UNIQA

General Insurance Terms and Conditions for Foreigners' Travel Health Insurance – UCZ/CZP/14

General Part

1. Introductory Provisions

1.1. Foreigner's travel health insurance (hereinafter "THI") provided by UNIQA pojišťovna, a.s. (hereinafter the "insurer") is governed by the legal order of the Czech Republic (hereinafter the "CR"). It abides by the Insurance Act, the relevant provisions of the Civil Code, these General Insurance Terms and Conditions (hereinafter "GITC"), and contractual provisions. If any of the conditions referred to above contains a provision at variance with the law, the provisions specified in the insurance terms and conditions or directly in the insurance policy will apply.
1.2. THI is taken out as loss insurance and comprises insurance in the event of sickness under Section 2847 of the Civil Code. However, it is not taken out to the extent of public health insurance.
1.3. The following types of insurance can be arranged within the framework of THI, each being governed by a special part of these GITC:
A) Insurance for comprehensive healthcare for foreigners (hereinafter "CHC");
B) Insurance for necessary and urgent healthcare for foreigners (hereinafter "NUC").
1.4. An insurance policy on THI is a document on travel health insurance during a trip of more than 90 days under Section 180j of Act No. 326/1999 Coll., on the residence of aliens in the territory of the CR, as amended.

2. General Provisions

2.1. Under an insurance policy concluded the insurer undertakes to pay the policyholder an agreed settlement in the event of an insured event, and the policyholder undertakes to pay the insurer an agreed single premium. There are no deductibles on the side of the beneficiary.
2.2. The policy limits are specified in the insurance policy.
2.3. Legal acts relating to the insurance coverage must be executed in writing. All changes must be made in writing or they will be deemed invalid. Only a signed document in paper form shall be regarded as being in writing. For the notification of an event which a person regarded as an authorised person links to a request for insurance benefits and the relevant communication, written form shall be regarded as having been maintained in communication by telephone call through the insurer's call centre, text message or e-mail. Czech is the communication language.
2.4. An assistance service or health insurance company operating in the CR may be the insurer's partner.
2.5. These GITC are published by the insurer in Czech and translated into English, Russian and Vietnamese. The decisive text is that written in Czech.
2.6. The rights and duties ensuing from THI are governed by Czech law. All disputes ensuing from the insurance scheme or in connection therewith will be resolved by the court with jurisdiction in the CR.

3. Duration of Insurance, Insurance Period

3.1. THI is taken out for a definite period of time. THI begins at 00:00 hours of the day designated as the commencement date of insurance in the insurance policy, though no earlier than 00:00 hours on the day immediately following the date on which the insurance policy is taken out, and ends at 24:00 hours on the day designated as the final day of insurance in the insurance policy. If the insured party has arranged the KOMPLEX2 plan, CHC also covers their newborn until the 14th day of their life inclusive for the duration of the policy.
3.2. **CHC insurance includes a waiting time in the event of pregnancy lasting 3 months from the insurance commencement date: in the event of birth the waiting time lasts 8 months from the insurance commencement date—**these waiting times do not apply if CHC insurance has been taken out under the KOMPLEX2 plan.
3.3. **In the event of nursing care, CHC insurance includes a waiting time lasting 36 months from the insurance commencement date.**

3.4. The insurance policy takes effect on payment in full of the single premium at the earliest, unless agreed otherwise in the insurance policy.
3.5. THI may not be discontinued, unless agreed otherwise.

4. Territorial Applicability of Insurance
4.1. The insurance only covers insurance events which occurred during a legal stay by the beneficiary in the territory of the CR or in the Schengen Area.
4.2. Outside the territory of the CR the insurance only covers tourist trips made by the beneficiary without any gainful activities being carried out, even on a short-term basis, and only covers the provision of necessary and urgent care, including expenses related to transport to the nearest suitable hospital, or to a doctor.

5. Premium
5.1. The premium is a payment for the provision of insurance coverage. The level of the premium is determined on the basis of rates set by the insurer for individual types of insurance coverage according to actuarial principles.
5.2. A premium is set for the entire insurance period agreed (single premium), unless agreed otherwise in the insurance policy.
5.3. The single premium is payable in full on the date the insurance policy is concluded. The insurer has the right to the premium for the full duration of insurance on the date the insurance policy is concluded.

