European Health Plan

Valid from 2008 · EUR

"I feel better knowing my health insurance **covers all** my needs"

Bupa

International Health Insurance **danmark a/s**

Your insurance guide

Page

We put your health above all

Have you ever thought about what would happen to your family, career and financial situation if you were struck by an unexpected illness? Our experience shows that long-term illness may have serious financial and social consequences.

International Health Insurance danmark a/s (IHI) guarantees to put your health above all, offering you the best suited insurance plan and advising you on health and wellbeing.

IHI – a company you can trust

We have built up a global network of business partners, local offices and well-respected medical consultants. As a Danish company, we are regulated by the strict standards set by the Danish Insurance Contracts Act and the European supervisory authorities.

IHI is a member of the worldwide health and care organisation Bupa which has been trading since 1947. Bupa looks after more than 8 million customers of 115 nationalities in more than 190 countries. As a provident association Bupa has no shareholders to pay, and profits are reinvested in better health and care services for our customers. Bupa Insurance Limited has been rated by Moody's and Fitch*.

** The rating from Moody's is A3. The ratings from Fitch are Long Term A, Insurer Financial Strength A+.*

Your European Health Plan cover

By opting for European Health Plan you and your family have the best health insurance and support should you need it. You can feel confident that we will be there for you, wherever you are. With the European Health Plan plan you are covered in Europe, and you also have the benefit of a worldwide emergency travel cover.

Benefits

- Take advantage of the fantastic hospital facilities across Europe.
- Avoid the waiting lists in the public system.
- Access private facilities.
- Enjoy complete freedom of choice concerning specialists, hospitals, etc.
- Feel safe with the worldwide emergency travel cover.
- You will have full cover regardless of your job, leisure interests and sports activities.
- Benefit from chronic conditions being covered in full if diagnosed after enrolment or if accepted by IHI.
- Cover of accidents resulting from terrorist acts.

Cover

- Annual insurance sum of EUR 1,400,000
- Choose a 350 EUR deductible or no deductible.
- 100% cover for hospital services, outpatient/day case treatment and emergency treatment.
- Cover for non-hospitalisation benefits, e.g. consultations with physicians and specialists and diagnostic tests etc.
- Cover for child birth, organ transplants, rehabilitation and home nursing.
- Medicines and appliances.
- Annual health check-up.
- Add the supplementary Dental & Optical cover.

Services

- 24-hour multilingual emergency service.
- Guidance and advice on choice of hospital, clinics or physicians,
- Extensive network of well-reputed facilities all over Europe.
- Access to IHI's highly qualified medical consultants for advice and second opinion.
- Access to a broad range of online services, e.g. the possibility of managing your policy on our website.

Where is cover provided

- You are covered in all of Europe (see Art. 5.1 and/or the Glossary for our broad definition of Europe)
- You will also be covered for acute illness and injury during business and/or pleasure travels outside Europe (non-planned treatment).
- You are free to choose any hospital, clinic or specialist you want, private or public.

Who can take out the insurance

- To take out the European Health Plan you must be legally resident in Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia or Slovenia.
- Any person that has not yet attained 80 years of age can apply.


“The **online customer solution** is perfect for me - I can check the **status of payments**, **claim**s etc. wherever I am ”

Manage your policy online

Online services

As an IHI customer you have access to a range of online services. Visit www.ihi.com and click on myPage, follow the guide and get access to:

- A complete overview of your policy
- All your documents (policy schedule, renewals, premium notices, receipts, reimbursement letters, etc.)
- Status on recent claims reimbursed
- Online premium payment
- A useful health and travel guide
- Online doctors: General advice from IHI's medical consultants on lifestyle diseases, exercise etc, including second opinions and counselling on treatments

Sign up as online customer - free and easy

Our online customer solution is a service for you who wish to avoid postal delays, letters lost in the mail, sorting of insurance documents and filing in binders. Sign up on www.ihi.com under myPage now and your policy will be serviced online exclusively.

We will notify you by e-mail when we have updates related to your insurance. That way you are always fully informed of your insurance status.

