GENERAL CONDITIONS

ARTICLE 1. INSURANCE CONTRACT

The General Conditions of the Insurance Contract as well as the Additional Insurance Conditions, the Insurance Policy, the written declarations made by the Applicant in the insurance application and in other relevant documents hereafter will be called the Insurance Contract.

ARTICLE 2. OBJECT OF INSURANCE

With this insurance contract, the insured persons are covered for the risks indicated in the insurance policy and insurance certificate.

ARTICLE 3. DEFINITIONS

The meaning of the following words in the policy shall be:

Insurer	Insurance Company, Sigma VIG sh.a
Contractor	The person who signs the insurance policy with the insurance company and who is responsible for paying the insurance premium.
The Insured	The person for whom the insurance policy is issued.
Premium	The amount of money that the Insured pays for the insurance within the agreed time interval.
Sum Insured	The maximum amount of money that the Insurer undertakes to pay during the period of insurance for all benefits, treatments or medical care covered by this insurance policy, regardless of the limits set out in the separate sections or appendices hereof Insurance contracts.
Addendum	Any addendum to the policy, which is subject to the general and special conditions, the relevant addendum articles and which provides additional insurance coverage.
Hospital Institution	Any medical institution licensed by the state authorities which carries out medical treatments or surgical interventions and in which patients are under the constant care of a doctor. They will not be considered medical institutions, centers that provide services for individuals seeking extended recovery and rehabilitation treatments, relaxation centers, centers for the elderly or for persons with motor and mental disabilities.

Illness	Unintentional deterioration of the health condition, as well as any abnormality that occurs in the functioning of the body organs of the insured person, which does not depend on the will of the insured person and is not a consequence of the accident, but which is caused by pathological changes that can be diagnosed by a doctor.
Accident	Any violent, external, unexpected, accidental, and completely independent act of the insured, which results in bodily injury independent of any other cause.
Waiting period	The period from the start date of the insurance, during which the insurance policy does not cover medical expenses but only expenses related to accidents, preventive care or medical emergencies.
Hospitalization	Is considered the treatment that must be done in a hospital institution and for which the insured must be hospitalized for at least 24 hours. It is not considered as hospitalization, the stay of the insured in a hospital institution for a longer period than is necessary or defined in the medical protocols, or if he is hospitalized and no pathological condition is diagnosed.
Outpatient Treatment	Treatments that do not require hospitalization or stay in the hospital for more than 24 hours. This includes medical checks by general practitioners or specialists, laboratory tests, imagery diagnostic, radiological tests that aim to diagnose or provide medical treatment, recommended by a relevant doctor, as well as daily surgery performed in a hospital institution.
Doctor	Any person practicing the profession of doctor who has a diploma and a licence recognized by the state, or an equivalent international diploma for practicing the profession of doctor is considered.
Pre-existing condition	Any disease, illness or injury that has been diagnosed by a doctor or required medical treatment including taking medication, as well as any disease or illness that has shown symptoms and is in the process of being diagnosed before the start date of the insurance, or that would encourage a prudent person to seek medical advice or treatment.
Chronic Condition	An illness or injury that has at least one of the following characteristics: • Continues for an indefinite period and requires continuous treatment with medications, monitoring, consultations, or examinations. • When repeated or likely to be repeated. • When it is necessary to rehabilitate or show special care to coexist with this disease.

Medical emergency	Immediate deterioration of the health condition of the insured because of an accident or an illness, the sudden occurrence of a serious, life-threatening condition that requires immediate medical attention and presents a risk to the insured person's life or his health.
Reimbursement amount	It is the defined amount of covered expenses for specific health treatments, determined in absolute value or percentage, and specified in the insurance certificate or policy.
Medical Evacuation	Shall be considered licensed ambulance service from the place of occurrence of the insured event to the nearest place where appropriate medical treatment can be provided, or emergency transfers between hospitals when medical treatment is not available and such transfer is required by the responsible medical team.
Day surgery	It will be considered surgery in a medical, hospital center where the insured does not have to stay in the hospital for more than 12 hours.
Medical treatment	Shall be considered any cure scientifically accepted and applied according to the approved protocols, which aims to restore or maintain the health, and which adheres to medical advice and is recognized as medical care by the national authorities of the country in which the treatment is given.
Diagnostic tests	shall mean necessary microbiological, biochemical, and imagery tests necessary for diagnosing a disease and to follow the treatment plan.
Medicines	shall be considered substances or preparations that have a main active ingredient, are sold in a pharmacy, are recommended by a doctor, are final products and represent a chemical substance or a combination of chemical substances and are intended to treat a disease. Food supplements, products used for weight control, stimulants, hormones and other doping substances, tonic products, cosmetic and personal care products, even if recommended by a doctor, products used for hygiene, contraceptives, vaccines, food and other baby products will not be considered medicines.
Preventive Care	includes medical examinations that are performed under routine conditions, before the appearance of symptoms of the disease, to prevent the disease; Shall be covered agreed routine medical check-ups at the clinic/hospital agreed or recommended by the Insurer.

