INSURANCE TERMS AND CONDITIONS

FOREIGNERS' COMPREHENSIVE MEDICAL INSURANCE EXCLUSIVE

KZPCE 1/25

effective as of 10 May 2025

1/25

PVZP

Contents:

SECTION A
JOINT PROVISIONS

Art. 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

Art. 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. **Without undue delay** is a very short period, up to a maximum ranging in days, which means urgent, immediate, imminent, or direct action leading to the fulfil of an obligation or to the execution of a legal act or other manifestation of will, given that the period of its duration will depend on the circumstances of the individual case.
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/she is provided with the necessary hospital diagnosis and curative care connected with his/her 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 6 months and did not call for hospitalisation or a deteriorate or a change in the treatment procedures or medicine.
7. **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.
8. A **Single Premium** is a premium determined for the entire period for which the Insurance has been agreed.
9. **Comprehensive Healthcare Services** is understood to mean medical services provided to the Insured Person in Contractual Healthcare Facilities of the Insurer without direct reimbursement of the treatment costs in order to maintain his/her state of health from the time prior to the conclusion of the insurance policy. Comprehensive Healthcare Services include outpatient as well as inpatient healthcare services, including diagnostic, preventative and dispensary services, as well as emergency and rescue services, provision of medicines and transport of patients, eventual repatriation of the Insured Person or transportation of his/her remains. The insurance also includes healthcare services related to the pregnancy of an insured mother and the birth of her child
10. **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 such a sudden and unexpected health disorder that directly threatens the health or the life of the Insured Person, independent of his own will, and which requires acute and urgent healthcare.
13. **Illness**, for the purpose of this Insurance, is the medically documented onset of the illness, the given that the is, for the purposes of this Insurance, a state which threatens the health or the life of the Insured Person and requires the provision of medical care.
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. A **Beneficiary** is a party with a right to an Insurance Benefit as a result of an Insured Event.
17. An **Insurance Certificate** is a written confirmation that an insurance policy has been concluded, which the insurer issues to the Policyholder.
18. The **Term of Insurance** is the period for which the personal Insurance was agreed.
19. 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.
20. An **Insured Peri**l is the possible cause of an Insured Event (the "cause").
21. An **Insurance Risk** is a measure of the probability of the occurrence of the Insured Event caused by an Insured Peril.
22. The **Policyholder** is the party which has concluded the insurance policy with the Insurer.
23. The **Insurer** is a legal entity entitled to carry on insurance activity according to special legislation.
24. The **Insured Person** is a person in respect to whose life or health the insurance relates.
25. **Postnatal Care** for a Newborn Baby is healthcare for a Newborn immediately following upon its birth and without interruption to the continuity of hospitalisation.
26. A **professional athlete** is a person who has concluded a professional contract with a sports club or other entity in this field and/or engages in sporting activity for remuneration, which is this person's main or predominant income, and/or engages in sporting activity for a duration of at least 20 hours per week (including weekend), including training.
27. A **professional sporting activity** is a sporting activity carried out by a person who is a professional athlete as defined in this Article.
28. 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, unless agreed otherwise in the insurance policy. The card serves the Insured Person for exercising the right to Insurance Benefit.
29. **Contractual Healthcare Service Provider (Contractual Healthcare Facility)** is such a Healthcare Service Provider with which the Insurer has concluded a contract for these purposes.
30. A **Loss Event** is an event resulting in damage which may constitute grounds for the establishment of a right to an Insurance Benefit.
31. **Loss Insurance** s insurance the purpose of which is to provide compensation for a loss arising from an Insured Event.
32. **Damage** refers to reasonable costs demonstrably spent on healthcare services provided to the Insured Person at the Place of Insurance.
33. A **Party to the Insurance** is 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 **Accident** is understood, for the purpose of this Insurance, to be the unexpected and sudden action of external forces or one's own strength independent of the insured person's will, which occurs during the Duration of the Insurance and results in damage to the insured person's health or his/her death, including work Accidents. An Accident 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.
    Damage to the health of an Insured Person caused by:
    a) localised festering following invasion of pathogens into an open wound caused by an Accident,
    b) tetanus or rabies infection in the course of an Accident, diagnostic, therapeutic and preventive interventions carried out to treat the consequences of an Accident,
    c) unexpected and uninterrupted exposure to high or low outdoor temperatures, gases, vapours, electric current (including lightning), radiation, toxic substances and poisons ((with the exception of microbial poisons and immunotoxic substances),
    d) drowning and death by drowning,
    e) bite, sting, or stabbing by an insect
    is also considered to be an Accident.
35. **Multiple Insurance** arises when two or more private insurance policies relate to the same insurance peril 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.
37. A **Healthcare Service Provider** (healthcare facility) is a registered facility providing outpatient, or outpatient and inpatient, diagnostic and medical care, which may also include necessary preventive measures (hospitals, outpatient doctors). A Healthcare Service Provider may be a natural person or a legal entity.

