PACIFIC CROSS
INSURANCE COMPANY LIMITED

Level 2, Lotemau Centre, Vaea Street, P.O. Box 3271, Apia, Samoa

TRAVEL HEALTH INSURANCE POLICY

(effective January 1, 2015)

INTRODUCTION

This Policy is issued in consideration of the payment of the premiums specified herein and in reliance on the statements contained in the Application, which forms the basis and a part of this Policy.

The Company will pay benefits in accordance with and subject to the terms of this Policy.

TERMS & CONDITIONS

SECTION 1: POLICYHOLDER, INSURED PERSONS AND ELIGIBILITY FOR INSURANCE

1. The insurance contract is a group insurance contract concluded by Association of the German Foreign Trade (VDAW), as the policyholder, and the Company.
2. Insured persons are the members of VDAW included in the group insurance contract and their close relatives up to the age of 75 (75th birthday), who are on a trip abroad for business reasons or have been sent abroad by their employer.
3. Persons non-eligible for insurance and not insured, despite having paid the premiums, are those who
   a) are in permanent need of care and persons who are excluded from participating in everyday life on a lasting basis. For categorization, the person's mental state and objective living circumstances in particular must be taken account of. Persons in need of care are persons who generally require the help and assistance of others to master the daily routines.
   b) engage in sporting activities in return for payment.

SECTION 2: COMMENCEMENT AND PERIOD OF INSURANCE COVER

1. Insurance cover commences for the insured persons after binding admission to the group insurance contract. For all insurance, the insurance cover for the individual persons insured commences, at the earliest, after payment of the premiums for all journeys within the scope of the insurance booked and undertaken after this point in time. Journeys already booked or embarked on before this point in time shall only be covered if this is explicitly agreed to in the group insurance contract.
2. The insurance cover for the individual persons insured also ends for still unsettled cases relating to events covered by the insurance:
   - at the agreed point in time
   - upon the death of the insured person in each case
   - if the prerequisites for a temporary stay abroad no longer apply
   - with the removal of the insured person from the circle of insured persons by the policyholder, subject to the deadlines and prerequisites specified in the tariff
   - upon the departure of the member from VDAW
   - if the prerequisites for insurance eligibility agreed to in the group insurance contract cease to apply
   - with the ending of the temporary stay of the insured person in the area of application as agreed to in the tariff
   - if the insured person has decided to remain permanently in the area covered by the tariff, or if the insured person finally returns to his or her home country.
3. If the group insurance contract is terminated, the insurance cover ends for all of the insured persons in the group insurance contract at the time of coming into effect of the termination. For events covered by the insurance that occur up to the point in time of the coming into effect of the termination, cover will be provided for a maximum period of 3 months as from the coming into effect of the termination.

SECTION 3: AREA OF APPLICATION

1. With the exception of the USA, Canada and China (including Hong Kong and Macau), insurance cover abroad is provided worldwide. The term "abroad" applies to the territory of the country in which the insured person is travelling or to which he or she has been sent by the employer for business reasons, though not to the territory of the Federal Republic of Germany and to the country of the employee's nationality.
2. Limited performance in the event of interruption of the trip abroad:
   a) In cases of trips abroad lasting for a period of at least a year, in the event of an interruption of the trip the insurance cover is continued subject to limitations. In this case the temporary return to the place of residence or the permanent place of abode will be equated to a trip abroad, provided the total period of the interruption does not exceed six weeks per commenced insurance year. The insurance year in this case is regarded as a period of twelve months, in each case, as from the date of commencement of the insurance. At the request of the Company, in the context of a claim, the policyholder is required to provide proof of the commencement and end of the interruption. The limitation of the insurance cover is such that benefits foreseen for inpatient hospital treatment are restricted to within the framework of general medical care, without selective treatment (private medical treatment) or within the framework of appropriate comparable performance (basic statutory care in the respective country), and for outpatient treatment in Germany the reimbursement rates are limited to the so-called threshold values of the scale of fees for doctors Gebührenordnung für Arzte (GOA) and dentists Gebührenordnung für Zahnärzte (GOZ). These threshold values are, in keeping with GOZ, 2.3 times the rate of the scale of fees and, in keeping with GOA, for personal treatment 2.3 times, for technical applications (benefits according to sections A, E and O of GOA) 1.8 times, and for laboratory examinations (benefits in keeping with no. 437 and section M of GOA) 1.15 times, the rate of the scale of fees for doctors.
   b) An interruption to the trip abroad is constituted by a temporary return to the home country, if the insured person returns thereafter to the foreign location in which he or she was previously located.