6. Insurance Settlement
6.1. The insurer pays insurance settlements to a maximum of the agreed sums insured, limits, and individual limits, with consideration for insurance exclusions, either to the authorised party after receiving the originals of the requisite documents, or directly to the relevant contractual health centre.
6.2. Insurance settlements are payable within 15 days of the date the insurer completes its investigation to determine the extent of its obligation to pay a settlement. The insurer must complete its investigations within 3 months of a report being made of the insured event associated with a request for payment. **If the insurer cannot complete its investigation within this period, it is obliged to inform the party which may be or is entitled to the settlement of the reasons it cannot complete its investigation and provide a reasonable advance upon request, if there is no reasonable reason to deny it. This period does not run if the investigation is prevented or complicated by the authorised person, policyholder or beneficiary.**
6.3. Insurance settlements are payable in the CR in the local currency by cashless payment, unless agreed otherwise in the insurance policy. The Czech National Bank exchange rate on the first business day of the month in which the insurance event occurred is used for foreign currency conversion.
6.4. In the case of loss insurance schemes the insurer is entitled to reduce the settlement by the amount of compensation which has been or will be provided by a third party obliged to pay damages resulting from an insurance event.

7. Termination of Insurance
7.1. If the insurance terminates prior to the insurance commencement date, the insurer will refund the premium, reduced by administrative expenses, usually 20% of the premium received, to the policyholder upon receiving all the documents issued.
7.2. The insurance terminates upon the death of the beneficiary (this does not apply in the case of the KOMPLEX2 plan), on the date that repatriation is refused by the beneficiary or his statutory representative, upon the termination of the validity of a visa to stay in the CR or upon a visa application to stay in the CR being rejected.
7.3. The insurance will also terminate on the date specified in a written agreement between the insurer and the policyholder or with the expiry of the period for which the insurance was agreed.

8. Rights and Duties of Policyholder, Beneficiary and Authorised Persons
8.1. In the case of insurance covering another beneficiary's risk the policyholder shall inform the beneficiary of the contents of the insurance policy relating to the coverage of its risk, and familiarise the beneficiary with its rights and duties ensuing therefrom no later than on the date coverage begins.
8.2. As well as the duties set forth by legislation, the policyholder or a person regarded as a beneficiary shall also:
a) truthfully and completely answer the insurer's written questions in the initial questionnaire;
b) inform the insurer immediately of any change to the information in the insurance policy and in the answers given in the questionnaire;
c) take all due care to ensure an insured event does not occur and take all possible measures to prevent or minimise its consequences;
d) follow the instructions of the insurer's partner, the insurer's instructions in the insurance manual, the GITC, and the insurance policy;
e) if direct payment of expenses was not made by the insurer's partner or the insurer, the policyholder or beneficiary shall immediately notify the insurer in writing of an insurance event; complete and send to the insurer a report of the insurance event and the requisite documents without unnecessary delay, or provide additional information on the insurance event and submit other required documents upon the insurer's request; all documents submitted must be drawn up in English, German or Czech – if this is not done the insurer will have said documents translated at the beneficiary's expense;

f) provide the insurer with all truthful information on the origin, course and consequences of an insured event and, in the event of any doubt, substantiate its entitlement to an insurance settlement to the insurer;
g) provide the insurer with all the necessary cooperation during the investigation of the insured event, above all inform the insurer of any other insurers and policy limits agreed in other insurance policies covering the same risk;
h) upon the insurer's request relieve third parties (especially doctors) of the duty of nondisclosure on matters relating to an insurance event;
i) secure compensation for damages caused by an insured event or similar rights from third parties, and transfer these rights to the insurer in writing up to the amount provided or to be provided in payment.

