Treatment without a specific time limit. However, it is imperative to contact and inform the Insurer or the Service Centre regarding the Hospital stay and Treatment before or within 3 (three) calendar days of admission to the Hospital. Failure to do so may result in the Insurer not fully covering the Claim.

Consultations and diagnostic services, including pathology, radiology, CT, MRI, PET and Palliative Medicine

The Insurance Policy will encompass all costs related to Medically necessary inpatient Treatment, covering examinations, diagnostics, and therapy as well as expenses related to pathology, radiology, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Palliative Medicine.

Hospital charges, including operating theatres, anaesthesia, intensive care wards, laboratories

This pertains to additional expenses associated with the utilization of specialised facilities, including operating theatres, intensive care units, and laboratories.

Surgery and anaesthetics

The Insurer will reimburse costs incurred for Medically necessary services in this context, such as medical services, anaesthesia, and the utilization of specialised facilities, if prescribed by a specialist Doctor.

Outpatient surgery instead of inpatient Treatment

This pertains to elective surgery typically conducted in a Doctor's office or Hospital setting, without the necessity for an overnight stay. **However, it excludes grade 1 or minor surgeries (invasive procedures involving only the resection of skin, mucous membranes, and connective tissue) and invasive operative procedures for obtaining tissue samples or bodily fluids, such as biopsies and colonoscopies.**

Drugs and Dressings

To qualify for cover under the Insurance Policy, Drugs and Dressings must be prescribed by a Hospital Doctor or Dentist in conjunction with inpatient Treatment. Additionally, the Drugs must be dispensed by a pharmacy, Hospital pharmacy, or another dispensary officially approved by competent authorities.

Nutritional food, tonics, mineral water, cosmetics, products for personal hygiene, as well as bath salts, are not deemed as Drugs eligible for cover under the Insurance Policy as part of Medical Treatment.

Physiotherapy, including massages

To qualify for cover under the Insurance Policy, physiotherapy and massages must be prescribed by a Hospital Doctor as integral components of inpatient Medical Treatment. Furthermore, these procedures must be administered by a Doctor or a qualified, certified Therapist. The prescription should be provided prior to the Start of Treatment and should

specify the diagnosis along with details about the type and number of required sessions.

Therapies, including occupational therapy, light therapy, Hydrotherapy, inhalation, packs, medical baths, cryotherapy, thermotherapy, electrotherapy

To qualify for cover under the Insurance Policy, physical-medical therapies must be prescribed by a Hospital Doctor as a component of inpatient Treatment. Furthermore, these therapies must be administered by a Doctor or a qualified, certified Therapist. The prescription must be provided before the Start of Treatment and should include details such as the diagnosis and the specific type and number of required sessions.

Therapeutic aids and appliances within the framework of inpatient Treatment

The Insurance Policy covers expenses related to therapeutic aids and appliances designed as life-saving measures such as cardiac pacemakers. These aids must be fitted or adjusted during the inpatient stay and should remain in the body of the Insured Person.

Additionally, the Insurer will reimburse costs for repairing therapeutic aids and appliances within the specified conditions during the Policy Period.

Cancer Treatment, oncological Drugs and Treatment, including reconstructive surgery for breast Cancer

Within the scope of inpatient Hospital care, the Insurance Policy includes cover for eligible medical expenses related to Medical Treatment for Cancer and direct consequences, including diagnostic tests, radiation therapy, chemotherapy, Drugs, and Hospital costs associated with inpatient Treatment. Additionally, reconstructive surgery for breast Cancer is covered.

Parent accommodation during inpatient Treatment of a minor child

The Insurance Policy includes cover for the supplementary accommodation expenses for one parent staying with a child under the age of 18 (eighteen) who is admitted for inpatient Treatment.

Inpatient Follow-Up Rehabilitation

The Insurer will reimburse the costs associated with Inpatient Follow-Up Rehabilitation, which is essential for continuing Medically necessary inpatient Treatment. This applies specifically to cases such as post-bypass surgery, cardiac infarction, transplants, and surgeries involving large bones or joints, subject to prior written approval from the Insurer before the Start of Treatment. Inpatient Follow-Up Rehabilitation must commence within 2 (two) weeks of Hospital discharge. **However, the Insurance Policy does not cover expenses related to Sanatorium Treatments, cures, stays in cure establishments, spas, convalescent homes, or nursing homes.**

Daycare

The Insurance Policy covers Treatment received in a Hospital that does not require an overnight stay. It also covers partial inpatient Treatment involving a visit to a day or night clinic or Hospital where the patient is present during the day or night, but where a full-day (24 (twenty-four)-hours) inpatient arrangement is no longer Medically necessary.