SECTION 4: SUBJECT MATTER OF THE INSURANCE COVER PROVIDED AND THE EXTENT OF LIABILITY IN RESPECT OF BENEFITS

1. An event covered by the insurance is that of medical treatment required by an insured person due to illness or to the consequences of an accident. The insured event begins with the commencement of required medical treatment and ends at that point in time at which medical findings deem that no further medical treatment is required. If the medical treatment has to be extended to include an illness or accident consequences not causally related to the previously administered treatment, this constitutes a new event covered by the insurance. Other cases covered by the insurance include essential medical treatment for complaints during pregnancy, premature births up to the 36th week of pregnancy, miscarriages, medically required abortions and death.
2. After deduction of the retained risk of US$31.25 per occurrence of an event covered by the insurance, the Company reimburses the standard local costs, in United States currency, for necessary medical treatment due to illness and accident during the journey. The retained risk does not apply in cases of inpatient treatment. While abroad the insured person may choose from among state recognized and licensed doctors and dentists in the given country, provided these charge for their services in accordance with the official scale of medical fees for doctors and dentists – if existing – or their fees are in keeping with those normally charged locally.

3. Within the scope of the contract, the Company pays for examination, treatment and medicaments that are widely approved in Germany by classical medicine. In addition to this, it reimburses methods and medicaments that in practice have proved just as successful, or are used because the methods of classical medicine or medicaments are not available. The Company can, however, reduce its contribution to that equivalent to the cost that would have been incurred if classical medical treatment or medicaments had been applied.

4. lf remuneration of one of the following types of performance is limited per insurance year, the insurance year is held to be the period of twelve months extending from 01.01 until 12.31 of each year. For insurance periods of less than twelve months, the reimbursement sum is calculated proportionately.

I. Costs of Medical Treatment Abroad

After deduction of the retained risk of US$31.25 per occurrence of an event covered by the insurance, the Company reimburses the costs incurred abroad for necessary medical treatment of an insured person. The retained risk does not apply in cases of inpatient treatment. The cost refund is limited per insurance year to US$250,000 per insured person.

1. Medical treatment in the sense of these terms and conditions includes:

   a) treatment by doctors as a consequence of medical complaints, including necessary treatment during pregnancy, child delivery up to the end of the 36th week of pregnancy (premature birth), treatment due to miscarriage and medically required abortions;

   b) prescribed medicaments and dressing materials (medicaments do not include foodstuffs, restoratives or cosmetic preparations – even if prescribed by a doctor);

   c) prescribed radiation treatment, light therapy and other physical forms of treatment;

   d) prescribed massages, medical packs, inhalation treatment and physiotherapy;

   e) prescribed medical supplies necessary for the first time as the result of an accident and serving to treat the consequences of the accident;

   f) X-ray diagnosis;

   g) urgent inpatient treatment, if this is given in a facility generally recognized in the country in question as a hospital, which is subject to permanent medical supervision and management, has adequate diagnostic and therapeutic capability and keeps records of clinical histories;

   h) transport by ambulance to the nearest suitable hospital for inpatient treatment, and to the nearest appropriate treatment point for primary medical care following an accident, and transport back again to one's accommodation;

   i) urgent operations that cannot be postponed;

   j) pain killing and preservative dental treatment including simple fillings and repair of existing dental prosthesis, provided this is undertaken or ordered by a dentist.