ARTICLE 4. ENTRY INTO FORCE OF THE INSURANCE CONTRACT

1. The insurance contract comes into effect with full rights at 24:00 on the date indicated in the policy as the insurance start day, provided that the insurance premium or its first installment has been paid to the Insurer's bank account.
2. The insurance contract comes into effect with full coverage after a waiting period of 60 days for persons who are insured for the first time with this insurance contract. During this period, expenses incurred as a result of accidents or medical emergencies will be covered, as well as the preventive care package. The waiting period may be different and the one specified in the insurance policy or certificate prevails, especially if the insured is immediately transferred from a health insurance contract.
3. The insurance contract will be in force for a period of 12 months, with the right of renewal after the insurance premium is paid.

ARTICLE 5. BINDING THE INSURANCE CONTRACT

1. The insured must sign the application form, and answer all questions accurately and fairly, not hiding any facts about his health. The application form will be part of the insurance contract.
2. The Insurer has the right to check the health condition of the Insured, according to the medical examinations recommended by the doctor authorized by the Insurer. For the insured who enter the insurance scheme for the first time, the assessment of the health condition will be made based on the preventive control package, which must be performed by the insured within 30 days from the start date of the insurance policy and the insurance premium is paid. If the insured fails to perform the preventive care package within the first 30 days of insurance, he does not lose the right to do it during the insurance period, but the relevant exceptions will apply at any time that these examinations are carried out.
3. In case that after performing the examinations, results a greater risk than the standard, the Insurer reserves the right to offer insurance conditions different from those specified in the request, or to refuse the insurance coverage of this risk or to return the part of insurance premium according to actuarial calculations.
4. The information received by the Insurer regarding the health condition of the insured, is treated confidentially and is used only for the purposes of contractual relations between the parties. The insured also releases from the obligation of professional secrecy any doctor, with whom he was consulted, as well as any hospital or medical clinic, public or private institution that possesses medical information about the insured, to make this information available to the Insurer and to provide reports and documents, before and after the insurance event has occurred.

ARTICLE 6. ELIGIBILITY OF INSURED PERSONS

Persons between the ages of 18 and 60, who meet the underwriting conditions and are resident in Albania during the insurance period, are eligible to be insured. Insureds who reach the age limit while the insurance contract is still in force will remain covered until the end of the term indicated in this insurance contract.

People who require permanent medical care, or who formally support their lives at third parties, or people who have developed drug and \ or alcohol addiction, cannot be insured.

Persons who are 60 years old or who will reach this age during the insurance period will not be accepted for the first time in insurance.

ARTICLE 7. PARTICIPANTS OF THE FAMILY

Provided that it has been agreed by the contracting parties and the insurance premium has been paid, insured persons include family members dependent on the insured and are limited to:

- Spouse - partner up to 60 years old;
- Children from 30 days to 17 years, or up to 25 years if they are in a study relationship and are not married.

Coverage for members of the insured's family is subject to the same conditions as the main insured. In addition, coverage begins and ends at the same insurance period with the main insured.

By partner we mean the person with whom the insured is not legally married, but with whom he, she lives and/or has dependent unmarried children, including children who live with the insured as part of the family.

The main insured must submit information on the health of the family members who depend on him when the children are minors, by signing the relevant application forms, and the Insurer shall approve their request to be insured.

ARTICLE 8. INSURANCE PREMIUM

The insurance premium is paid annually as soon as the insurance policy has been issued. Payment of the premium or installment will be made via bank transfer to the Insurer's account. If it has been agreed a payment in installments, the first installment cannot be less than 50% of the total payment and the last installment must be paid within the first six months of the policy.

Delay in premium payment gives the Insurer the right to suspend or terminate the insurance contract without notice.

If the payment of installments is delayed up to a period of 15 days, the contract will be in force with the same conditions. This condition does not apply to the first insurance installment. If the insurance premium is not paid by the end of this period, then the policy ends, and the last date of insurance coverage is the date when the premium should have been paid.

The insurer has the right to change the insurance premium at the beginning of the new insurance year (contract renewal). In this case the insurer must inform the contractor or the insured about the new conditions within 15 days before the end of the insurance coverage. The insured or the contractor must notify the Insurer in writing of the acceptance of the new conditions and the renewal of the insurance contract before the last day of insurance.

ARTICLE 9. TERMINATION OF THE INSURANCE CONTRACT

Insurance coverage ends:

1. When the Insurer ascertains such circumstances, which, if known at the time of the insurance request, would constitute a reason for not issuing the insurance policy.
2. When the insurance premium has not been paid.
3. On any other date on which he does not meet the underwriting conditions.
4. When the limit of the Sum insured has been fully executed.