IHI's medical centre - IHI Assist

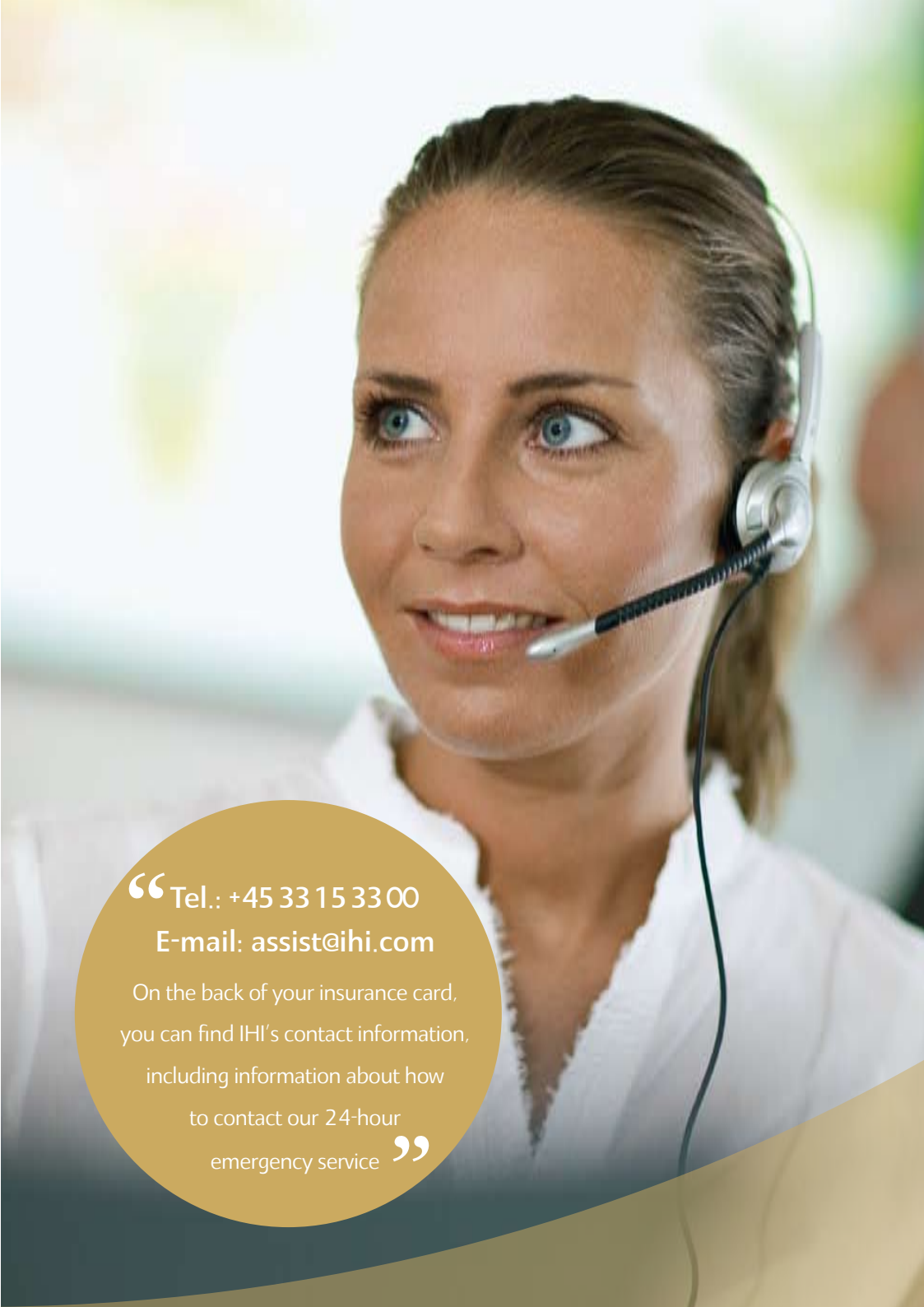
One of the advantages of being a customer at IHI is our in-house medical centre - IHI Assist. Our professional, careful and service minded staff are ready to assist you 24 hours a day, 365 days a year, and several of our own medical consultants are always on duty. Our medical centre gives you:

- Assistance in case of illness and emergency - including arrangement of medical evacuations
- Assistance in practical matters related to a hospitalisation
- Guidance when finding the right place of treatment. You only need to send us medical information together with the diagnosis and we will provide you with information on relevant and appropriate places of treatment in the countries of your choice
- Counselling on treatments
- Medical advice
- Advice on health, security and vaccinations
- Advice when planning journeys abroad
- Access to national and international networks of doctors, clinics, ambulance companies, hospitals, etc.

The purpose of our team of medical consultants is to advise should you become ill and ensure that immediate and correct treatment is arranged. The team is carefully put together and includes 13 medical consultants with specialities within cancer, musculoskeletal diseases, cardiac diseases, wound healing and also tropical and aeromedicine.

We are often in contact with nurses and doctors at the hospitals before, during and after the course of treatment, and we get many questions in connection with routine treatments, hospitalisations and evacuations which can be answered immediately due to the experience and knowledge of our nurses and customer consultants.

IHI's medical centre has access to our policy and service systems and co-operates closely with your service team, meaning that the solution is tailored to your specific needs. We provide service to our own customers exclusively and have in-depth knowledge about the specific different insurance products: We make the correct decisions - fast and efficiently. We are one step ahead when you need our help.