Art. 3
Extent and Place 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 Policyholder shall choose which types of insurance cover shall be arranged for which persons and, if applicable, their type, any supplementary insurance, period insured, and the upper limit of the Insurance Benefit.

3. Insurance is effective only at the agreed Place of Insurance, which is stipulated in the other sections of these Insurance terms and conditions.

.

Art. 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 Insurance Benefit 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 the Insurance Benefit, that he/she 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, the 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 Benefit within three months of the 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 the Insurance Benefit with an appropriate advance on the Insurance Benefit 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. The Insurer is entitled to reduce 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 18,
   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.
   f) if the Policyholder or the Insured Person fails to supply the insurer with the required medical documentation.
9. If the Policyholder or the Insured Person breaches any of the obligations set forth in these Insurance terms and conditions, the Insurer may reduce the Insurance Benefit with respect to the seriousness and nature of the breach of this obligation.
10. 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 ascertain 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.
11. The Insurance Benefit is limited to insurance benefit limits. The insurance benefit limits for individual types of Insurance are 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 of these Insurance terms and conditions.

Art. 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 the Policyholder also has an insurable interest in the life and health of another person, if he/she 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/she 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 Person 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.

Art. 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.

Art. 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).

Art. 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 is 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, unless agreed otherwise in the insurance policy.
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.

Art. 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, on the date that the legal entity is wound up without a legal successor or on the date when the Insurer's notification of the refusal to pay the Insurance Benefit is received.
4. The termination of the insurable interest terminates all of the insured person's insurance in the following cases:
   a) rejection of a visa application by the Department of Asylum and Migration Policy of the Ministry of the Interior of the Czech Republic,
   b) expiration of a visa's validity on the territory of the Czech Republic.
   c) on the day on which the expulsion decision or the decision on administrative expulsion come into force.
5. The termination of the insurance by the termination of the insurable interest does not occur at the end of the stay of the insured person in the Czech Republic, if this person still has a valid visa after the end of his or her stay.

6. 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. If the insured person has an insured interest, the insurer will offer the insured person insurance of a different scope and for a different premium.
7. 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.
8. 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.
9. If the Policyholder or the Insured Person breaches the duty stipulated in paragraph 1 or 2 of Article 14, 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 7 or 8 of Article 11. 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 7 or 8 of Article 11.
10. If the policyholder, the insured, the agent or any third party breaches the obligation to answer truthfully and completely the insurer's written questions and the cause of the insured event is an accident or illness occurring before the conclusion of the insurance contract or, in the case of an illness whose symptoms occurred before the conclusion of the insurance contract, the insurer shall not provide the insurance benefit.
11. 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.
12. Exceptionally, in justified cases (e.g. due to a pandemic), the insurance contract may be terminated by a written agreement of the contracting parties under agreed conditions.
13. The insurance policy may be assigned only with the Insurer's consent.
14. 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/she 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.
15. If the Insurer issues the Policyholder with a notice reminding it to pay the premium and, as part of this reminder notice, and instructs the Policyholder 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.
16. The Insurance does not expire due to the termination of the Insured Person's residence at the Place of Insurance prior to the expiry of the Term of Insurance.
17. The insurance policy terminates upon the expiry of all Insurances of all persons.