The Insurance Contract can be terminated at the request of one party to the other party, however, the result of this request comes into force after 30 calendar days.

Issuance, termination, or modification of the terms of the Contract is done only by the Insurer. For issuing, terminating, or modifying the terms of the Contract, no prior approval or notification is required from the insured or the beneficiaries, but only from the Contractor. Any change in the limits of insurance amounts does not have automatic validity. The validity starts from the date that the Insurer and the Contractor have agreed and accepted the changes in writing and the payment of the insurance premium has been made.

ARTICLE 10. WAITING PERIOD

A waiting period of 60 days will apply to all first-time insured individuals and is subject to the conditions below:

- During the waiting period, only expenses incurred because of an accident or medical emergency will be covered. During this period, the costs of preventive care will also be covered.

- The waiting period will not apply if the insured is transferred from a group health insurance contract to an individual health insurance contract or in cases where he is transferred from one health insurance scheme to another scheme, with the same Insurer, unless otherwise provided in the insurance contract.
- The waiting period will not apply to contracts that are renewed unless the renewal of the contract is carried out after a period of 30 days from the date of termination of the first contract.

A 12-month waiting period will apply for the following diseases.

1. *Disc herniation.*
2. *Ischemic heart disease, surgical operations for cardiac and vascular diseases.*
3. *Diseases related to the uterus, ovaries, breasts for which surgical interventions must be performed.*
4. *Surgical treatments for cancer as well as chemotherapy and radiotherapy treatments.*
5. *Surgical treatment for stones in the bladder, gall bladder, urinary tract, and kidney systems.*

SECTION 11. THIRD PARTY COVERAGE

1. If the Insured requests coverage of expenses or reimbursement of payments that are also covered by another insurance policy, in these cases the Insurer will coordinate the payment and will not be responsible for more than the proportional share depending on the Sum insured.
2. If reimbursement is required for expenses that are fully covered by another insurance policy, then the Insurer is not liable to cover any expenses.
3. The Policyholder and the Insured shall notify the Insurer and take all reasonable steps against third parties to be indemnified and protect the interests of the Insurer. If the Insurer pays compensation to the insured, but this expense should have been covered by another insurance policy or a third party, the Insurer has full rights to request reimbursement from these parties.

SECTION 12. AREA OF COVERAGE

- The coverage area is the countries in which the Insured is entitled to receive medical treatment. Based on the plan of the chosen insurance, and if it is specified in the insurance certificate, the insured benefits up to 100% coverage of the expenses within the territory of Albania and up to 70% of the expenses outside the territory of Albania, but within the limit of the Sum insured.
- The territory of coverage is the area in which the Insured has the right to benefit if the insured event occurs.

ARTICLE 13. COMPETENT COURT

For any dispute between the Contractor or any other interested party and the Insurer, the Tirana Judicial District Court is the only body authorized to resolve it.

ARTICLE 14. OBLIGATIONS AND TAXES

Any current or forthcoming taxes, on behalf of third parties, which are related to the insurance policy, will be charged to the Contractor, the insured, or the beneficiary.

ARTICLE 15. DOCUMENTS THAT HAVE NO LEGAL EFFECT

The insurer is only liable for documents that are signed by persons authorized by its legal representative, are sealed with the company seal, have a serial number according to the insurer's internal system or a protocol number according to the insurer's register. No one else has the right to sign or modify insurance policies on behalf of the insurer or issue legal statements or documents.

ARTICLE 16. HEALTH INSURANCE BENEFITS

The insurer is responsible to pay for medical expenses intended to diagnose and cure diseases, accidents, and their consequences, which are covered by the insurance contract, and which occurred to the insured within the period of validity of the insurance policy, according to the coverages listed on the certificate of insurance, in the territory described as the territory of coverage.

16.1 Benefits for inpatient treatment

The insurer undertakes to reimburse to the extent indicated in the insurance policy the costs of hospital services that require at least one night of hospitalization as follows:

- Room and board expenses for each day of hospitalization of the insured. Reimbursement of bed and board expenses will be limited in total to the price paid for a double room. Personal expenses such as telephone calls, television or the assistance of an interpreter are not reimbursed.
- Expenses for the payment of the specialist doctor, surgeon, anesthesiologist.
- Use of operating room equipment and apparatus.
- Diagnostic checks, examinations with RXT, CT scanner, MRI scanner, PET scanner, ultrasounds.
- Treatment in the emergency room.
- Intensive Care.
- Medications for hospital use as well as blood plasma and oxygen;
- Prostheses and similar medical devices

The insurer covers the expenses of the accommodation of the parent or guardian in a hospital institution if the admitted person is a minor child under 8 years old and if this is required and reccomended by the doctor.