“Tel.: +45 33 15 33 00
E-mail: assist@ihi.com

On the back of your insurance card, you can find IHI’s contact information, including information about how to contact our 24-hour emergency service”

Cover of your expenses

Waiting periods

In the event of an acute, serious illness or injury, the cover will come into force immediately on the policy commencement date. Under other circumstances, there will be a waiting period of four weeks from the policy commencement date - subject to the following exceptions:

- If you switch to IHI from another equivalent international health insurance plan with another company, the cover will come into force immediately on the policy commencement date.
- The waiting period is 12 months in connection with pregnancy and childbirth. After the waiting period, newborn babies are covered from birth provided that a birth certificate is sent to IHI no more than three months after the birth and that premium is paid for the child.
- In case of orthodontics, the waiting period is 24 months.

If you subsequently upgrade your cover, e.g. if you wish to lower your deductible, or add the Dental & Optical cover, the waiting period will again apply under the new cover. During the waiting period, the cover that you upgrade from applies.

Hospital treatment, outpatient treatment and day case treatment

We have worked with hospitals throughout the world for many years and are therefore thoroughly aware of the practical circumstances that must be in place prior to a hospital admission. If you wish, we can take care of the details in connection with planned or non-acute admissions.

If you are hospitalised, we can issue a payment guarantee - matched to your cover. The bill can then be sent directly to us, enabling you to concentrate on getting better.

In the event of emergency admission, we should be notified as soon as possible in order to avoid misunderstandings about the insurance cover. You must state the date of admission, diagnosis, treatment and expected date of discharge.

Expenses in connection with the notification of hospital admission will be refunded by IHI (e.g. your call to IHI from another country).

Non-Hospitalisation benefits

If you have expenses for non-hospitalisation benefits, such as a bill from a specialist, physician or dentist, you must pay the bill before claiming reimbursement.

To claim reimbursement just send the bill to any of our offices mentioned on the back of the brochure.

To make it as easy as possible, you do not need to send in a claim form. We do, however, need the original, paid, receipted and clearly itemised bills. Physicians' bills should also include a diagnosis and bills for medicines must be accompanied by the corresponding prescriptions.

Please remember to state your policy number in all correspondence with IHI.

Do you want to know more?

Please contact your intermediary or IHI or visit www.ihi.com

List of Reimbursements

Valid from 1 May 2008

Please note that the List of Reimbursements is part of the Policy Conditions. It is therefore recommended to read both the List of Reimbursement and the Policy Conditions carefully.

European Health Plan

Reimbursements under the European Health Plan are effected according to the list below. If you have chosen a deductible, you will be reimbursed as soon as the qualified expenses exceed the amount of the deductible.

Reimbursements will not in any case exceed the overall annual maximum cover per person per policy year.

All amounts are in EUR

Maximum cover	
Annual max. cover per person per policy year	1,400,000

Hospital services	100%
Private/semi-private room	100%
Intensive care room	100%
Room and board for an parent accompanying a insured child	100%
Surgery	100%
Medical treatment, laboratory tests, x-rays	100%
Medicine while in hospital	100%
Prostheses: Artificial body parts designed to form a permanent part of a person's body e.g. pacemaker	100%
Psychiatric treatment Max. of 40 days day case or inpatient treatment per policy year	100%
Physiotherapy Max. of 40 days per policy year. By a registered physiotherapist, when referred by a medical practitioner	100%

Outpatient treatment / Day case treatment in a hospital or clinic	
Surgery	100%
Chemotherapy and radiotherapy	100%
Dialysis	100%

Childbirth	
Normal delivery, complicated delivery and elective caesarean delivery Including pre- and postnatal treatment. Max. per delivery	5,500
Medically prescribed caesarean Including pre- and postnatal treatment. Max. per delivery	11,000
Home delivery, physician/specialist, midwife	140
Home nursing in connection with home delivery	415
Delivery following fertility treatment is reimbursed according to the reimbursement rate for normal delivery. Excluding pre- and postnatal treatment (excluded in the Policy Conditions, Art. 8.2 h)	

Organ transplant	
Per diagnosis and course of treatment all included, max.	140,000
Organ transplant Only human organs. The procurement of the organ must be pre-approved by the Company	

Hospital cash benefit	
If room, board and treatment is received free of charge, per night max.	85
Max. 25 nights per policy year (must be pre-approved by the Company)	

Pre and post hospital treatment	
Examinations, test and check-ups before hospitalisation	100%
Follow-up treatment received after discharge from hospital	100%

Emergency treatment	
Emergency room treatment in connection with acute illness or accident	100%
Acute emergency dental treatment due to serious accident requiring hospitalisation In case of doubt, the decision will be left with the Company's dental consultant	100%