2. Newborn Babies

   In cases of premature birth, the costs of necessary treatment of newborn babies abroad are also refunded up to the sum of US$62,500.

3. Emergency Medical Evacuation

   Travel and transportation costs reasonably incurred when an insured person:

   a) cannot be safely treated at the location where the insured event occurs; and

   b) is incapable of travelling as an unaccompanied, seated passenger on a public or private conveyance; and

   c) is taken to the nearest suitable medical facility by way of the most economical form of conveyance which can be used without threat of damage to life or health.

   Provided all arrangements must be made through the Company's designated assistance companies and monitored by them on behalf of the Company.

   The Company and its service provider(s) cannot be held responsible for failure to provide services or for delays caused by strikes or conditions beyond its control, including, but not limited to, flight conditions or where local laws or regulatory agencies prohibit the Company and its service provider(s) rendering such services.

4. Repatriation of Remains

   In the event of the death of the insured person, with the Company's prior approval, its designated assistance company will assist with the necessary formalities and will be responsible for the transportation charges exclusively for repatriation of the mortal remains to home country up to the sum of US$12,500.

II. Additional Benefits after Expiry of a Waiting Period of Six Months as from the Beginning of the Insurance Cover in Keeping with this Tariff

After a waiting period of six months, the Company additionally reimburses, after deduction of a retained risk of US$31.25 per occurrence of an event covered by the insurance, the costs of

1. Medical supplies, etc., prescribed by a doctor.

   a) bandages and dressings, hernia bandages, inlays, crutches and elastic (medical) stockings at 100% of the invoice costs;

   b) first-time purchases of hearing aids, corrective splints, artificial limbs / prostheses, supportive shells for sitting and lying, seat lifts, respiration monitoring devices, intravenous piston pumps, inhalators, oxygen insufflators, surveillance monitors for infants, orthopaedic body supportive devices, arm support devices and leg support devices, as well as speaking devices subject to the prior written consent of the insurance company, at a rate of 100% of the invoice amount to a maximum of US$1,250 per insurance year;

   c) costs of repair of existing medical supplies at a rate of 100% of the invoice amount to a maximum of US$312.50 per insurance year;

2. Dental prostheses at 80% of the invoice amount up to a maximum of US$625. An insurance year is a period of 12 months as from the date of commencement of this insurance tariff and all dates of extension of contract.

III. Additional Benefits after Expiry of a Waiting Period of Eight Months as from the Beginning of the Insurance Cover in Keeping with this Tariff

After expiry of a waiting period of eight months, the Company additionally reimburses the costs of prenatal care examinations up to US$312.50 per insurance year, and the costs of child delivery by doctors up to US$6,250 per insurance year. The reimbursement of costs for corresponding examination and treatment by midwives is limited to US$2,000 per pregnancy and is only possible if the costs are not invoiced by a doctor at the same time.

SECTION 5: LIMITATIONS ON INSURANCE COVER

1. No insurance liability exists

   a) for illnesses and complaints known to the insured person at the time of conclusion of contract, or of conclusion of a follow-up contract, and their foreseeable consequences, or for the foreseeable consequences of illnesses and accidents of the insured person treated within a period of six months prior to the conclusion of contract;

   b) for treatment abroad constituting the sole reason, or one of the reasons, for embarking on the journey in the first place;

   c) for treatment for which it was clear at the time of commencement of the journey that, assuming everything went according to plan, such treatment would be necessary, unless the journey was undertaken because of the death of a husband or wife, or of a very close relative;

   d) for diseases, including the consequences of such, as well as for the consequences accidents caused by warlike occurrences, or active participation in civil disturbances and not expressly included in the insurance cover;

   e) for illnesses, accidents and their consequences resulting from wilful intent;