If it is specified in the insurance policy, this coverage can also be obtained in the territory of Europe (excluding Switzerland and the United Kingdom), to the extent of 70% of the cost, within the limit of the Sum insured and according to the percentages defined in the policy.

16.2 Benefit for outpatient treatment (without hospitalization)

The insurer, in accordance with the general conditions of the contract or its special conditions, covers the insured for the risks of accidents and diseases that do not require hospitalization, up to the limits defined in the Table of Benefits, which include:

- Expenses for consultations with the general practitioner. The normal cost of a GP visit will be covered.
- Expenses for the specialist doctor as well as diagnostic tests recommended by the doctor. The normal cost of a visit with a specialist doctor who is on duty at the time of the visit will be covered. If a consultation with a particular specialist doctor is required, which costs more than the normal charges offered by the hospital institution, the Insurer reserves the right to cover up to the value of the normal cost of the visit.
- Expenses incurred for the purchase of medical bandages.
- Expenses for the purchase of medications (if defined in the insurance policy) according to the doctor's recommendation for the necessary and diagnosed treatment.
- Day surgery as an outpatient.
- Diagnostic, laboratory, biochemical, imaging controls.
- This will also include the medical equipment recommended by the doctor only in the event of an accident, for the treatment of the case such as external prostheses, collars, orthopedic nets, but not measuring devices such as blood pressure devices, diabetes, diabetes tablets, aerosol devices, even if the diagnosis is covered by insurance conditions. Orthopedic insoles will not be covered.
- Physiotherapy in case of illness or accident if it is specified in the insurance policy. The maximum cost of a physiotherapy session covered by this contract is 3,000 ALL.

The coverage of this section is limited only in Albania, regardless of the territory of coverage defined in the insurance certificate.

16.3 Preventive Care

Preventive care includes the pre-defined examination package in the insurance policy, according to the agreed package. It must be performed within one week and all examinations must be performed within the same hospital institution contracted by the Insurer.

This coverage applies only in the territory of Albania and only in the clinics or hospitals that are contracted by the Insurer to perform this service.

For the first year of the insurance policy, the preventive care package will be carried out within 30 days from the conclusion of the contract.

16.4 Transportation to hospital

In case of emergencies, the insurer will pay the costs of a road ambulance for the transport of the insured from the place of the incident to the nearest medical institution, which can treat the insured. If the emergency transport was requested by the isured, and it was covered by the Insurer, but it was not necessary because of Insured's health condition as it was not a medical emergency, the Insurer has the right to request reimbursement of expenses from the contractor or the insured.
Carriage by air is not covered by this contract, unless otherwise specified in the insurance policy.

16.5 Dental Accident Care.

The insurer is liable to cover up to the amount specified in the table of benefits, emergency care treatments for the repair or replacement of damaged teeth because of an oral injury caused by an accident. Treatment must be performed within 48 hours of the accident. Expenses incurred because of accidents while chewing or injury due to placing any object in the mouth will not be covered by this contract.

16.6 Pregnancy Coverage

In case the Insured has been insured for an uninterrupted period of five years, the Insurer will cover the expenses for normal pregnancy and birth (caesarean section or natural) or the expenses for complications of pregnancy and birth up to the limit defined in the insurance certificate. If this coverage is not specified on the certificate of insurance, no refund will be provided.

16.7 Radiotherapy and chemotherapy

The insurer undertakes to cover the costs of radiotherapy and chemotherapy up to the amount specified in the table of benefits.

ARTICLE 17. GENERAL EXCLUSIONS

This policy does not cover expenses for events, accidents or illnesses caused or contributed directly or indirectly by:
a) Illnesses that are caused by pre-existing conditions, disabilities, structural disorders that existed before the start of the insurance, of which the policyholder or the insured were aware at the time of applying for insurance. They must be declared in writing in the insurance application. In case the Insurer does not accept in writing the coverage of these diseases, no expenses related to them will be reimbursed.
b) Diseases or health problems that are known or unknown by the insured and are diagnosed for the first time during the waiting period or during the first preventive checkup by the insured. If the insured must perform the preventive check during the first