Art. 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. The premium is arranged as a Single Premium.
2. The Premium is payable on the date of the conclusion of the insurance policy 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. If the insurance expires before the date of the commencement of the insurance, the insurer shall refund to the policyholder the premium paid, only reduced by the costs for the conclusion of the insurance contract and for its administration, which shall amount to 20 % of the premium received, up to the maximum amount of CZK 3,000.-. This provision shall apply to terminations of insurance pursuant to the Article 9 paragraphs 3, 4 and 12 of this section.
5. If the insurance expires after the date of the commencement of the insurance and in the course of the period of insurance the insured event did not occur, the insurer refunds the unused premium that was already paid, only reduced by the costs for the conclusion of the insurance contract and for its administration, which shall amount to 20 % of the premium received, however, up to the maximum amount of CZK 3,000.-, and furthermore reduced by the amount corresponding to the proportionate part of the Premium Standard (Section B, Art. 4, paragraph 6 and 7), by which the insured person has overdrawn the earned part of the Premium Standard corresponding to the actual duration of insurance. This provision applies to the terminations of insurance referred to in Art. 9, paragraphs 3, 4 and 12 of this section.
6. If the insurance terminates as a result of the policyholder's termination or as a result of his/her notification of the transfer of the insured person to the public health insurance of the Czech Republic during the period of insurance and no insured event has occurred in the course of the period of insurance, the insurer shall refund, after having returned all issued documents, to the policyholder the unused premium, only reduced by the costs for the conclusion of the insurance contract and for its administration, which shall amount to 20 % of the premium received, up to the maximum amount of CZK 3,000.- and the amount corresponding to proportional part of the Premium Standard (Section B, Art. 4, paragraphs 6 and 7), by which the insured person has overdrawn the earned part of the Premium Standard corresponding to the actual duration of the insurance. This provision applies to the terminations of insurance referred to in Art. 9, paragraphs 6, 7 and 8 of this section.
7. If the insurance terminates for other reasons than those referred to in Art. 9 of this section, the insurer shall not refund the unused premium.
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(11) 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.

Art. 11

Rights and Obligations of the Insurer

1. The Insurer is entitled to verify the submitted documents, to demand the submission of expert reports and/or to consult complicated Loss Events with healthcare providers 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 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. 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.

8. 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.
9. 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.

Art. 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 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.

Art. 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 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 insurance,
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.

Art. 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 him/herself to be a Beneficiary links his/her claim to an Insurance Benefit, he/she 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/she shall also submit to the Insurer the required documents (e.g. the Insured Person's medical documentation) 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 these 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 4 of this article shall be deemed as having been received after the Insurer:

I.) was notified of the event via the Insurer's form, which has been duly completed and delivered to the Insurer,

II.) was handed 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,
   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 Outpatient 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.

6. The parties to the Insurance submit copies of documents to the Insurer, or originals upon the Insurer's request.
   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.
   The Insurer shall not return originals of documents. If the Insurer is not obliged to provide an Insurance Benefit, it shall return originals of the documents upon written request.
7. 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.
8. 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.
9. 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.
10. The Policyholder and the Insured Person are obliged:
    a) to notify the Insurer in writing without undue delay 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.
11. The parties to the Insurance must not assign a claim for Insurance Benefit under the Insurance without the Insurer's consent.

Art. 15

Delivery of Documents

1. Correspondence delivered via the holder of a postal licence (hereinafter the "post office") shall be sent:
   a) to the Insurer at the address of the registered office stated in the insurance policy, or another address that is communicated to the Policyholder by the Insurer;
   b) by the Insurer to the correspondence address of the relevant person (addressee) stated in the insurance policy or otherwise notified to the Insurer. If the correspondence address is not stated in the insurance policy or subsequently notified to the Insurer, the correspondence will be sent to the address stated in the policy or notified to the Insurer as the residence or permanent residence, or the registered office of such a person.
2. Unless agreed otherwise, correspondence may also be delivered electronically (for example, via a data box, the Insurer's internet app, by e-mail) to the contact information provided for the purpose of electronic communication. Correspondence sent by the Insurer electronically to the last contact address provided by the addressee shall be deemed as delivered on the third business day after its sending, if the date of its delivery cannot be ascertained or if the relevant legal regulations do not stipulate otherwise.
3. Correspondence may also be delivered by an employee of the Insurer or another person authorised by the Insurer, especially to the addresses pursuant to paragraph 1 b), but also to any other place where the addressee will be willing to

accept the correspondence. The correspondence thus delivered shall be deemed as delivered on the day of its receipt.
4. The parties to the Insurance are obliged to notify the Insurer without undue delay of any change in the facts relevant to the delivery and to notify each other of their new postal address, e-mail address or data box or telephone number.
5. If not a case of the delivery pursuant to paragraphs 6 to 8, correspondence sent by the Insurer by registered post with an advice of delivery shall be deemed as delivered on the day specified as the day of receipt of the correspondence on the advice of delivery, with correspondence sent by the Insurer by registered post without an advice of delivery, or sent by regular mail, being deemed as delivered on the third business day after dispatch, and in the case of delivery to an address in a country other than the Czech Republic, on the 15th business day after dispatch.
6. If the addressee deliberately thwarts the delivery of correspondence, 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 delivery of correspondence by failing to take delivery of the correspondence.
8. 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.
9. Correspondence sent by the Insurer by registered post or registered post with an advice of delivery shall be deemed duly delivered even in the case that they are received by another person in place of the addressee (e.g. a family member), to whom the post office delivered the correspondence in accordance with the legal regulations pertaining to postal services.