   f) for treatment in a spa or sanatorium as well as for rehabilitation measures, unless such treatment follows an insured period of inpatient hospital treatment due to a severe stroke, a bad heart attack or a serious skeletal disease (surgery of the intervertebral discs, hip endoprosthesis) and is intended to shorten the period of treatment in the acute hospital, and the treatment was approved by the Company in writing prior to its commencement;

   g) for withdrawal treatment including withdrawal cures;

   h) for outpatient therapy in a spa or health resort. This limitation does not apply, if the therapy becomes necessary as the result of an accident that happened there. In the event of illness, this limitation does not apply if the insured person's stay in the spa or health resort was for a short period only and was not for curative purposes;

   i) for expenses arising from the methods of treatment applied and the medicament prescribed, if such treatment / medicament is not generally scientifically recognized in either the Federal Republic of Germany or in the country of application. An exception is made here for services in accordance with Section 5, point 3;

   j) for medical supplies, even if they have been prescribed by a doctor, unless these are necessary for the first time solely as the result of an accident and directly serve to treat the consequences of the accident;

   k) for treatment administered by the insured party's spouse, parents or children. Proven material costs are reimbursed in accordance with the insurance tariff;

   l) for treatment of persons with whom the insured person lives together within his or her own family or the host family. Proven material costs are reimbursed in accordance with the insurance tariff;

   m) for treatment or accommodation due to infirmity, need of care or safe custody;

   n) for hypnotic, psychoanalytic and psychotherapeutic treatment;

   o) for dental prostheses, post crowns, inlays, caps and crowns, orthodontic treatment, prophylactic treatment, occlusal overlays and splints, analytic and therapeutic functional treatment and dental treatment in the field of implantology;

   p) for treatment of HIV infections and their consequences;

   q) for immunization measures;

   r) for treatment due to disturbances and/or damage to the reproductive organs;

   s) for suicide, attempted suicide and the consequences;

   t) for precautionary examinations;

   u) for organ donations and the consequences.

2. The Company is discharged from the obligation to compensate, if:

   a) the insured person has wilfully brought about the illness or accident;

   b) the policyholder or the insured person has wilfully attempted to deceive the Company as to circumstances of importance relating to the reason for, or the amount of, benefits presumably due.

3. Insurance cover is not provided for damage due to strike action, nuclear energy, confiscation, dispossession or other acts of high authority.

4. If the level of medical treatment provided exceeds the necessary amount or if the costs of medical treatment exceed those customarily charged locally, the Company can reduce the benefits paid by it to an appropriate level.

5. If a claim for benefits from statutory accident or pension insurance, or from statutory medical or accident care exists, the Company can, without prejudice to claims for hospital day payment benefits, deduct the level of statutory benefits due from the insurance benefits due.

SECTION 6: OBLIGATIONS AND THE CONSEQUENCES OF VIOLATION OF OBLIGATIONS

1. Obligation to Minimize Costs

   The insured persons are obliged, upon the occurrence of illness or of an accident,

   a) to keep the level of damage as low as possible and to avoid any action that could lead to an unnecessary increase in costs;

   b) in the event of inpatient hospital treatment and before the commencement of extensive diagnostic and therapeutic measures, to immediately call the Company's emergency service number at (852) 2807-1728;

2. Obligation to Give Information

   The policyholder and the insured persons are obliged, upon the occurrence of illness or of an accident,

   a) to notify the Company immediately and in any event within thirty days of the occurrence about the damage, submitting at the same time all relevant documents;

   b) to permit the Company to undertake all reasonable investigations as to the cause of the occurrence and the level of benefits due, to provide all useful information in this connection, to submit original receipts and any other evidence as may be reasonably required by the Company in respect of such occurrence no more than sixty days upon request by the Company. Late submission may result in declination of liability by the Company.