30 days, this exception applies whenever this check is performed during the insurance period.
c) Examination and treatment of congenital, genetic diseases, refractory anomalies, growth disorders and complications even if they are diagnosed at a later age.
d) ACL knee arthroscopy, meniscus repair, unless it is caused by an accident which is proven by a report of the authorities, or which also caused other bodily injuries.
e) Psychiatric diseases, epilepsy, parkinson, alzheimer and other geriatric diseases as well as psychotherapy.
f) Cosmetic surgery only if this is necessary because of the accident, dietary and weight loss treatments, massage, acupuncture, hemopathy, hydrotherapy, mesotherapy, cosmetic care, dermatological care, diagnosis of dermatological problems.
g) Medical problems or injuries that occur while practicing sports as a professional or as an amateur. Expenses for the treatment of injuries will not be covered even while practicing sports as an amateur, such as football, mini football, volleyball, basketball, boxing, skiing, martial arts, etc.
h) Any corrective surgery that is needed because of malpractice of doctors or medical institutions.
i) Any examination related to oral, maxillofacial, dental problems as well as their treatment, except when they are the result of an accident, and are specified in the insurance policy.
j) Expenses for finding and receiving organs for transplant as well as medical and hospital expenses of the donor.
k) Occupational diseases and infectious diseases which are officially recognized by government authorities.
l) Analysis, examinations, visits or routine treatments that are not related to health problems, prophylactic medication and vaccinations (except tetanus and rabies vaccines) when not specified in the insurance policy.
m) Testing of vitamins levels. Vitamins, supplements, mineral combinations, contact lenses, oral contraceptives, preparations for hair loss and dandruff, medicated powders and liquids with fruit orgy, smoking cessation preparations, herbal diets, artificial sweeteners, herbal fibers, herbal medicines, tea medical products and toothpastes for mouth care, shampoos, creams, cosmetic products, diapers, baby formula, pacifiers, feeding bottles for children, even when these are with the doctor's recommendation.
n) Examination of allergy, and its treatment. Immunotherapies are not covered by this insurance contract.
o) Sexually transmitted diseases, diagnosis, tests and treatments for HIV, AIDS, sterility, contraception for men and women, infertility, procedures and treatments related to sexual transformations, sexual dysfunction or sexual incompatibility. Pathologies related to the use of alcohol or different types of narcotic substances.
p) Childbirth and complications, abortion and in general any situation related to childbirth or complications during childbirth, unless otherwise stated in the insurance policy.
q) Sclerotherapy for superficial varicose veins. Multiple sclerosis, Lupus and other autoimmune diseases.
r) Deviation of the nasal walls, nasal septum, treatments resulting from its deformation, any surgery for the nose and cochlea.

s) Screening and treatment for menopause and osteoporosis and other menopause-related diseases.
t) Expenses for examinations of eye or vision problems, radial keratomic surgeries in case of myopia, astigmatism, hypermetropia or presbyopia, lenses, frames, or optical glasses, if not specified in the insurance policy.
u) Hemodialysis, blood transfusion or kidney dysfunction.
v) Self-inflicted injury, suicide or any other attempt (whether mentally healthy or not);
w) Diagnosis, examination, and treatment for chronic diseases that require continuous treatment with medications and examinations. Chronic diseases will be considered diabetes, thyroid, asthma, multiple sclerosis, parkinson, rheumatism, lupus, arthritis, hypertension, and other conditions that meet the definition of chronic diseases.

ARTICLE. 18 PAYMENT OF CLAIMS AND REIMBURSEMENT OF EXPENSES.

In any case, the insured must present the insurance card, so that he can benefit from the prices contracted by the company. If the Insured does not present the insurance card, and payment for the service is made in full, the Insurer reserves the right to reimburse referring to the cost that would be paid in case of presentation of the card.

The procedure to be followed by the Insured to benefit from compensation or reimbursement of expenses will be as follows:

a) Prior approval

The insured must obtain prior approval for the following treatments:

- Hospitalization treatment
- Surgery without hospitalization
- Medical Evacuation / Emergency Repatriation
- Transport for treatment outside Albania
- Return of the patient's body to Albania
- Advanced imaging controls (CT Scanner, MRI, Pet Scan, Colposcopy)
- Computed axial tomography (CAT)
- Coronarography

Prior approval must be obtained from the Insurer in writing by submitting all supporting medical documentation and an estimation of medical expenses. After completing the necessary documentation, the Insurer must give prior approval for hospitalization treatments within seven working days, while for other cases, prior approval will be given within two working days.

If prior approval is not obtained, the Insurer reserves the right to pay only 70% of the amount it would have paid if notice had been given in time and if the medical treatment was covered by the insurance policy.

b) Medical treatment in medical institutions outside the Sigma VIG medical network

The medical service covered by the insurance contract and received by the Insured outside the network of medical institutions, will be covered by the Insurer to the extent of 70%, applying the other conditions of co-insurance.

The medical service covered by the insurance contract and received by the Insured in Albania at a medical institution within the Company's network, will be covered by the Insurer to the extent specified in the insurance policy.

The Insurer's medical network will include hospitals, clinics and certified medical centers that have an agreement with the company and that have been chosen by the latter to provide service to the Insured.