Art. 16
Form of Legal Acts

1. The insurance policy must be concluded in writing, unless the Civil Code provides otherwise.
2. In the event that the Policyholder's acceptance of the offer is found to be invalid due to a failure to accept the offer in writing or for any other reason, and the Policyholder pays the first premium or an instalment thereof in the amount and within the time period specified in the offer (if no time period is stated in the offer, then within one month of the delivery of the offer), the offer shall be deemed to have been received by virtue of the payment of this first premium or an instalment thereof.
3. Legal acts, notices, and requests must be made in writing if they have an affect on:
   a) the duration and termination of the insurance,
   b) changes in the premium,
   c) changes in the scope of the insurance.
4. A legal act, for which a written form is required, shall be valid, in particular, where it is personally signed by the acting person, or where the signature is replaced by a mechanical means, where this is usual, if made by means of a data box, if provided with a guaranteed electronic signature pursuant to a special law, or if it is made via the Insurer's protected internet client portal.
5. Legal acts, notices, and requests, not mentioned in paragraph 3. may be made in writing, over the telephone, by e-mail, via the Insurer's internet application or via a data box, if the Insurer permits delivery to a data box. This applies namely to the reporting of an Insured Event, notification by the Policyholder or the Insured Person pertaining to a change in the surname, residential address, correspondence address, and other contact details, as specified in the policy. Legal acts, notices, and requests pursuant to this paragraph, made other than in writing must be subsequently supplemented in written form, if the Insurer so requests.
6. The insurer is entitled, as regards matters relating to the insurance relationship, namely in connection with the administration of the Insurance and the settlement of Insured Events, to contact other parties to the Insurance by electronic or other technical means (e.g. via telephone, SMS, e-mail, fax, data box), unless agreed otherwise. In electing the form of communication, the Insurer shall take into account the obligations stipulated by the relevant legal regulations and the nature of the information communicated.
7. Legal acts, notices, and requests shall be effective against the other contracting party as soon as they have been received by this party.

Art. 17
Rescue Costs

1. If the Policyholder purposefully incurs costs in averting the 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.

.

Art. 18
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/she lives in a joint household or is dependent on him/her, unless he/she 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

Art. 19
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. 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.

Art. 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 Insurance Benefit limit.
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.

Art. 2
Insured Event

1. An Insured Event is the drawing by the Insured Person of the purposefully incurred costs for healthcare services provided by the healthcare provider to the Insured Person 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.
2. In the event of the occurrence of the Insured Event, the Insurer shall provide an Insurance Benefit within the scope of Article 4 of this section.

Art. 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 shall not be applied in the event of the conclusion of "Newborn Baby" cover in the insurance policy.

3. The Policyholder shall elect the period insured, the upper limit of the Insurance Benefit (limits of the Insurance Benefit) for healthcare services, including repatriation and transaction, or for agreed supplementary insurance, as the case may be, and the type of insurance, in the following extent:
   "Standard" insurance encompasses comprehensive healthcare services provided to the Insured Person; the insurance does not relate to events for which the Insurance Benefit is conditional on the arrangement of the Newborn or Professional Sports insurance type,
   "Newborn" insurance beyond the scope of the "Standard" insurance type also relates to events specified under letter d) para. 5. of Article 4 of this section,
   "Professional Sports" insurance beyond the scope of the "Standard" insurance type also relates to events specified under letter e) para. 5. of Article 4 of this section.