In both scenarios, the duration of the Hospital stay ranges from 8 (eight) to 24 (twenty-four) hours and must not surpass the 24 (twenty-four)-hour limit.

Transport to the nearest suitable Hospital for initial Treatment following an Accident or an Emergency

The Insurer will cover the Usual, Customary and Reasonable expenses for transporting to the closest suitable Hospital or medical facility. Unless otherwise agreed, the provision of transportation services must be carried out by a duly licensed service provider.

4.2 Outpatient Benefits

The Insurance Policy provides cover for the following Benefits in relation with Outpatient Treatment:

Maximum Outpatient Limit

The Benefits shall not exceed the Maximum Outpatient Limit, unless otherwise specified in the scope of Benefits.

Consultations and diagnostic services, including pathology, radiology, CT, MRI, PET and Palliative Medicine

The Insurance Policy includes cover for incurred expenses related to Outpatient Treatment, encompassing examinations, diagnostics, and therapy.

The Benefits offered include reimbursements for a range of services, including but not limited to pathology, radiology, Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), and Palliative Medicine.

Cancer Treatment, oncological Drugs and Treatment

The Insurance Policy covers eligible Medically necessary measures for examination, diagnosis, and therapy in the context of Outpatient Treatment for Cancer and direct consequences, including chemotherapy, and other oncological procedures.

Drugs and Dressings

To qualify for cover under the Insurance Policy, prescriptions for Drugs and Dressings must be issued by a Doctor, Practitioner, Dentist, or a person authorized to do so under their supervision. These Drugs and Dressings must be obtained from a pharmacy or an officially approved supplier.

Items such as nutritional food, tonics, mineral water, cosmetics, products for personal hygiene, and bath salts are not categorized as Drugs. Consequently, they do not meet the criteria for Medical Treatment covered under the Insurance Policy.

Transport to the nearest suitable Doctor or Hospital for initial Treatment following an Accident or an Emergency

The Insurer will reimburse qualifying Usual, Customary and Reasonable expenses for Emergency transportation to the nearest appropriate Doctor, Hospital, or facility following an Accident or Emergency. Unless otherwise agreed, the provision of transportation services must be carried out by a duly licensed service provider.

4.3 Medical Assistance Benefits

The Insured Persons can claim the services of the Insurer's Service Centres in line with the Plan level chosen whenever an insured event or Emergency happens. With the Insurer's service and assistance network of competent and experienced partners on the ground, the Insurer offers the Insured Persons individual support worldwide as well as comprehensive, competent consultation for any situation.

This network is represented in more than 180 countries and delivers excellent support, reliability and service. The Insurer provides a wide range of services as well as, and as part of, the health insurance cover to support during the time abroad (for covered conditions only).

These services are available 24 (twenty-four) hours a day, 7 (seven) days a week, 365 days a year. If the Insured Person needs help from them, it simply calls the number shown in the insurance documents at any time, day or night.

When the insurance cover ends according to the Insurance Policy, the Insured Person will no longer be entitled to these services.

24-hour phone and e-mail service with experienced counsellors, Doctors and specialists

Medical assistance is accessible every day of the year, around the clock, either through e-mail or by contacting the medical assistance hotline.

Medical evacuation and Repatriation

This service encompasses a medically justified and necessary ambulance service, either within the Country of Residence or to a cross-border location if the inpatient medical care or hygiene standards in the local Hospital are deemed inadequate. The service also includes the costs of Medically necessary medical accompaniment during transport.

The Insurer will cover the expenses for transporting a patient under the following conditions:

- Evacuation or Repatriation must be prescribed by the treating Doctor and deemed Medically necessary.
- The Insurer or the Service Centre must grant prior approval.

Following consultation with the Insurer or the Service Centre and the attending Doctor, the Insured Person will be transported (within the selected Geographical Area) to:

- a more suitable location for its Treatment in another country.
- the Insured Person's Country of Residence if the insured event occurred outside this country.
- the Insured Person's Country of Departure or Home Country.