In case the insured chooses to perform a surgical intervention in a public hospital, he will benefit from compensation in the amount of 30% of the value that this intervention would cost in the public hospital listed in the insurance policy as a reference.

c) Medical treatments outside the territory of Albania

The insurer is liable to pay the insured medical treatments of a hospitalization abroad up to 70% of the cost up to the limit of Sum Insured, if it is defined in the insurance policy and according to the coverages specified in the insurance scheme. In any case, the insured must obtain prior approval from the Insurer. In case the insured does not receive prior approval, the insurer will pay an indemnity not higher than the value that would be paid for this treatment in one of the private hospitals in Albania, defined as the reference private hospital in the insurance policy.

For cases of treatment outside the territory of Albania, the requested documentation must be presented in original, translated and notarized when requested by the Insurer. In the case of accidents, the minutes kept at the place of the event by a competent authority of the country where it occurs, and which proves the circumstances of the event are required.

d) Procedure for reimbursement of expenses and payment of damages

1. Applications for reimbursement of expenses will be made based on claim forms approved by the company. Claims for compensation for children under the age of 18 will be made by their parents or legal guardians, and reimbursement will be transferred to the account of one of the parents or legal guardians.
2. The insured must submit detailed invoices for the incurred expenses accompanied by other supporting documentation from the doctor or medical center. Expense invoices and documents proving their payment must be original,

and recognized by the tax authorities, otherwise they will not be considered by the insurance company.

3. Reimbursement for medicines will be based on a prescription given by a doctor. In these cases, a photocopy of the medication prescription given by the doctor and attached tax invoice and the original payment voucher will be considered a valid document.
4. The Insured, his relatives or the contractor is obliged to notify the Insurer in writing within four days of any case of illness for which compensation is requested.
5. Requests for reimbursement of expenses must be submitted to the Insurer not later than 30 days from the date the expenses were incurred, or the services are performed, whichever is earlier. The expenses for the collection and translation of the documents are borne by the insured.
6. After the necessary documents have been submitted, the Insurer will make the reimbursement according to the Terms of this contract within 30 days from the date of submission of complete documentation.
7. Reimbursement will be transferred in the currency specified in the insurance policy or in other currencies when stated otherwise in the policy.
8. If a claim is rejected in part or in whole, the Insurer will send a written notice including the reasons for this rejection.
9. In addition to the documents cited above, the insured must submit to prove the validity of the claim, any other document deemed necessary by the Insurer.

ARTICLE 19. REASONABLE AND USUAL EXPENSES

1. If the Insurer believes that the expenses incurred for medical treatment are not reasonable for such treatment in the country where they are incurred, the level of reimbursement will be limited to the medical values and associated costs, as well as the duration of hospitalization according to the normal standard in the country where the patient is treated.
2. A "reasonable payment" is a payment for a service or facility that has been previously paid for, or that has a fixed price in that country or that is provided by those in a similar profession, whichever is smaller.

ARTICLE 20. MEDICAL EXAMINATION

The insurer has the right, at its own expense, to assign a doctor to examine any person covered by this contract, during his hospitalization, the process of diagnositication or even later. In case the insured refuses this medical examination, the Insurer has no obligation to pay compensation to the insured.

ARTICLE 21. SANCTIONS CLAUSE

Regardless of any provisions of different content within this Insurance Policy, the Insurer shall not be deemed to provide cover and the Insurer shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover , payment of such a claim or the provision of such benefit would expose that Insurer to

any sanction, prohibition or restriction under the United Nations Resolutions or the trade or economic sanctions, laws or regulations of the European Union, as well as according to Albanian legislation, the United Kingdom or the United States of America.

ARTICLE 22. ILLNESS CONTAGIOUS EXCLUSION CLAUSE

Regardless of any provisions of different content within this Insurance Policy, the Insurer shall not be deemed to provide cover and the Insurer shall not be liable to pay any claims arising out of bodily injury (incl. Emotional distress or mental trauma or phobia), any kind of material loss or damage which is actually or allegedly caused by, contributed to by or in any way related to: Acquired Immune Deficiency Syndrome (AIDS) or its pathogenic agents or hepatitis;
Communicable Disease.
A Communicable Disease means any disease which can be transmitted amongst humans, animals, or plants, or by means of any substance or agent from any organism to another organism where:
-the substance or agent includes, but is not limited to, a virus, bacterium, parasite or other organism or any variation thereof, whether deemed living or not, and
-the method of transmission, whether direct or indirect, includes but is not limited to, airborne transmission, bodily fluid transmission, transmission from or to any surface or object, solid, liquid or gas or between organisms, and
-the disease, substance or agent can cause or threaten damage to human health or human welfare or can cause or threaten damage to, deterioration of, loss of value of, marketability of or loss of use of property.

ARTICLE 23. CLAUSE EXCLUSION OF CYBER ATTACKS

Notwithstanding the provisions contained in this insurance or any endorsement, it is agreed that this insurance excludes loss, actual and personal property damage, costs or expenses of any nature, caused directly or indirectly by any cyber attack, resulting from the use of means that cause damage to any computer, computer system, computer software, malicious code, computer viruses or any other electronic system or equipment.