Art. 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. 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.
3. The Insurer shall not render Insurance Benefits for services drawn outsider of the Duration of the Insurance.
4. The Insurance Benefit is limited by Insurance Benefit limits.
5. The Insurer renders Insurance Benefits up to the limits pursuant to paragraph 11. of this article to the extent of:
   a) healthcare services to the extent of the list of healthcare procedures reimbursed to the Insured Persons of public medical insurance of the Czech Republic (hereinafter merely as "healthcare") with arranged Insurance Benefit limits.
      This healthcare shall only be rendered by the Insurer at contractual Healthcare Service Providers. 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 provider.
   b) repatriation of a sick Insured Person with the approval of the attending doctor, should his/her state of health allow it, 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.
   e) if, at the time of the occurrence of the Insured Event, the "Professional Sports" cover is in effect, the Insurer shall provide an Insurance Benefit even in the case of the operation of professional sporting activity and during preparation for such activity,
   f) 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.
6. The Insurer shall reimburse the Insured Person in excess of the framework of the Insurance Benefit to the extent of para. 5. of this article for the costs he/she had incurred for premium healthcare services (hereinafter the "Premium") stated below, up to the amount of the limit for the Premium stated in the insurance policy:
   a) vaccination (vaccine, including its application), which is not covered under this Insurance as standard (e.g. against tick-borne encephalitis),
   b) over-the-counter medicines and medical devices purchased from pharmacies (without prescription) and from stores selling medical devices,
   c) plastic immobilisation (lightweight plaster),
   d) hormonal contraceptives,
   e) earpieces, spectacles, and contact lenses,
   f) walkers and wheelchairs for the disabled (as well as those electrically powered),
   g) reimbursement of the costs of transporting the Insured Person to the healthcare facility for the purpose of treatment or hospitalisation; besides the submission of documents proving that the transport costs have actually been incurred, reimbursement of these costs is also conditional on the submission of a medical report confirming the occurrence of the Insured Event to the extent of para. 5 of this article; this benefit is limited to CZK 500 per event,
   h) preventative examinations, tests, and consultations to detect a specific disease (e.g. laboratory tests of blood, prostate; examination for malignant melanoma), including the issue of a extract from the medical documentation, and other examinations not covered under public medical insurance (for the purpose of driver's licence confirmation, for sporting activities, etc.),
   i) dental hygiene and premium stomatological material (white fillings, etc.),
   j) premium hospital room or meals during the hospitalisation of an Insured Person.
7. In addition to the insurance benefit within the scope of paragraph 5 of this Article, the insurer shall reimburse the costs incurred by the insured for optional vaccinations, if insurance for optional vaccinations is provided for in the insurance contract, up to the limit specified in the insurance contract.
8. The costs of the healthcare services detailed in paragraph 5 of this article shall be paid by the Insurer directly or via the assistance service provider to the healthcare provider, the Insured person or another party that has demonstrably incurred these costs.
9. The Insurer shall reimburse the costs of premium healthcare and other services pursuant to paragraph 6 of this article to the Insured Person or a person who demonstrably incurred these costs, following the submission of proof of their payment.
10. Direct reimbursement of the costs of healthcare and other services:
    a) If the Insured Person or another person made a direct payment of the costs of healthcare services pursuant to paragraph 5 of this article, which represent an Insured Event and were rendered to the Insured Person in a healthcare facility located in the Czech Republic, the Insurer shall subsequently reimburse the Insured Person or another person who incurred these costs the reasonable healthcare costs demonstrably incurred.
    b) The Insurer shall provide an Insurance Benefit for an Outpatient Medicine prescribed by a doctor or a voucher for medical devices. An Insurance Benefit is understood to mean the amount specified in the Code List of VZP CR for mass-produced medicinal products, medical devices, and individually prepared medicinal products marked as MAX and valid at the time of the Insured Event occurring.
11. 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/her repatriation, he/she shall be treated at a healthcare facility designated by the Insurer until such time as his/her state of health improves to such a degree as to allow for his/her repatriation,
    b) If the state of health of the Insured Person allows for his/her repatriation, his/her repatriation may be carried out with the consent of the attending doctor.
12. 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 5 of this article (Healthcare services, including repatriation and transportation) applies to the Insurance Benefit for every single Insured Event.
    b) The benefit limit for costs under letter d) of paragraph 5 of this article (Postnatal care of a newborn baby of an insured mother), which further applies to the Insurance Benefit for the sum of all Insured Events occurring within the Duration of the Insurance.
    c) The benefit limit for costs pursuant to letters a) to j) of paragraph 6 of this article (Premium) limits the benefit for all premium healthcare and other services for the Duration of the Insurance. The Insurer shall render this Premium benefit in excess of the framework of limits stated in paragraph 5 of this article.

Art. 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 dela**y, if his/her 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/she 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 (the healthcare provider),
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 s service provider.

Art. 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 7 days a week. 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 provider,
   - recommendation of an appropriate procedure in the case of a Loss Event,
   - monitoring developments in the state of health during the course of hospitalisation,
   - provision of a liquidity guarantee to the contractual healthcare provider 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
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.

Art. 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 Insurance Benefit limit.
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.

Art. 2
Insured Event

With the exception of the agreed exclusions, an Insured Event is a change in the state of health (including a sudden change in a long-term stabilised chronic disease) 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.