If Medically necessary, the Insurer will also arrange for a Doctor to accompany the Insured Person during the journey. The Insurer will only cover transport to a location deemed suitable for Treatment.

Information on medical infrastructure

In the event of an insured incident or Emergency, the Insurer or the Service Centre will inform the Insured Person about the locally available medical care. Information regarding the designation of Doctors, Hospital consultants, Hospitals, and specialised medical facilities in the vicinity of the Insured Person can be provided in English, German, French and Spanish. Additionally, guidance and assistance in choosing a Treatment location, in case of a Medically necessary transfer or change of care provider, can also be offered.

Support and information, including Second Opinion

The Insured Person can reach out to the Insurer or the Service Centre via phone whenever local medical assistance is needed. Upon the Insured Person's request, the Insurer or the Service Centre can inform the Insured Person's relatives about the occurrence of an insured event or Emergency, provided it is technically feasible.

In cases involving potentially fatal illnesses or serious permanent disabilities, the Insured Person has the option to seek a Second Opinion directly from another Doctor or, if necessary, through the Insurer or the Service Centre. When it comes to planning Hospital admissions or discharges for inpatient Treatment, the Insurer or the Service Centre will assist the Insured Person.

For cases requiring inpatient Treatment, the progress of the illness can be monitored by Doctors associated with the Insurer or the Service Centre. This monitoring also extends to Outpatient Treatments designed to prevent Hospital stays.

Guarantee of payment – GOP

In the event of an Emergency requiring inpatient Treatment, the Insured Person must promptly contact the Insurer or the Service Centre. If there is a planned inpatient Treatment or surgery qualifying as Outpatient Treatment instead of inpatient Treatment, the Insured Person shall notify the Insurer or the Service Centre at least 7 (seven) days before the scheduled Hospital admission. This notification is crucial for proper planning, whether for planned inpatient Treatment or Emergency inpatient Treatment, enabling the Insurer or the Service Centre to handle the necessary formalities and ensure cost cover for Doctors or the Hospital.

These formalities include conducting a medical review of invoices to verify their adherence to Usual, Customary and Reasonable standards. The Insurer will also coordinate with the Hospital on invoice submission addresses and payment terms, ensuring direct payment of invoices. In such cases, the Insured Person will receive written or email notification from the Insurer or the Service Centre regarding the process.

Failure to inform the Insurer or the Service Centre beforehand or immediately in case of an Emergency may result in the Insurer not paying the full Claim.

Return of mortal remains

In the event of a death abroad, the Insurer or the Service Centre can provide assistance:

- Securing the death certificate or Accident report, as permitted by law.
- Liaising with public authorities and consulates in the foreign country.
- Determining which surviving relatives are authorized to make decisions regarding the Repatriation or cremation of the deceased.
- Managing all formalities for Repatriation, cremation, or a local funeral in compliance with the regulations of the relevant country.

The Insurer will reimburse:

- Direct costs incurred for repatriating the deceased to the Country of Departure or Home Country, including all associated formalities. This also covers a family member traveling with the mortal remains if they were accompanying the deceased member at the time of death.
- Costs related to repatriating the urn to the Country of Departure or Home Country if the deceased has been cremated in the Country of residence. This includes a family member traveling with the mortal remains if they were accompanying the deceased member at the time of death.

However, funeral costs per se will not be eligible for reimbursement.

Additional appropriate medical support

Whether an insured event has occurred or not, and upon the request of the Insured Person, the Insurer or the Service Centre will offer to the Insured Person general information about the destination, local customs, and required formalities. Additionally, they will provide medical information, including advice on vaccinations and medical consultations by phone, to assist in preparing for the journey. Furthermore, guidance will be given on what to include in a personal first-aid kit.

In the event of an insured event, the Insurer or the Service Centre will provide general information about the nature, potential causes, and available Treatments for the illness. They will clarify the medical terminology used and provide details on Drugs, their potential side effects, and interactions.

For cases requiring Outpatient Treatment, the Insurer or the Service Centre will coordinate and monitor the Treatment and progress, facilitating consultations between Doctors if necessary and arranging any additional support needed.

Online services

The Insured Person is entitled to use the dedicated online service in the provided online member area.