Local transport by ambulance	
Medically prescribed transport to and from hospital, max. per person per policy year	1,400

Rehabilitation & Home nursing	
Max. cover, per person per policy year	4,200
Rehabilitation Medically prescribed rehabilitation in connection with treatment at an authorised rehabilitation centre Max. per day for max. 3 months per illness	280
Home nursing Expenses incurred for medically prescribed assistance in your private home by a qualified nurse Max. per day for 40 days per policy year	110
Rehabilitation & Home nursing must be pre-approved by the Company	

Emergency out of area cover **(non-planned treatment)**	
Worldwide cover of medical expenses in case of acute illness or injury during business or pleasure travel for up to 30 days per trip Must be pre-approved by the Company	100%

Online services

Online services
• Manage your policy online, e.g. online payments, status on recent claims • General health advice and second opinions from IHI's medical consultants • Access to a range of health related information • and much more...

Non-Hospitalisation benefits

Non-Hospitalisation benefits	
Max. cover, per person per policy year	28,000

Physicians and specialists	
Physicians consultations, max. per consultation	55
Specialist consultations E.g. psychiatrist, eye and ear specialist, oncology, max. per consultation	85

Therapists	
Dietetic guidance and speech therapy, per consultation Max. 4 consultations, per policy year	45
Physiotherapy, chiropractors, osteopaths and ergotherapy, max. per consultation Max. 40 consultations per policy year	45

Examination and other medical assistance	
Diagnostic tests and procedures, incl. X-rays, ECG, CT, PET, MRI scans, pathology and laboratory tests, max. per test	415
Surgical intervention	100%

Medicine and appliances	
Maximum cover, per person per policy year	850
Prescribed medicine Medicine which could have been purchased without a medical prescription is not covered	100%
Prescribed slings and bandages, dressings, arch support, rent of appliances	100%
Prescribed hearing aids Max. per appliance EUR 200 Max. 2 appliances are reimbursed per policy year	50%
Injection and vaccination, per injection	30

Annual health check-up	
Medical examination Max. 1 per year	140

Supplementary Dental & Optical cover

Maximum cover, per person per policy year	4,500

Routine dental treatment	80%
Examinations, max.	20
Tooth cleaning, max.	35
Fillings per tooth, max.	50
Root treatment per tooth, max.	75
Tooth extrations per tooth, max.	35
Surgery, max.	70
X-ray, max.	35
Anesthesia, max.	15
Special assistance, max.	35

Special dental treatment	50%
Bridgework, crowns, periodontitis, orthodontics (tooth adjustment), dentures; per policy year, max. per policy year	1,800

Glasses and contact lenses	80%
One pair of glasses (excl. frames) per policy year, max.	140
Contact lenses, per policy year, max.	90
Frames and sunglasses are not covered	

Policy Conditions

Valid from 1 May 2008

In accordance with Danish Insurance Contracts Act.

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Art. 1 Acceptance of the insurance

1.1: International Health Insurance danmark a/s, hereinafter called the Company, shall decide whether the insurance can be accepted. In order for the insurance to be accepted and the Company to become liable, the application must be approved by the Company and the necessary premium paid to the Company.

1.2: In order for the insurance to be accepted by the Company on standard terms, the applicant must be of sound health at the time of acceptance and must not suffer nor have suffered from any recurring disease, illness, injury, bodily infirmity or physical disability, and the applicant must not have attained 80 (eighty) years of age at the time of acceptance.

1.2.1: If the conditions in Art. 1.2 are not met at the time of acceptance, the Company may offer the insurance on special terms. If the Company decides to offer the insurance on special terms, the policyholder will receive a policy schedule in which these terms are stated.

1.**2.2**: The applicant must be legally resident in Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia or Slovenia.

1.3: In the event of a change in the applicant's state of health after the application has been signed and before the Company's approval thereof, the applicant shall be under the obligation to notify the Company of such change immediately.

1.**4**: All underwriting and issuance of policy schedules are made from the Company's headquarters in Copenhagen, Denmark. The Company may choose to have data processed in our outside the EU.

Art. 2 Commencement date

2.1: The insurance shall be valid as of the date on which the application is approved by the Company. The commencement date is stated in the policy schedule. The Company may agree on another date with the policyholder.

Art. 3 Waiting periods in connection with new insurance contracts and extension of cover

3.1: When a new insurance contract is entered into, the right to reimbursement under the new insurance contract shall only take effect 4 (four) weeks after the commencement date of the insurance. However, this does not apply when the policyholder can prove simultaneous transference from an equivalent insurance with another international health insurance company.

3.1.1: In the event of acute serious illness and serious injury, the right to reimbursement shall, however, take effect concurrently with the commencement date of the insurance.