3. Written Verification

The following proof, which will become the Company's property, must be submitted to the Company:

a) claim form, original receipts bearing the name of the person treated, identification of the illness and details as to the type of treatment provided by the attending doctor, and the place and period of treatment. If other insurance cover exists and claims for medical costs have first been made to this other insurance, copies of the invoices indicating the compensation payments made are adequate as proof;

b) prescriptions together with invoices for medical treatment, invoices for medicaments and for adjuvants;

c) a medical certificate, issued by the attending doctor abroad, indicating the necessity of a medically prescribed return transportation. The requirement that agreement must be reached with the company's doctor is not affected by this;

d) further proof and receipts that the Company regards as being necessary for checking its benefit obligations, and request in the case of damage, provided their procurement can be reasonably expected of you.

4. Obligation to Secure Compensation Claims Against a Third Party

If the policyholder or the insured person has a claim against a third party, this claim passes to the Company, to the extent that the latter compensates for the damage. Such transfers of claim must not be enforced to the disadvantage of the policyholder / insured person. The policyholder / insured person must safeguard the compensation claim, or the right to secure this claim, taking account of the required form and deadline regulations and cooperating in the implementation of the claim, if necessary. If the compensation claim is directed against a person with whom the policyholder / insured person had lived in the same household at the time of occurrence of the damage, the transfer of the claim cannot be enforced, unless this person caused the damage intentionally. Claims of the policyholder, or of the insured person, against attending medical personnel or organizations on the basis of excessive fees shall pass to the Company, inasmuch as this is legally permissible, to the extent that the latter has settled the relevant invoices. If necessary, the policyholder or insured person must provide assistance in enforcing such claims. In addition, the policyholder or the insured person is obliged, if necessary, to make a declaration of assignment in favor of the Company.

5. Legal Consequences of Violation of Obligations

If the policyholder or the insured person wilfully violates a contractually agreed obligation, the Company is not obliged to pay benefits. In the case of gross negligence leading to violation of the obligation, the Company is entitled to reduce the insurance benefits by an amount corresponding to the seriousness of the fault attributable to such behavior by the policyholder or the insured person. The onus of proof that gross negligence did not play a role lies with the policyholder.

SECTION 7: PAYMENT OF INSURANCE BENEFITS, PERIOD OF LIMITATION

1. Reimbursements for costs incurred are made in United States currency.

2. lf the Company has proof of both the conclusion of an insurance contract and the payment of the premiums, and if the reason for payment of benefits and the amount of such benefits have been established, payment in compensation must be made within two weeks.

3. One month after notification of the Company as to the damage incurred, partial payment of the claim amount may be requested for the minimum sum due, on the basis of the facts on hand. This period may be extended if the processing of the claim by the Company is delayed for reasons for which the policyholder or the insured person can be held responsible.

4. Costs incurred in a foreign currency are converted to United States currency at the rate of exchange applicable on the day on which the receipts were received by the Company.

5. Claims based on this insurance contract fall under the statute of limitations after three years. The period of limitation begins at the end of the year in which the claim for benefit can be raised.

SECTION 8: INDEMNIFICATION FROM OTHER INSURANCE CONTRACTS AND CLAIMS AGAINST THIRD PARTIES

If, in the event of a claim, indemnification can be claimed from another insurance contract, this other contract is to have priority over the current contract. This also applies if, in one of the other insurance contracts, such a subordinate contract clause has also been agreed to, regardless of when the other insurance contract was concluded. If the event covered by the insurance is first reported to the Company, it will initially undertake payment and will then contact the other company directly for purposes of sharing the costs. The Company will, however, waive sharing the costs with a private health insurance company if this would be to the disadvantage of the insured person, e.g. loss of premium refund.

SECTION 9: OFFSETTING

The insured person can only offset claims of the Company to the extent that the counterclaim is uncontested, or has been legally established.

SECTION 10: DECLARATION OF INTENT AND NOTIFICATIONS

Declarations of intent and notifications intended for the Company must be submitted in writing.

SECTION 11: APPLICABLE LAW / CONTRACT LANGUAGE

This policy shall be governed by the laws of Hong Kong Special Administrative Region. The contract language is English.

SECTION 12: PROFIT SHARING COMPONENT

This insurance does not entail any participatory bonus.