4.4 Additional Assistance Benefits

Telemedicine

The Insurer grants all Insured Persons access to telemedical services. In collaboration with a third-party provider, the Insurer offers a complimentary app, available on both iOS and Android platforms. Access is open to all Insured Persons aged 18 (eight-teen) and above, actively covered under this Insurance Policy, and who have given consent for the processing of personal data. Stringent security measures are employed to safeguard both access and data, mitigating any potential security breaches.

The available services include telephone consultation, video consultation, and chat, all provided in English, German, and Spanish. These services are accessible around the clock, 7 (seven) days a week.

5. Exclusions

The Insurer does not cover expenses for the following Treatments or Medical Conditions under the Insurance Policy, unless they are explicitly listed in the scope of Benefits or any other written addendum to the Insurance Policy.

Acting against medical advice

The Insurer does not cover Treatments resulting from the Insured Person's failure to seek or follow medical advice, or from traveling against medical recommendations.

Bone marrow and organ transplants

The Insurer will not reimburse expenses for Treatment of bone marrow or organ transplantation (such as heart, kidney, liver, pancreas).

Complications caused by excluded cover

The Insurer will not provide cover for expenses resulting from complications directly arising from an illness, injury, or Treatment that are excluded or have limited cover.

Cosmetic/plastic surgery

Expenses incurred for cosmetic or plastic surgery and Treatment will not be reimbursed.

Dental Treatment

The Insurer will not reimburse expenses related to dental care or Treatment, including but not limited to routine dental check-ups, cleanings, fillings, extractions, root canals, orthodontic procedures (e.g., braces), prosthetic devices (e.g., dentures, crowns, bridges), cosmetic dentistry, or any surgical procedures involving the teeth or gums.

Detoxification programmes including therapies

Detoxification programs, including Treatments for drug addiction and alcoholism, are not covered by the Insurance Policy. However, Benefits for an initial detoxification will be paid if the Insured Person is unable to claim a refund elsewhere, and in the case of inpatient detoxification, the Insurer will only reimburse expenses related to basic Hospital services, including medical Treatment and Drugs.

Any subsequent Treatment resulting from or directly associated with harmful, hazardous, or addictive use of any substance, including alcohol and Drugs, will not be covered.

Developmental disorders

The Insurer does not provide cover for services, therapies, educational testing, or training associated with learning disabilities or disorders of psychological development. This includes conditions such as developmental delays, scholastic skills, pervasive disorders, mental retardation, perceptual handicap, brain damage not caused by accidental injury or illness, minimal brain dysfunction, dyslexia, or apraxia.

Dialysis

The Insurer will not reimburse Expenses for Dialysis, encompassing essential Medication and all associated costs.

Epidemics, pandemics and Disease outbreaks

Expenses associated with Treatment, medical evacuations, and/or Repatriations, whether directly or indirectly resulting from epidemics, pandemics, or Disease outbreaks of comparable scale that have been brought under the control of local public health authorities, will not be reimbursed unless otherwise approved by the Insurer in writing.

Experimental and investigational Treatments

The Insurer will not provide cover for any form of Treatment or drug therapy that it deems to be experimental or investigational. A service, technology, supply, procedure, Treatment, drug, device, facility, equipment, or biological product is considered experimental or investigational when it does not meet all of the following requirements:

- It must have a final license and clear approval from at least one of the following: EMA (European Medicines Agency), FDA (Food and Drug Administration – phase III completed), European network for Health Technology Assessment (EUnetHTA). Interim approval is not sufficient. The approval is only valid for the corresponding medical indications and conditions. In the case of procedures and approved clinical pathway

guidance, it must be clearly stated as such on one of the following guidelines: NICE (National Institute for Health and Care Excellence), AWMF (Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften), AHRQ National Guideline (Agency for Healthcare Research and Quality – National Guideline Clearinghouse).
- All approvals and guidance must be conclusive and must not indicate the need for more research, be under a research environment, have limited evidence, insufficient evidence, or lack clinical utility.

Extreme sport and high-risk activities

Extreme sport and high-risk activities are not covered under the Insurance Policy.

Extreme sports and high-risk sporting activities encompass any form of sport or athletic pursuit characterized by a heightened level of inherent danger.