3.1.2: In addition, the waiting periods listed below shall apply for the insurance contract:

a) for expenses incurred in connection with pregnancy and childbirth and consequences thereof, the right to reimbursement shall only take effect 12 (twelve) months after the commencement date of the insurance.

b) for expenses incurred for orthodontics the right to reimbursement shall only take effect 24 (twenty-four) months after the commencement date of the insurance.

3.2: The insured may change his/her insurance cover to another type of cover as from a policy anniversary by giving 1 (one) month's written notice to the Company and subject to proof of insurability according to Art. 1.

3.3: The Company will process the extension of cover as a new application in accordance with Art. 1.

3.4: If extended cover is taken out under the insurance contract, the right to reimbursement under such extension shall only become effective 4 (four) weeks after the commencement date of the extension. However, Art. 3.1.2 a) and b) shall still apply. During the waiting period, the previous cover shall apply.

3.4.1: In the event of acute serious illness and serious injury, the right to reimbursement under the extended cover shall, however, take effect concurrently with the commencement date of the extension.

Art. 4 Who is covered by the insurance?

4.1: The insurance shall cover the insured person(s) named in the policy schedule, including children registered therein.

4.2: An application must be submitted for newborn children

4.2.1: If the insurance of 1 (one) of the parents has been valid for a minimum of 12 (twelve) months, newborn children of the parent can be insured, irrespective of Art. 1.2, without submitting an application, cf. however Art. 8.2 h). A copy of the birth certificate must, however, be submitted within 3 (three) months after the birth.

4.2.2: In case of adoption, the insured must submit a Medical Questionnaire for the adopted child.

Art. 5 Where is cover provided?

5.1: The insurance shall provide cover in the European Continent, i.e. Europe including Russia towards the east until the Ural Mountains and the Asiatic and African countries bordering the Mediterranean Sea, (cf. definition of "Europe" in the Glossary).

5.2: The insurance shall cover acute illness and injury during business and/or pleasure travels in countries outside Europe (cf. Art. 5.1) for a period of 30 (thirty) days per trip. The cover shall begin from the time the insured leaves his/her residence or workplace to conduct the travel.

Art. 6 What is covered by the insurance?

6.1: The insurance shall cover the medical expenses incurred by the insured in accordance with the cover chosen and the applicable reimbursement rates. The valid reimbursement rates are stated in the List of Reimbursements.

6.2: Reimbursement shall be paid following the Company's approval of the expenses as being covered by the insurance after the original, receipted and itemised bills, provided with the policy number, have been received by the Company.

6.3: Once the covered expenses have met the annual deductible, the reimbursable amount will be paid. The deductible shall be reduced by amounts not exceeding the maximum rates specified in the valid List of Reimbursements. The deductible shall apply per person per policy year.

6.4: Physicians, specialists, dentists etc. performing the treatment must have authorisation in the country of practice. Furthermore, the method must be approved as being suitable for the given diagnosis by the public health authorities in the country where the treatment takes place. Methods of treatment not yet approved by the public health authorities, but under scientific research will only be covered if approved in advance by the Company's medical consultants.

6.5: In no event shall the amount of reimbursement exceed the amount shown on the bill. If the insured receives reimbursement from the Company in excess of the amount to which he/she is entitled, the insured shall be under the obligation to repay the Company the excess amount immediately, otherwise the Company will set off the excess amount in any other account between the insured and the Company.

6.6: Reimbursements shall be limited to the usual, customary and reasonable charges in the area or country in which the treatment is provided.

6.7: Any discount which has been negotiated directly between the Company and providers will be specifically used by the Company for the overall benefit of the insured persons within the insurance product as a whole.

6.8: Any ex-gratia payments are at the Company's discretion. If the Company makes a payment to which the insured is not entitled under the insurance, this will still count toward the annual maximum cover per person per policy year.

Art. 7 Supplementary Module - Dental & Optical

7.1: If the insurance has been extended to include Dental & Optical cover, the following terms shall also apply:

7.1.1: The Dental & Optical cover can only be taken out as a supplement to the European Health Plan.

7.1.2: The Dental & Optical cover shall cover the insured's expenses for dental treatments and glasses and lenses in accordance with the

applicable reimbursement rates as stated in the List of Reimbursements.

7.1.3: Any bill for expenses incurred by dental treatment and glasses and lenses shall be reported by submitting the original, receipted and itemised bills provided with the policy number to the Company.

Art. 8 Exceptions for reimbursement

8.1: The insurance shall not cover expenses incurred for any disease, illness or injury known to the policyholder and/or the insured at the time of application, unless agreed upon with the Company.