8.3. If an insured event occurs, as well as the duties specified in the general section of these GITC, the beneficiary shall:
a) take all reasonable measures to ameliorate the consequences of the insured event;
b) unless its state of health prevents it, always and immediately contact the insurer's partner or the insurer itself, follow their instructions, and upon request undergo a medical examination at a health centre specified by the insurer's partner;
c) identify itself using the beneficiary's certificate in the event medical treatment is necessary;
d) follow the instructions of the examining doctor and the treatment prescribed;
e) undergo an examination or treatment by a doctor specified by the insurer's partner or the insurer;
f) undergo repatriation organised by the insurer's partner if their state of health so permits or if the period during which healthcare is provided exceeds the duration of the insurance cover;
g) upon being requested by the insurer, relieve the healthcare provider of a non-disclosure duty and award the insurer written authorisation to acquire information which is subject to statutory confidentiality on the part of health centres, commercial and health insurance companies, the Czech Police Force and the Ministry of the Interior, and which is essential for the insurer's investigation in the event of an insurance event.

8.4. If a non-contractual health centre requests payment from the beneficiary of the expenses arising from an insurance event, the beneficiary shall:
a) accept the originals of all requisite documents and submit them without unnecessary delay to the insurer's partner or insurer;
b) pay reasonable and demonstrable expenses in cash to the non-contractual health centre.

8.5. The report of an insurance event, including the appendices thereto, shall contain the following:
a) the exact date, place, cause and circumstances giving rise to an insurance event and the extent of the event;
b) the original medical report or other documents containing a description of the beneficiary's state of health, including the diagnosis codes, a complete list of treatment provided with descriptions thereof, codes, point-based evaluation, and, as the case may be, the price, the date on which measures were undertaken, the names and quantities of prescribed medication, including the prices thereof, a list of healthcare materials used and services, including the prices thereof; the originals of documents (invoices and receipts) on payment of expenses specifying the amounts and subject of payment;
c) a copy of the prescription made out by the doctor in the case of out-patient treatment;
d) payments of expenses specifying the amounts and subject of payment.
The insurer may request other documents, e.g. a police report, official death certificate, etc.

8.6. The policyholder, beneficiary or authorised party has the right to contact the insurer's control division or the Czech National Bank (regulation and supervision of insurance companies section) with a complaint.

9. Rights and Duties of the Insurer

9.1. The insurer has the right to reduce the insurance settlement if the beneficiary fails to comply with contractually agreed obligations, especially in the case of late notification of an insured event and in the case of incomplete data in the notification of an insured event, if this complicates the investigation into the extent of damages.

9.2. The insurer is entitled to compensation for special purpose costs of the investigation of the facts regarding which such data was communicated to it in a knowingly incorrect or grossly distorted manner, or was knowingly concealed.

9.3. As well as the duties laid upon it by legal regulations, if the insurance policy or beneficiary's certificate is lost or destroyed, the insurer is obliged to provide the policyholder a relevant copy thereof upon the latter's request and at the latter's expense.

10. Delivery of Written Materials

10.1. The insurer will deliver documents and correspondence by post or by some other appropriate means.

10.2. If documents or correspondence cannot be delivered to the addressee, where the addressee is known to be at the given address, documents or correspondence can be delivered to another adult person living in the same apartment or building, working at the same place of business or employed at the same workplace, if this person is willing to deliver the documents or correspondence. If documents or correspondence cannot be delivered in this way, documents or correspondence will be left with the post office, which will ask the addressee to collect the delivery in a suitable manner. If an addressee does not collect a consignment, the consignment sent using the postal service is regarded as having been delivered on the third working day after sending, or the fifteenth

working day in the event it is sent abroad. Unless the opposite is found, the addressee is regarded as living at the place of delivery. If a consignment is returned to the insurer because the addressee has relocated, the date on which it is returned to the insurer will be deemed the delivery date

Special Part

Part A

Foreigner's Comprehensive Healthcare Insurance (hereinafter "CHC")

Article 1 – Definition of Terms

1. **Comprehensive healthcare** refers to healthcare provided to the beneficiary with the aim of maintaining that state of health enjoyed by the beneficiary from the period prior to the insurance policy being concluded. Comprehensive healthcare comprises out-patient and institutional healthcare, including diagnostic care, preventative care, dispensary care, emergency and rescue services, the provision of medication, and the transportation of sick persons and possible repatriation of the beneficiary or their physical remains. The KOMPLEX2 plan also contains care relating to the pregnancy of an insured mother and the birth of her child. The provision of comprehensive healthcare is guaranteed in a network of contractual health centres (i.e. centres in the CR with which the insurer has concluded a contract on the provision of healthcare in connection with this insurance scheme), always up to the extent of but not beyond healthcare paid as standard from public health insurance in the CR (i.e. up to the extent of but not beyond healthcare that is fully, and in the case of medication partially, paid from public health insurance in the CR and the provision or payment of which is not bound to a decision of a review physician, specialist commission or other body of a health insurance company – regulatory payments and surcharges are not deemed payment for healthcare).