APPENDIX OF THE IFAM HEALTH INSURANCE CONTRACT

PERSONAL ACCIDENT INSURANCE

ARTICLE 1. DEFINITIONS

In addition to the words defined in the general conditions of health insurance, the meaning of the following words in this appendix shall be:

Case / Event of insurance	Death or disability of the insured caused by the accident.
Accident	Any violent, external, unexpected, accidental, and completely independent act of the insured, which results in bodily injury independent of any other cause.
Accidental Death	The loss of life of the insured, other than natural death or as a result of an illness, caused by accidental, violent, visible, external means, independent of the will of the insured.
Permanent total disability	Total loss of the insured's ability to perform the duties in his profession or any other profession, caused by the accident, certified as such by the competent medical authority, after the expiry of the period of 52 weeks from the beginning of the disability.
Permanent partial disability	Partial loss of ability to work, caused by the accident, resulting in anatomical loss or permanent functional damage of one or several organs or limbs of the Insured.
Limb loss	Physical or functional loss of a hand, at or above the elbow joint, or of a leg, at or above the knee joint.
Beneficiary	The person who is entitled to the sum insured based on the will expressed in this policy by the insured, in case the latter dies accidentally. In the case where the insured does not determine the beneficiary by his will, then the beneficiary is determined by a court decision according to the legal provisions on inheritance.

Article 2- THE RIGHT TO BE INSURED

As a result of this appendix, people who are up to 60 years old, who do not require permanent medical care and who do not support their living in the care of third parties, have the right to be insured. Insureds who reach the age limit, when the insurance

contract is in force, will remain covered until the end of the term indicated in the insurance policy.

ARTICLE 3. DEFINITION OF ACCIDENTS

This appendix covers cases in which the accident, as described in the general conditions of the contract, causes direct, visible, verifiable bodily injuries to the insured, which constitute the direct, exclusive, and proven cause of the death or permanent disability of the insured.

ARTICLE 4. BENEFICIARY

The beneficiary is designated by the insured. In case no beneficiary is designated, the insured amount is paid to the legal heirs.
Substitution of the beneficiary is valid from the date of completion of the written application for substitution. In case the beneficiary dies before or simultaneously with the insured and no substitute beneficiary has been designated, the insured amount is paid to the legal heirs of the insured.

ARTICLE 5. COMPENSATION FOR ACCIDENTAL LOSS OF LIFE

If the Insured dies because of an accident, immediately or no later than 12 months from the date of the accident, the Insurer will pay the beneficiary the Sum Insured for Accident specified in the insurance policy, in case of accidental death.

ARTICLE 6. COMPENSATION FOR PERMANENT TOTAL DISABILITY

Permanent total disability as a result of the accident is the disability due to which the insured is totally disabled for life. The insurer will pay the beneficiary the Su Insured for Permanent Disability specified in the insurance policy.

For the effect of this appendix, permanent total disability will be considered:

- Loss of vision in both eyes.
- Anatomical or mobility loss in at least 2 limbs (hemiplegia, paraplegia).

ARTICLE 7. COMPENSATION FOR PERMANENT PARTIAL DISABILITY

Permanent partial disability because of an accident is the disability due to which the insured person becomes partially disabled throughout life. The benefit is calculated as a percentage of the insured amount of Total Permanent Disability according to the percentages defined in the disability table.

If the insured is left-handed, and this has been declared to the Insurer, the percentages for the left limbs apply to the right and vice versa.

In case the anatomical or functional loss of an organ or limb damaged before the accident is caused, the percentages shown in the table will be deducted, taking into account the degree of previous disability.

In case of physical or functional losses of more than one body organ or limb in the same accident, which are unrelated to each other and do not lead to permanent total disability as described above, compensation for all disabilities together, cannot be greater than 80% of the sum insured for Permanent Total Disability.

Inability	The right	The left
Loss of an entire arm or hand	60%	50%
Loss of movement of the entire shoulder	25%	20%
Total loss of movement of the entire elbow or wrist	20%	15%
Total loss of the thumb or index finger	30%	25%
Total loss of three fingers except thumb or index finger	25%	20%
Total loss of the thumb and one finger except the index finger	25%	20%
Total loss of the index finger and one finger except the thumb	20%	15%
Total loss of thumb	20%	15%
Total loss of index finger	15%	10%
Total loss of middle finger, ring finger or little finger	10%	8%
Total loss of ring finger and little finger	15%	12%
Partial amputation of the foot or all the toes	30%	
Loss of the entire lower limb or the entire leg	50%	
Fracture of the lower limb or leg which has not healed and has not returned to normal conditions	25%	
A fracture of the kneecap that has not healed and has not returned to normal conditions	20%	
Cartilage fracture that has not healed and has not returned to normal conditions	15%	
Total loss of mobility of the knee or pelvis	20%	
Total loss of big toe	5%	
Total loss of one toe except the big toe	3%	
Shortening the leg by at least 5 cm	15%	
Loss of vision in one eye or reduced vision in both eyes	25%	
Complete and incurable deafness in one ear	15%	
Complete and incurable deafness in both ears	40%	
Fracture of a lower jaw which has not returned to its normal condition	25%	
The ankylosis part of the spine together with the deformity	40%	
Fracture of the ribs with deformation of the thorax and organic abnormalities	20%	