8.2: Furthermore, the Company shall not be liable to pay reimbursement for expenses which concern, are due to or are incurred as a result of:

a) cosmetic surgery and treatment unless medically prescribed and approved by the Company,

b) obesity surgery,

c) venereal diseases, AIDS, AIDS-related diseases and diseases relating to HIV antibodies (HIV positive). However, diseases relating to AIDS and HIV antibodies (HIV positive) are covered, if proven to be caused by a blood transfusion received after the commencement of the policy. The HIV-virus will also be covered if proven to be contracted as the result of an accident occurring during the course of a normal occupation. The insured shall notify the Company within 14 (fourteen) days after such accident and at the same time provide a negative HIV antibody test,

d) abuse of alcohol, drugs and/or medicines,

e) intentional self-inflicted bodily injury,

f) contraception, including sterilisation,

g) induced abortion unless medically prescribed,

h) any kind of fertility test and/or treatment, including hormone treatment, insemination, or examinations and any procedures related hereto, including expenses for pregnancy, pre- and postnatal treatments of the newborn child/children. An application must therefore be submitted for children born as a result of fertility treatment and/or born by a surrogate mother. The application will undergo the standard underwriting procedure, according to Art. 1,

i) treatment of sexual dysfunction,

j) any kind of care which is experimental, not part of a medical or surgical treatment, including stays in nursing homes,

k) treatment by naturopaths or homoeopaths and naturopathic or homoeopathic medications and other alternative methods of treatment, unless specified in the List of Reimbursements,

l) health certificates,

m) treatment of diseases during military service,

n) treatment for sickness or injuries directly or indirectly caused while actively engaging in:

war, invasion, acts of a foreign enemy, hostilities (whether war has been declared or not), civil war, terrorist acts, rebellion, revolution, insurrection, civil commotion, military or usurped power, martial law, riots or the acts of any lawfully constituted authority, or army, naval or air services operations whether war has been declared or not,

o) nuclear reactions or radioactive fallout,

p) treatment performed by the insured, his/her spouse, parents or children or an enterprise owned by 1 (one) of the aforesaid persons,

q) epidemics which have been placed under the direction of public authorities,

r) treatment by a psychologist.

s) medicine, whether given by injection or otherwise, medical articles and auxiliary appliances which have not been administered during hospitalisation, unless specified in the List of Reimbursements,

t) hospitalisation, if the sole purpose is administration of medicine, treatment by a therapist or any other treatment when this could take place as outpatient treatment.

Art. 9 How to report a claim

9.1: Any claim for reimbursement of expenses incurred for treatment by a physician or specialist as well as hospital treatment and medicine shall be reported by submitting original, receipted and itemised bills provided with the policy number to the Company.

The Company scans original bills upon receipt. Any retrieval of the original invoice is not possible. The scanned bill stamped 'Certified as a true Copy' represents the original.

9.2: Any claim shall be reported to the Company immediately and no later than 3 (three) months after the circumstances underlying the claim have become known to the insured.

9.2.1: In case the insured is unable to report the claim to the Company immediately for reasons beyond his control, the ultimate time limit for filing a claim is set to 2 (two) years.

9.2.2: Complaints regarding the Company's claims handling shall be filed no later than 30 (thirty) days after receipt of the amount of reimbursement

9.3: The Company shall be notified immediately of any stays in hospital, and such notification must include the physician's diagnosis. All notifications should be made by telephone, fax or e-mail; the Company shall defray all expenses incurred in this connection.

Art. 10 Cover by third parties

10.1: Where there is cover by another insurance policy or healthcare plan, this must be disclosed to the Company when claiming reimbursement.

10.2: In these circumstances, the Company will co-ordinate payments with other companies and the Company will not be liable for more than its rateable proportion.

10.3: If the claim is covered in whole or in part by any scheme, programme or similar, funded by any Government, the Company shall not be liable for the amount covered.

10.4: The policyholder and any insured person undertake to co-operate with the Company and to notify the Company immediately of any claim or right of action against third parties.

10.5: Furthermore, the policyholder and any insured person shall keep the Company fully informed and shall take any reasonable step in making a claim upon another party and to safeguard the interests of the Company.

10.6: In any event, the Company shall have the full right of subrogation.

Art. 11 Payment of premium

11.1: Premiums are determined by the Company and shall be payable in advance. The Company adjusts the premiums once a year as from the anniversary date on the basis of changes in the cover and/or the loss experience in the insurance class during the previous calendar year.

11.2: The premium is age-related and will therefore also be adjusted on the first due date after the insured's birthday.

11.3: The initial premium shall fall due on the commencement date. The policyholder may choose between quarterly, semi-annual and annual payment.

11.4: Changes in the terms of payment can only be made at 30 (thirty) days' written notice prior to the policy anniversary.

11.5: There are 10 (ten) days of grace on each premium due date.

11.6: The policyholder shall be responsible for punctual payment of the premium to the Company, and if a premium is not received by the Company within the 10 (ten) days' grace period at any premium due date, the Company's liability shall cease.