2. **Necessary and urgent care** refers to healthcare provided to the beneficiary or a newborn insured within the framework of the KOMPLEX2 plan. Necessary and urgent care comprises the essential care provided by health emergency and rescue services, transportation indicated by a doctor to the nearest specialist health centre, the stipulation of a diagnosis and medical procedure, including essential treatment, necessary and urgent healthcare measures, including essential medication and materials, essential hospitalisation for a necessary period, up to the extent but not beyond of necessary and emergency care paid from public health insurance in the CR**.** It also applies that the level of the insurance settlement provided to non-contractual health centres in the CR (or in another country of the Schengen Area) may not exceed the standard payment from public health insurance in the CR (or in another member country of the Schengen Area) that would be paid for this care.

3. **A female beneficiary giving birth** refers to an event which commences with the initiation of the first health treatment related to the birth that is not contained in pregnancy care.

Article 2 - Subject of Insurance

1. The subject of insurance are the healthcare expenses provided to the beneficiary to the extent of comprehensive health care but not beyond. The extent of the insurance depends on the type of trip being taken by the beneficiary, on the place where the beneficiary is staying, and on the healthcare provider, which is either a contractual or non-contractual health centre.
2. These expenses must be incurred by virtue of a change in the state of health of the beneficiary or the need to prevent unfavourable changes to the state of health of the beneficiary.

Article 3 – Insured Persons

1. Only a foreigner in a good state of health may become a beneficiary.
2. Persons with serious nervous indispositions, persons with psychological problems and persons suffering deafness (both sided), blindness (both sided), paralysis, drug or alcohol addiction or dependence on prescription drugs, cirrhosis of the liver, cancer, malignant tumours (carcinomas), tuberculosis, kidney dialysis, HIV infection or AIDS, cannot be insured.
3. An insurance policy will not be concluded with uninsurable persons.

Article 4 - Insured Event

1. An insurance event refers to a sickness, injury or negative change to the beneficiary's state of health, as a consequence of which it was necessary to provide the beneficiary healthcare or assistance services in accordance with the scope of the insurance coverage taken out, and the beneficiary had a duty to pay those expenses to the health centre which were incurred on the provision of healthcare or has a duty to pay expenses to the assistance services provider.
2. The subject of the insurance settlement is the necessary and reasonable expenses, legitimately and demonstrably incurred in accordance with valid health and legal regulations, for the following:
   a) comprehensive healthcare provided to the beneficiary by a contractual health centre;
   b) necessary and urgent healthcare provided to the beneficiary by a local non-contractual health centre only to the essential extent or until a state of health is attained which allows for the transport of the beneficiary to a contractual health centre or for their repatriation;

c) post-natal healthcare for a newborn insured under the KOMPLEX2 plan;
d) repatriation of a sick beneficiary that is organised by the insurer's partner;
e) repatriation of the physical remains of the beneficiary that is organised by the insurer's partner.

3. Events arising from the one cause and including all the facts and consequences thereof, between which there exists a causal, temporal or other direct link, are deemed to be one insured event.