ARTICLE 8 EXCLUDED RISKS

This appendix does not cover:

9.1 Insured's disability or physical injuries that existed before the policy was issued, related complications, as well as accidents that are the result of the insured's previous disabilities.
9.2 Accidents of the insured while he was under the influence of narcotic drugs, sedatives, stimulants, or strong alcoholic beverages.
9.3 Accidents due to the entry of the enemy, war or civil war, rebellions, or civil unrest in which the insured has been actively involved, or the insured's involvement in illegal or criminal activity.
9.4 Attempted suicide, or voluntary mutilation, regardless of the insured's mental state, as well as acts committed or attempted by the policyholder or beneficiary to the detriment of the insured.
9.5 Accidents due to the insured's active participation in sports as a professional or as an amateur. Accidents while practicing sports as an amateur, such as football, mini football, volleyball, basketball, boxing, skiing, martial arts, scuba diving and mountain climbing, will not be covered.

ARTICLE 9. APPLICABLE PAYMENT CASES

If, because of the same accident, the damages suffered by the insured are ineligible, the Insurer will pay the highest amount, deducting the previous payments.
If, after payment of any benefit under this appendix, a claim for higher compensation arises, the Insurer will pay the difference, considering the payment previously made.

Physical injuries, complications or corrective interventions one year after the accident will be considered as illnesses.

ARTICLE 10. PAYMENT OF COMPENSATION

Any indemnification made under this addendum shall be paid to the policy beneficiaries or legal heirs. The payment will be made by the Insurer within 30 days from the completion of the necessary documentation for handling the insurance case.

The sum insured for accidents is included in the total Sum Insured. If the insurer has covered medical expenses for the accident, and it still results in disability or loss of life, the compensation in this case will not exceed the total amount of the insurance.

ARTICLE 11. OBLIGATIONS OF THE CONTRACTOR - THE INSURED

The Insured, his relatives or the contractor is obliged to notify the Insurer in writing within four days of any accident covered by this appendix.

The contractor, the insured, or the beneficiary, in the event of an accident, must submit to the Insurer any necessary information and must allow any examination or investigation related to the accident and deemed reasonable by the Insurer.

The expenses for the collection and preparation of the documentation for compensation are borne by the Policyholder, the Insured, or the Beneficiary.

ARTICLE 12. SANCTIONS CLAUSE

Notwithstanding the provisions of this Insurance Policy, the Insurer shall not be obligated to pay any claim for damages or provide any benefit under this contract, if the provision of such coverage, the payment of such claim or the provision of such benefit would expose the Insurer to any sanctions, prohibitions or restrictions, under United Nations Resolutions or trade or economic sanctions, laws or regulations of the European Union, also under Albanian Law, the United Kingdom or the United States of America.

ARTICLE 13. INFECTIOUS DISEASES EXEMPTION CLAUSE

Notwithstanding the provisions of this Insurance Policy, the Insurer will not provide coverage and the Insurer will not be obligated to pay any claim for damages for any loss related to bodily injury (including Emotional Stress or mental trauma or phobia), any type of damage or material losses, which are or are alleged to have been caused by, affected by or in any way related to acquired immunodeficiency syndrome (AIDS/AIDS) or its pathological agents or hepatitis.

Communicable disease shall mean any disease which can be transmitted between humans, animals, or plants, or by means of any substance or agent from any organism to another organism, when the substance or agent includes but is not limited to a virus, bacterium, parasite or other organism or any modification thereof, whether or not considered living, and

- the method of transmission, whether direct or indirect, includes but is not limited to, airborne transmission, transmission of body fluids, transmission from or to any surface or object, solid, liquid or gas or between organisms.
- the disease, substance or agent may cause or threaten harm to human health or human welfare or may cause or threaten damage, deterioration, loss of value, marketability or loss of use of property.

ARTICLE 14. CLAUSE EXCLUSION OF CYBER ATTACKS

Notwithstanding the provisions to the contrary contained in this insurance or any endorsement, it is agreed that this insurance excludes loss, actual and personal property damage, costs or expenses of any nature, caused directly or indirectly caused by any cyber attack, resulting from the use as means to cause damage to any computer, computer system, computer software, malicious code, computer viruses or any other electronic system or equipment.