This includes activities demanding advanced expertise, extraordinary physical exertion, specialised equipment, performance of daring stunts and activities in which the Insured Person has signed a liability waiver, such as inter alia the following:

- Abseiling, mountaineering (apart from indoor climbing and low mountain areas fully equipped for sports climbing) and racing of any kind,
- Bobsleigh, luge, skeleton, off-piste skiing, and off-piste snowboarding,
- Bungee and cliff jumping,
- Combative sports,
- Downhill mountain biking and cross-country cycling,
- Extreme tourism (e.g. tours to Antarctica),
- Horseback hunting, horse jumping, polo, steeplechasing, or any form of horse racing,
- Motorcycle sports, including motorcycle riding and quad biking,
- Microlight flying, wingsuit flying, ballooning, hang gliding, paragliding, parascending, and parachute jumping,
- Solo caving (potholing) or cave diving, scuba diving beyond 10 meters, high diving, white water rafting, and canyoning,
- Ultra marathons or activities similar in nature,
- Any other hazardous activity similar in risk to the before mentioned ones, such as e.g. train surfing.

Search and rescue services for extreme sport and high-risk activities, including but not limited to cave, sea and mountain rescue, are also excluded from the cover provided for under the Insurance Policy.

Eyesight

The Insurer will not provide cover for any Treatment or surgery aimed at correcting an Insured Person's eyesight, including procedures such as laser Treatment, refractive keratotomy (RK), and photorefractive keratectomy (PRK). Cover does apply to the correction of the Insured Person's vision when this is Medically necessary (e.g., cataract or detached retina).

Gender reassignment

The Insurer will not provide cover for the alteration of biological sexual characteristics through surgery and hormone Treatment to transition to the characteristics of the opposite sex.

Genetic testing

The Insurance policy does not cover the expenses related to genetic testing unless particular genetic tests are explicitly mentioned as part of the Insured Person's Plan, or the Insurer expressly gives prior written approval.

Illnesses, Accidents and their consequences caused by intent or gross negligence

The Insurer will not provide cover for illnesses, Accidents, and their ensuing consequences, if they are intentionally caused or caused by gross negligence.

The Insurer defines an illness or Accident as intentionally caused or caused by gross negligence when the individual involved had a reasonable understanding of the outcomes of their actions and willingly accepted the resulting harm. This includes, but it is not limited to

- self-inflected injuries,
- attempted suicide,

- stays in an institution for drug withdrawal and
- injuries caused in the context of criminal acts.

Infertility Treatment

The Insurer will not reimburse expenses related to diagnostics and Treatments as part of Infertility Treatment. This includes measures to prevent future miscarriages, investigations into miscarriage, and assisted reproduction, along with associated complications.

Injuries caused by military service

The Insurer will not provide cover for illnesses, Accidents, and their resulting consequences that occur while the Insured Person is engaged in military operations, military service, riot and civil commotion.

Maternity care and childbirth

The Insurer will not reimburse Expenses related to childbirth, pregnancy, or pregnancy-related illnesses, including complications to childbirth, pregnancy, or pregnancy-related illnesses.

Need for long-term care and custody

The Insurer will not reimburse any expenses related to accommodation necessitated by long-term care and custody.

Non-medical Hospital expenses

The Insurance Policy does not cover expenses caused by any person accompanying the Insured Person, and does further not cover non-medical consumables, catering, and any media-related expenses (such as TV and radio).

Nuclear, chemical and biological contamination

The Insurer does not provide cover for illnesses, Accidents, and their consequences caused by nuclear energy (including nuclear reactions, radiations, and contamination), as well as illnesses, Accidents, and their consequences resulting from chemical or biological weapons.

Nursing Home

The Insurance Policy excludes cover for expenses associated with staying at home or receiving non-medical care at home, in a convalescence home, psychiatric home, or similar facilities.

Post-natal classes

The Insurer will not provide cover for post-natal classes aimed at addressing the physical effects on the body resulting from pregnancy and childbirth.

Professional Sports

The Insurer does not provide cover for Treatments or diagnostic procedures related to injuries or illnesses resulting from participation in Professional Sports.

Psychiatric and Psychotherapy Treatment

The Insurer will not reimburse expenses incurred for psychiatric and psychotherapy Treatment, or any other mental health-related Treatments, whether provided on an inpatient or outpatient basis. This includes, but is not limited to, consultations with psychiatrists, psychologists, psychotherapists, or counselors, as well as any prescribed Medications or therapies related to mental, emotional, or behavioral disorders.