Art. 3
Extent and Place of Insurance

1. The Insurance is only effective 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).
2. No differentiation is made in the Insurance as regards the type of stay (trip). The Insurance is effective as regards stays (trips) taken for the purposes of tourism as well as business.
3. The Insurance applies to recreational trips and stays taken whilst undertaking common recreational and relaxation sports, which are specified in the List of Activities and Sports (hereinafter referred to as the "List") as sports Not Requiring Supplementary Insurance and sports which are specified in the List of sports requiring supplementary insurance – Dangerous sports. The Insurance does not apply to sports specified in the List as Extreme Sports and for Uninsurable Sports.

Art. 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, (Insured Person or person who actually incurred the costs) the costs of the damage that had actually been incurred.
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, with the consent of the attending doctor, if his/her state of health allows it, 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 payment of the costs of healthcare and other services:
   If the Insured Person or another person made a direct payment of the costs of healthcare services pursuant to paragraph 2 of this article, which represent an Insured Event and were rendered to the Insured Person in a healthcare facility located in the Schengen Area, the Insurer shall subsequently reimburse the Insured Person or another person who incurred these costs the reasonable healthcare costs demonstrably incurred upon the receipt of at least a copy of the required documents.
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 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 all of the Insured Person's Insured Events for the Duration of the Insurance.
   b) The partial limit detailed in letter a) of this paragraph is the benefit limit for costs pursuant to letter e) of paragraph 2 of this article (Urgent dental care) stipulated in the insurance policy and limits the Insurance Benefit for all of the Insured Person's Insured Events arising in one year for Duration of the Insurance.

Art. 5
Exclusions from the Insurance

Unless it is otherwise agreed in writing by the contracting parties, the Insurer shall not provide Insurance Benefits for the following cases:

1. events where medical treatment is provided as a result of illness, accident or other conditions for which the Insured Person was treated prior to the Insurance being taken out, or events where medical treatment is provided in connection with the treatment of illness, accident, or other conditions, the cause or symptoms of which occurred prior to the Insurance being taken out or during the waiting period,
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,

6. treatments not associated with the sudden onset of Illness or Injury,
7. rehabilitation, physical therapy, chiropractic operations, exercise therapy and self-reliance training,
8. organ transplants, haemophilia treatment, interferon treatment, insulin therapy except during the provision of first aid, chronic haemodialysis,
9. replacements for spectacles, contact lenses and hearing aids and the production and repair of orthopaedic prostheses,
10. costs connected with contacting the Insurer or the assistance service (telephone call charges, etc.),
11. examination and treatment of psychiatric disorders not associated with any other sudden onset of illness or injury, psychological tests and psychotherapy,
12. procedures and diagnostic methods that are not medically recognised or performed by a qualified healthcare professional, including hospitalisation provided at such facilities,
13. cosmetic measures,
14. 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,
15. acupuncture and homeopathy,
16. complications that may arise during the treatment of illnesses, conditions or injuries not covered by the Insurance,
17. examinations and treatment of venereal and sexually transmitted diseases and AIDS from the determination of a diagnosis,
18. 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,
19. 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,
20. 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,
21. 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,
22. events which the Policyholder, Insured Person or Beneficiary could foresee or which they knew of at the time the insurance policy was taken out,
23. 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,
24. events which were caused to the Insured Person by another person at the instigation of the Insured Person, the Policyholder or the Beneficiary,
25. 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,
26. 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,
27. events which have occurred during test trials of Transport Means,
28. events which have occurred during stunt activities and the taming of beasts of prey,
29. events which have occurred during activities at locations not designated for that purpose,
30. 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,
31. 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.
32. events occurring and healthcare services provided on the territory of the Czech Republic,
33. events occurring during the preparation and performance of extreme and uninsurable sports stated in the Activities and Sports List 1/20,
34. events arising during the preparation and performance of professional sports activities; this exclusion does not apply if professional insurance of the "Professional Sports" cover for Medical Insurance pursuant to Section B of these Insurance terms and conditions is in effect at the time of the occurrence of the Insured Event; the agreed type of Insurance is specified in the insurance policy.

Art. 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 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/she 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 (the healthcare provider),
    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.

Art. 7

Assistance Services

1. 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. Contact details for the provider of the assistance services are contained in the Insured Person's Card.
2. Assistance services are provided 24 hours a day 7 days a week to the following extent:
    - provision of a liquidity guarantee to the contractual healthcare provider in the event of a claim for an Insurance Benefit,
    - medical assistance in the event of outpatient 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.

Art. 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.