Article 5 – Insurance Settlement

1. The insurance is taken out to the extent of comprehensive care that is provided up to the extent of but not beyond public health insurance, but with agreed exclusions from coverage and with insurance settlement limits agreed on.
2. The insurance relates to the following:
   a) out-patient medical treatment;
   b) a hospital stay in a standard room for the period of time necessary, which is backed up by a medical report;
   c) bandages and dressings on the basis of a prescription;
   d) medical resources required to mend a broken limb backed up by an examination;
   e) X-ray diagnosis;
   f) expenses for transport to the nearest suitable hospital or doctor when the state of health so requires;
   g) urgent operations;
   h) medication prescribed by an out-patient doctor in the name of the beneficiary in connection with the provision of healthcare to the extent agreed in the insurance plan, with the exception of the exclusions specified in these GITC and up to the limit agreed on in the insurance policy; The maximum level of the insurance settlement for payment of the expenses for medication prescribed by an out-patient doctor is equal to the level of these medications under public health insurance in the CR, which is specified in the currently valid regulation of the Ministry of Health (list of medications paid and partially paid for from health insurance);
   i) dispensary care relating to sickness and injuries the cause of which occurred after the commencement of insurance;
   j) treatment in connection with allergies if this is the first appearance of the given type of allergy in the beneficiary, including the essential follow-up allergenic or immunological treatment – however, this does not relate to medications and subsidiary products related to the diagnosis;
   k) if the KOMPLEX2 insurance scheme is valid at the time an insured event occurs or the waiting times have already elapsed in the case of the KOMPLEX plan, then all medical care which the insured person undergoes in connection with pregnancy and birth in the insurer's contractual centre or other centre approved in advance by the insurer is paid for;
   l) post-natal healthcare for a newborn in the case of the KOMPLEX2 plan, up to 14 days of the newborn's life;
   m) dental treatment with the aim of removing pain, simple fillings;
   n) the insurer will provide an insurance settlement by means of the provision of assistance services, i.e. repatriation of the sick beneficiary or their physical remains organised by the insurer's partner after approval by the beneficiary's doctor or a specialist of the insurer's partner, to the country for which the beneficiary owns or owned a travel document, or the country in which they have or had their permitted residence.
3. The insurance also relates to preventative care to the following extent:
   a) a preventative examination with a GP once a year for an adult and once a year for children up to 18 years old;
   b) a preventative examination with a gynaecologist for women aged 15 and over once a year;
   c) a preventative dental examination once a year;
   d) obligatory inoculations to a maximum limit of CZK 1,000 per year.
4. **The level of the insurance settlement limit agreed for one insurance event is €60,000, unless agreed otherwise in the insurance policy.**

Article 6 - Exclusions from Insurance

1. The insurance does not cover events which occurred:
   a) prior to payment of the premium;
   b) outside the territory of the CR in connection with a trip made by the beneficiary that was not a tourist trip.

2. The insurer is not obliged to pay an insurance settlement in the event of:
   a) illness or injury suffered in connection with military events, civil war, civil unrest, acts of violence, including terrorist attacks in which the beneficiary was an active participant; radiation leak, nuclear reaction or radioactive contamination; the effects of chemical or biological weapons;
   b) in vitro fertilisation, examinations and treatment of infertility or sterility, contraception and measures related thereto, abortions undertaken without there being any serious documented threat to health;
   c) physical care during stays at a spa, sanatorium, treatment facility, convalescence centre, therapeutic facility, etc.;

d) **cosmetic treatment and the consequences thereof, chiropractic measures or therapy, acupuncture or homeopathy, dental and orthodontic procedures, the production and repair of prostheses, braces, dentures, glasses, contact lenses, hearing aids, electric wheelchairs and myoelectric prostheses, the treatment of speech defects;**
e) **examinations and treatment of psychological illnesses and disorders not related to the treatment of an injury or sickness covered by the insurance; psychological treatment and psychotherapy; the treatment of addiction, including the examination thereof;**
f) **the examination and treatment of venereal diseases or AIDS, including treatment for HIV positive;**
g) **procedures conducted outside of health centres which are not carried out by a physician or nurse with the requisite qualifications, or treatment which is not scientifically or medically recognised, or procedures conducted in a health centre which does not provide Czech citizens this care as standard (e.g. private clinics);**
h) **rehabilitation, training therapy and training in independence, with the exception of post-injury or post-op procedures;**
i) **the treatment of chronic kidney insufficiency by haemodialysis or peritoneal haemodialysis, the treatment of haemophilia and other blood coagulation diseases, insulin therapy (with the exception of diabetes in a beneficiary aged 15 or younger and the provision of first aid), viral hepatitis if the diagnoses was reached within 6 months of the commencement of insurance, organ transplant, treatment using growth hormones, the treatment of congenital defects or injuries ascertained prior to the commencement of insurance;**
j) **sickness and injuries resulting from the practice of publicly organised sports competitions, matches or races in any type of sport, the professional pursuit of any type of sport. This exclusion does not apply if the KOMPLEX+ plan has been agreed;**
k) **events the symptoms of which appeared prior to the insurance policy being concluded or which must have been known to the beneficiary or policyholder prior to the insurance policy being concluded;**
l) **events which involved the beneficiary travelling to the CR or another country of the Schengen Area for the purpose of seeking healthcare or undergoing an operation;**
m) **events arising after the refusal of treatment by the doctor specified by the insurer or its partner;**
n) **payment for medication or healthcare resources not prescribed by a doctor;**
o) **post-natal care for a newborn born to the beneficiary during the term of insurance, unless the KOMPLEX2 plan was agreed.**