Routine health checks

The Insurer will not reimburse expenses incurred for routine health checks that involve examinations or screening tests conducted in the absence of clinical symptoms.

Sleep disorder

The Insurer does not provide cover for examinations or Treatment related to sleep disorders, including insomnia. This encompasses CPAP (continuous positive airway pressure machine) and BIPAP (bilevel positive airway pressure machine).

Spa and wellness massages

The Insurer will not provide cover for stays or Treatments in a cure centre sanatorium, spa, health resort, or recovery centre, even if medically prescribed. This restriction also includes thermal baths, saunas, and various wellness massages.

Sterilisation, sexual dysfunction and contraception

The Insurer will not provide cover for procedures intended to render a person incapable of reproduction, any procedures, Treatments, or Medications aimed at preventing pregnancy, or any Treatment for sexual dysfunction (unless part of infertility Treatment).

Surrogacy

The Insurer will not reimburse expenses associated with Treatments directly related to surrogacy, regardless of whether the Insured Person is serving as a surrogate or are the intended parent. Children born to a surrogate mother are not covered under the Insurance Policy.

Transport costs

Transport costs, other than Emergency ambulance services, will not be refunded unless the Insurer expressly gives prior written approval.

Treatment in sanatoriums, convalescent and nursing homes

The Insurer does not provide cover for therapies and Treatments in sanatoriums or convalescent and nursing homes. However, based on the selected Plan level, the Insurer may partially refund expenses for Follow-Up Rehabilitation.

Treatment by certain Doctors, Dentists and other Therapists, as well as in certain Hospitals

The Insurance Policy does not cover Treatments administered by physicians, Dentists, and other Therapists, as well as Hospital services whose invoices the Insurer has declined to settle for substantial reasons.

Nevertheless, this release from the obligation to provide Benefits is applicable solely to insured events occurring subsequent to the Insured Person's notification of Benefit exclusion. If an insured event has already occurred at the time of notification, the Insurer's exemption from Benefits will only pertain to expenses incurred more than 1 (one) month after receiving notice.

Treatment by marital or non-marital partners, parents or children

The Insurer will not reimburse expenses if the Insured Person receives Treatment from its spouse, husband, non-marital partner, parents, or children. However, the documented cost of materials required for the Treatment, in accordance with the Plan, will be eligible for reimbursement.

Unlawful Acts and Hazardous Behaviour

The Insurer will not cover any illnesses, Accidents, or resulting consequences that arise from unlawful acts or hazardous behaviour. This includes, but it is not limited to:

- activities undertaken in violation of explicit warnings or prohibitions issued by medical professionals, public health authorities, or law enforcement agencies,
- consequences of drunkenness and/or intoxication,
- disturbances and measures taken to combat such disturbances, unless the Policyholder and/or Insured Person proves that the Insured Person did not actively participate in them,
- quarrels and/or heated arguments, except in case of legitimate self-defence (a report from the authorities will be used as proof), and
- betting and/or defiance.

Vaccinations and immunization

The Insurer will not reimburse the costs associated with vaccinations and Prophylactic Measures, regardless of whether such measures are recommended for the Insured Person's Country of residence.

Vision aids

The Insurer will not reimburse Expenses for eyeglass, frames and lenses, including contact lenses.

Vitamins and minerals

The Insurer will not reimburse expenses for items categorized as vitamins or minerals, with the exception of Medically necessary instances during pregnancy or for the Treatment of diagnosed, clinically significant vitamin-deficiency syndromes.

This exclusion also applies to dietary supplements, including special infant formula and cosmetic products, even if they are medically recommended, prescribed, or acknowledged for therapeutic effects.

Products such as nutriments, tonics, mineral water, cosmetics, hygiene and body-care products, and bath additives are not considered Medically necessary, and costs incurred for them will not be refunded.

War, civil unrest, acts of terrorism

The Insurance Policy does not cover illnesses or Accidents and their consequences, as well as death attributable to acts of war, civil unrest or acts of terrorism, unless the Insured Person is injured as an uninvolved third party who has not wilfully or negligently disregarded the danger and the Insured Person has not deliberately entered the area of conflict.