11.7: The policyholder's attention is drawn to Art. 6.5 regarding payment of outstanding amounts.

Art. 12 Information necessary to the Company

12.1: The policyholder and/or the insured shall be under the obligation to notify the Company in writing of any changes of name, any changes to the legal residency and changes in health insurance cover with another company. The Company must also be notified in the event of death of the policyholder or an insured. The Company shall not be liable for the consequences if the

policyholder and/or the insured fails to notify the Company in such events.

12.2: The policyholder and/or the insured shall also be under the obligation to provide the Company with all obtainable information required for the Company's handling of the policyholder's and/or the insured's claims against the Company.

12.3: In addition, the Company shall be entitled to seek information about the insured's state of health and to contact any hospital, physician, etc. who is treating or has been treating the insured for physical or mental illnesses or disorders. Furthermore, the Company shall be entitled to obtain any medical records or other written reports and statements concerning the insured's state of health.

Art. 13 Assignment, cancellation and expiry

13.1: Without the prior written consent of the Company, no party shall be entitled to create a charge on or assign the rights under the insurance.

13.2: The insurance is automatically renewed on each policy anniversary.

13.2.1: The insurance can be cancelled by the policyholder as from the anniversary date with 1 (one) months' written notice. The insurance shall be effective for 12 (twelve) months as a minimum.

13.3: Where upon taking out the insurance or subsequently, the policyholder and/or the insured has fraudulently changed original documents or disclosed incorrect information or withheld facts which may be regarded as being of importance to the Company, the insurance contract shall be void and shall not be binding on the Company.

13.4: Where upon taking out the insurance or subsequently, the policyholder and/or the insured has disclosed incorrect information, the insurance contract shall be void, and the Company shall not be liable if the Company would not have accepted the insurance if the correct information had been disclosed. If the Company would have accepted the insurance but on other terms, the Company shall be liable to the extent to which the Company would have undertaken the obligations in accordance with the agreed premium.

13.4.1: In the event that the insurance contract is considered void, according to Art. 13.3 or Art. 13.4, the Company shall be entitled to a service charge which is set as a specified percentage of the premium paid.

13.5: Where upon taking out the insurance, the policyholder and/or the insured neither knew nor should have known that the information disclosed by him/her was incorrect, the Company shall be liable as if such incorrect information had not been disclosed.

13.6: The Company can stop or suspend an insurance product at 3 (three) months' notice prior to the policy anniversary, and offer the insured an equivalent insurance cover.

13.7: Upon expiry of the insurance, the right to reimbursement shall cease. However, expenses covered under the insurance and defrayed during the insurance period shall be reimbursed up to 3 (three) months after the expiry of the insurance. After-effects of an injury or illness incurred during the insurance period shall not be covered for more than 3 (three) months after the expiry of the insurance.

13.8: The insurance shall automatically expire in the event that the insured is no longer legally resident in Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia or Slovenia.

Art. 14 Disputes, venue, etc.

14.1: Any disputes arising out of or in connection with the insurance contract shall be settled in accordance with Danish law, with Copenhagen as the agreed venue. The Company is affiliated to Ankenævnet for Forsikring, Anker Heegaards Gade 2, 1572 Copenhagen V, Denmark (The Danish Insurance Complaints Board).

Glossary

This Glossary with definitions is part of the Policy Conditions.

Acute serious illness: an "acute serious illness" shall be determined to exist only after review and agreement by both the attending physician and the Company's medical consultant.

Anniversary date: the renewal of the insurance.

Applicant: a person named on the Application Form and the Medical Questionnaire as an applicant for insurance.

Application: the Application Form and Medical Questionnaire.

Claim: the financial demand covered in whole or in part by the insurance. In the Company's evaluation/determination of the claim, the time of treatment is decisive, not the time of the occurrence of the injury/ illness.

Commencement date: the date indicated in the policy schedule on which the insurance commences, unless otherwise stated in the Policy Conditions.

Deductible: the total amount of money noted in the policy schedule which each insured agrees to pay each policy year before being reimbursed by the Company.

Documents: any written information related to the insurance including original bills, policy schedules and the like.

Due date: date on which a premium is due to be paid.

Europe: Europe including Russia towards the east until the Ural Mountains, Albania, Algeria, Andorra, Austria, Belgium, Belorussia, Bosnia and Herzegovina, Bulgaria, Channel Islands, Czech Republic, Croatia, Cyprus, Denmark, Egypt, Estonia, Faroe Islands, Finland, France, Germany, Gibraltar, Greece, Greenland, Hungary, Iceland, Ireland, Isle of Man, Israel, Italy, Jordan, Latvia, Libyan Arab Jamahiriya, Liechtenstein, Lithuania, Luxembourg, Malta, Moldova, Monaco, Montenegro, Morocco, Netherlands, Norway, Poland, Portugal, Rep. of Macedonia, Romania, San Marino, Serbia, Slovakia, Slovenia, Spain, Svalbard and Jan Mayen, Sweden, Switzerland, Syrian Arab Republic, Tunisia, Turkey, Ukraine, United Kingdom and Vatican City State.