Part B

Foreigners' Necessary and Urgent Healthcare Insurance (hereinafter "NUC")

Article 1 – Definition of Terms

1. **Necessary and urgent care** refers to healthcare provided to a beneficiary. Necessary and urgent care comprises essential care provided by emergency and rescue services, transport recommended by a doctor to the nearest specialist health centre, the stipulation of a diagnosis and medical procedure, including the necessary examinations, necessary and urgent healthcare procedures, including essential medication and healthcare materials, essential hospitalisation for the period of time absolutely necessary, to the extent of but not beyond the necessary and urgent care paid from public health insurance in the CR. It also applies that the level of the insurance settlement provided to non-contractual health centres in the CR (or in another country of the Schengen Area) may not exceed the standard payment from public health insurance in the CR (or in another member country of the Schengen Area) that would be paid for this care.

Article 2 – Subject of Insurance

1. The subject of insurance comprises the healthcare expenses provided a beneficiary to the extent of but not beyond necessary and urgent healthcare. The extent of the insurance depends on the type of stay being undertaken by the beneficiary.

Article 3 – Insured Persons

1. Only a foreigner in a good state of health may become a beneficiary.
2. Persons with serious nervous indispositions, persons with psychological problems and persons suffering deafness (both sided), blindness (both sided), paralysis, drug or alcohol addiction or dependence on prescription drugs, cirrhosis of the liver, cancer, malignant tumours (carcinomas), tuberculosis, kidney dialysis, HIV infection or AIDS, cannot be insured.
3. An insurance policy will not be concluded with uninsurable persons.

Article 4 – Insured Event

1. An insurance event is an acute illness or injury suffered by the beneficiary as a consequence of which it was necessary to provide healthcare or assistance services to the beneficiary in accordance with the insurance

scheme taken out, and when the beneficiary has a duty to pay the health centre those expenses incurred on the provision of said healthcare or a duty to pay expenses to the assistance service provider.

2. The subject of the insurance settlement is the necessary and reasonable expenses, legitimately and demonstrably incurred in accordance with valid health and legal regulations, for the following:
   a) necessary and urgent healthcare provided to the beneficiary by a contractual health centre;
   b) necessary and urgent healthcare provided to the beneficiary by a local non-contractual health centre only to the essential extent or until a state of health is attained which allows for the transport of the beneficiary to a contractual health centre or for their repatriation;
   c) repatriation of a sick beneficiary that is organised by the insurer's partner;
   d) repatriation of the physical remains of the beneficiary that is organised by the insurer's partner.
3. Events arising from the one cause and including all the facts and consequences thereof, between which there exists a causal, temporal or other direct link, are deemed to be one insured event.