Insurance cover shall not be granted under any circumstances if the Insured Person enters an area of direct warfare or renders services for one of the warring parties. The exclusion of Benefits shall apply regardless of whether or not war has been declared. If the Insured Person acquires knowledge of the war, civil unrest or terrorist acts while in the country, the Insurance Policy will only cover Emergency, life-saving Treatment and only for as long as the insured Person is prevented from leaving the country or region concerned, but for not more than 28 (twenty-eight) days at most.

Other limitations to pay Benefits

If the Treatment or other agreed-upon measure exceeds what is Medically Necessary or the claimed amount falls outside the Usual, Customary and Reasonable range, the Insurer reserves the right to reduce the payment/reimbursement. The Insured Person will be responsible for any costs that do not align with the Usual, Customary and Reasonable standards, as the Insurer does not cover amounts beyond this threshold. The Insurer retains the right to assess any cost or estimate with the input of medical professionals to determine its conformity with Usual, Customary and Reasonable standards.

If the Insured Person can claim Benefits from a statutory health insurance fund or any other provider, the Insurer will only reimburse expenses that remain Medically necessary despite those Benefits. **Complications arising from excluded conditions are not covered.**

6. Glossary

This Glossary is to be read together with the Glossary included in the General Conditions of Insurance.

Cancer
The general term used for all malignant disorders caused by the uncontrolled multiplication of mutated cells (new growths or tumours). These cells can destroy the surrounding tissue and produce metastases (secondary growths).

Co-Payment
A Co-Payment is the portion of the cost of a covered medical service that the Insured Person is required to pay, as a percentage of the total eligible expense for every Claim. The remaining balance is paid by the Insurer, subject to the terms and conditions of the policy.

Computed Tomography (CT)
Computed Tomography (CT) is a diagnostic procedure that uses special x-ray equipment to get cross-sectional pictures of the body. The CT computer displays these pictures as detailed three-dimensional images of organs, bones, and other tissues. This procedure is also called CT scanning, computerised tomography, or computerised axial tomography (CAT).

Congenital Conditions
Any Disease or illness, abnormality, birth defect, premature birth or malformation present at birth including any related condition, whether diagnosed or not.

Conventional Medicine
The form of medicine based on accepted scientific methods which are taught at universities and are generally acknowledged and used.

Country of Departure
The last country in which the Insured Person had his habitual residence.

Daycare
Daycare refers to the Treatment received in Hospital without involving an overnight stay. The length of stay in Hospital is between 8 (eight) and 24 (twenty-four) hours.

Deductible
The effect of a Deductible is that the Insured Person bears a certain portion of the costs. The Deductible is the share to be borne by the Insured Persons, up to an agreed limit. If a Deductible has been agreed, this will be shown in the Insurance Policy.

Dentist
A Doctor or Practitioner who focuses on Diseases of the teeth and mouth.

Eligible Expenses
The costs incurred for Medically Necessary healthcare services, Treatments, and procedures that are covered under the Terms and Conditions of this Insurance Policy. These expenses typically include charges for hospitalization, physician consultations, diagnostic tests, surgical procedures, prescribed Medications, and other approved medical interventions. To qualify as eligible, the services must be provided by licensed healthcare professionals or accredited medical facilities, and must align with the Insurance Policy's cover guidelines, exclusions, and any applicable Waiting Periods or pre-authorization requirements.

(Inpatient) Follow-Up Rehabilitation
A medical Treatment aiming at recovering the initial state of health after an illness or serious surgery, for example following bypass surgery, cardiac infarction, transplants and surgery involving large bones or joints, or after a serious Accident.

Geographical Area
The following Geographical Areas to which the insurance cover provided under the Insurance Policy may apply:

Geographical Area I: Worldwide including USA
Geographical Area II: Worldwide excluding USA

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

Home Country
The country that the Insured Person is a citizen or national of.

Hydrotherapy
Hydrotherapy is the targeted Treatment by external application of water.

Implants
Dental Implants (metal or ceramic) which are embedded as a substitute for the root of a tooth or in the toothless jaw.

Insurance Period
Period of 3 (three), 6 (six) or 9 (nine) months that starts on the Effective Date of the Insurance Policy.