Hospitalisation: surgery or medical treatment in a hospital or clinic as an inpatient when it is medically necessary to occupy a bed overnight.

Insurance: the Policy Conditions and policy schedule representing the insurance contract with the Company and setting out the scope of the insurance terms, the premium payable, deductible and reimbursement rates.

Insured: the policyholder and/or all other insured persons as listed in the valid policy schedule.

Local transportation: medically transport necessary to and from hospital.

Medically prescribed: a service or product required for medical reasons. A formal statement from the treating physician indicating the need is required.

Normal occupation: normal occupation in accordance with Art. 8.2 c) includes only the following professions: physicians, dentists, nurses, laboratory personnel, ancillary hospital workers, medical and dental assistants, ambulance personnel, midwives, fire brigade personnel, policemen/-women, and prison officers.

Outpatient/Day case treatment: surgery or medical treatment in a hospital or clinic where it is not medically necessary to occupy a bed.

Policy Conditions: the terms and conditions of the insurance purchased.

Policyholder: the person identified as the policyholder on the Application Form.

Policy schedule: policy details showing the type of insurance purchased, deductible and any special terms.

Pre-existing condition: the medical history, including the illnesses and conditions listed in the Medical Questionnaire, which may affect the Company's decision to insure or not to insure or to impose special terms.

Prescribed medicine: Cover is restricted to medicine, for which a prescription is required, over-the-counter medicine is not covered.

Reimbursement rates: the maximum amount of money which will be paid by way of reimbursement of medical expenses in 1 (one) year from the commencement date or from each anniversary date, as further detailed in the Policy Conditions.

Renewal: the automatic renewal of the insurance as per the anniversary date.

Serious injury: a "serious injury" shall be determined to exist only after review and agreement by both the attending physician and the Company's medical consultant.

Special terms: restrictions, limitations or conditions applied to the Company's standard terms as detailed in the policy schedule.

Standard terms: the Company's standard insurance terms with no special restrictions, limitations or conditions.

Subrogation: the insurer's right to enforce a remedy which the insured has against a third party and the insurer's right to require the insured to repay the insurer if the insurer has paid expenses recouped by the insured from a third party.

Surgery: a surgical treatment/intervention, which does not include endoscopies and scannings even though these examinations may require anesthesia.

Terminal phase: when the advent of death is highly probable and medical opinion has rejected active therapy in favour of the relief of symptoms and support of both patient and family. This decision must be confirmed by the Company's medical consultants.

Usual, customary, and reasonable charges: standard prices for the treatment or medical care in a particular country or region. The prices will be compared with standard prices in the public or private market, depending on where the insured has chosen treatment.

Waiting period: a period of time from the commencement date where the insurance provides no cover unless as per specification in Art. 3.

Valid from 1 May 2008

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IHI.COM

International Health Insurance danmark a/s

Direct Sales
Tel: +45 70 23 23 13
E-mail: ihidirect@ihi.com
www.ihi.com

Customer Service
Tel: +45 33 15 30 99
Fax: +45 33 32 25 60
E-mail: ihi@ihi.com
www.ihi.com

IHI Assist
(24-hour emergency service)
Tel: +45 33 15 33 00
E-mail: assist@ihi.com
www.ihi.com

Denmark - Copenhagen
Head office
8, Palaegade
DK-1261 Copenhagen K · Denmark
Tel: +45 33 15 30 99

Opening hours for telephone inquiries:
08:00 a.m. - 10:00 p.m. (CET) on weekdays
All calls are recorded and may be monitored.

Spain - Fuengirola (Málaga) Tel: +34 952 47 12 04 · E-mail: spain@ihi.com
France - Nice Tel: +33 (0)4 92 17 42 42 · E-mail: france@ihi.com
USA - Miami Tel: +1 (305) 270-3944 · E-mail: us@ihi.com · Toll Free Number: 1-888-5DANMARK
Bolivia - Santa Cruz Tel: +591 3 3412842 / +591 3 3412841 · E-mail: bolivia@ihi.com
Mexico - Mexico City Tel: +52 (55) 5202-5870 · E-mail: mexico@ihi.com
Hong Kong Tel: +852 2529 2723 · E-mail: hongkong@ihi.com
Japan - Tokyo, Representative office Tel: +81 3 34 05 07 94 · E-mail: info@ihidanmark.jp

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