Article 5 – Insurance Settlement

1. The insurance covers necessary and urgent care that is provided to the extent of public health insurance but not beyond, but with agreed exclusions from insurance and with agreed settlement limits.
2. The insurance relates to the following:
   a) out-patient medical treatment;
   b) a hospital stay in a standard room for the period of time necessary, which is backed up by a medical report, i.e. treatment, procedures and operations that cannot be postponed in light of the state of health of the beneficiary;
   c) bandages and dressings on the basis of a prescription;
   d) medical resources required to mend a broken limb backed up by an examination;
   e) X-ray diagnosis;
   f) expenses for transport to the nearest suitable hospital or doctor when the state of health so requires;
   g) urgent operations;
   h) medication prescribed by an out-patient doctor in the name of the beneficiary in connection with the provision of healthcare to the extent agreed in the insurance plan, with the exception of the exclusions specified in these GITC and up to the limit agreed on in the insurance policy; The maximum level of the insurance settlement for payment of the expenses for medication prescribed by an out-patient doctor is equal to the level of these medications under public health insurance in the CR, which is specified in the currently valid regulation of the Ministry of Health (list of medications paid and partially paid for from health insurance);
   i) dental treatment with the aim of removing pain, simple fillings;
   j) the insurer will provide an insurance settlement by means of the provision of assistance services, i.e. repatriation of the sick beneficiary or their physical remains organised by the insurer's partner after approval by the beneficiary's doctor or a specialist of the insurer's partner, to the country for which the beneficiary owns or owned a travel document, or the country in which they have or had their permitted residence.
3. **The level of the insurance settlement limit agreed for one insurance event is €60,000, unless agreed otherwise in the insurance policy.**

Article 6 – Exclusions from Insurance

1. The insurance does not cover events which occurred:
   a) prior to payment of the premium;
   b) outside the territory of the CR in connection with a trip made by the beneficiary that was not a tourist trip.

2. The insurer is not obliged to pay an insurance settlement in the event of:
   a) illness or injury suffered in connection with military events, civil war, civil unrest, acts of violence, including terrorist attacks in which the beneficiary was an active participant; radiation leak, nuclear reaction or radioactive contamination; the effects of chemical or biological weapons;
   b) pregnancy tests, any complications after the 26th week of pregnancy, birth, in vitro fertilisation, examinations and treatment of infertility or sterility, contraception and measures related thereto, abortions undertaken without there being a serious documented threat to health, unless the insurance policy provides otherwise;
   c) physical care during stays at a spa, sanatorium, treatment facility, convalescence centre, therapeutic facility, etc.;
   d) cosmetic treatment and the consequences thereof, chiropractic measures or therapy, acupuncture or homeopathy, dental and orthodontic procedures, the production and repair of prostheses, braces, dentures, glasses, contact lenses, hearing aids, electric wheelchairs and myoelectric prostheses, the treatment of speech defects;
   e) examinations and treatment of psychological illnesses and disorders not related to the treatment of an injury or sickness covered by the insurance; psychological treatment and psychotherapy; the treatment of addiction, including the examination thereof;

f) **the examination and treatment of venereal diseases or AIDS, including treatment for HIV positive;**
g) **procedures conducted outside of health centres which are not carried out by a physician or nurse with the requisite qualifications, or treatment which is not scientifically or medically recognised, or procedures conducted in a health centre which does not provide Czech citizens this care as standard (e.g. private clinics);**
h) **rehabilitation, training therapy and training in independence, with the exception of post-injury or post-op procedures;**
i) **the treatment of chronic kidney insufficiency by haemodialysis or peritoneal haemodialysis, the treatment of haemophilia and other blood coagulation diseases, insulin therapy (with the exception of diabetes in a beneficiary aged 15 or younger and the provision of first aid), viral hepatitis if the diagnosis was reached within 6 months of the commencement of insurance, organ transplant, treatment using growth hormones, the treatment of congenital defects or injuries ascertained prior to the commencement of insurance;**
j) **sickness and injuries resulting from the practice of publicly organised sports competitions, matches or races in any type of sport, the professional pursuit of any type of sport. This exclusion does not apply if the KOMPLEX+ plan has been agreed;**
k) **events the symptoms of which appeared prior to the insurance policy being concluded or which must have been known to the beneficiary or policyholder prior to the insurance policy being concluded;**
l) **events which involved the beneficiary travelling to the CR or another country of the Schengen Area for the purpose of seeking healthcare or undergoing an operation;**
m) **events arising after the refusal of treatment by the doctor specified by the insurer or its partner;**
n) **payment for medication or healthcare resources not prescribed by a doctor;**
o) **post-natal care for a newborn born to the beneficiary during the term of insurance, unless the KOMPLEX2 plan was agreed.**

These General Insurance Terms and Conditions take effect on 1 January 2014.