Magnetic Resonance Imaging (MRI)
A diagnostic technique in which radio waves generated in a strong magnetic field are used to provide images of the body's tissues and organs.

Maximum Outpatient Limit
The maximum sum that the Insurer will reimburse for the aggregate of all outpatient Benefits per Insured Person and per Insurance Period for a specific insurance Plan.

Medical Condition
Any illness, Disease, injury or any physical, mental or psychological abnormality as well as pregnancies.

Nutritional and/or Dietary Supplements
Products used to boost the nutritional content of the diet, including vitamins, minerals, herbs, meal supplements, sports nutrition products, natural food supplements.

Outpatient Treatment
Any Treatment given by a qualified and licensed Doctor which does not need an overnight stay (including Hospital stays for less than 8 (eight) hours).

Overall Limit per Policy Period
The maximum which will be paid for all Benefits in total for each Insured Person, for each Insurance Period.

Palliative Medicine
Palliative Medicine is the extensive and active Treatment of patients with a limited life expectancy for which curative therapy is no longer possible in their condition. This type of Treatment provides the best possible quality of life for the patient and its family.

Policy Period
The Policy Period is the period in time during which the insurance cover is granted under the Insurance Policy, which the Policyholder has selected for the Insured Persons in the Application Form.

Positron Emission Tomography (PET)
A non-invasive imagery process based on the detection and imagery of a substance with positron emitters spread inside the patient's body. The concentration of these "markers" in a tumour can then be quantified, the substance is injected intravenously, and the radiation is detected with external detectors. With the help of PET important biological processes can be visualised in tumours.

Practitioner
A person who, besides Doctors, also has recognised and well-founded training in their area of Treatment and are authorised for Treatment in that speciality in the country in which the Treatment is to be provided. The following are understood to be Practitioners: naturopaths, speech Therapists and midwives as well as independent Practitioners practicing in state approved medical ancillary professions (for example massage Therapists and medical attendants, physiotherapists). The Insured Persons are free to choose a Practitioner who meets these criteria.

Pre-Existing Conditions
Pre-Existing Conditions refer to any Medical Conditions, Diseases, Bodily Injuries, or their consequences that the Policyholder or any Insured Person was aware of, or received medical advice, diagnosis, or Treatment for, prior to signing the Application Form.

This includes:
i. Any condition for which the Insured Person underwent diagnostic testing (including preventive screenings or routine health check-ups) that resulted in abnormal findings, regardless of whether a formal diagnosis was made.
ii. Any signs or symptoms, whether diagnosed or not, as well as any physical or organic abnormalities, congenital anomalies, disabilities, or deformities.
iii. The presence of any medical devices such as Implants, stents, prostheses, or any other devices permanently or temporarily attached to the body.

Additionally, any illness, injury, or Medical Condition that arises between the date of signing the Application Form and the date of signing the Particular Conditions will also be considered a Pre-Existing Condition.

Pre-Existing Conditions are not insured under the Insurance Policy.

Professional Sports
Any sports the Insured Person is being paid for taking part in.

Repatriation
If a Medical necessary Treatment for which the Insured Person is covered is not available locally, the Insurer covers the return to the Home Country for Treatment, rather than to the nearest appropriate medical centre. This only applies when the Home Country is located within the Insured Persons Geographical Area of cover.

Sanatorium Treatment
A cure or Treatment different from a Medical Treatment that serves to rehabilitate a person's state of health or Fitness.

Second Opinion
The medical advice given by a second independent Doctor not involved in the Treatment. The Insured Person can also consult a second Doctor through the relevant Service Centre to get a Second Opinion if potentially fatal illnesses or serious permanent disabilities are involved.

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

Therapist
A Doctor, but also anyone who has received in-depth training in their field and is licensed or authorised to give Treatment in the country in which Treatment is provided. This includes Practitioners of complementary medicine, speech Therapists and midwives and obstetric nurses, as well as members of state-approved assistant medical professions with their own practice, such as masseurs and physiotherapists. The Insured Person can choose any Therapist who meets these conditions.

Usual, Customary and Reasonable
Usual, Customary and Reasonable charges refer to the average fee charged for a specific medical service by licensed medical Practitioners within a defined geographic region (e.g. city or country), based on publicly available fee schedules or databases maintained by recognized health authorities or insurance industry benchmarks.

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