HENNER SAS
INDIVIDUAL INSURANCE CONTRACT
HEALTH -1st USD/ 1st EURO

Policy No. 080719/501(USD) 080719/502 (EUR)

SUMMARY PLAN DESCRIPTION

Preamble

HENNER SAS has subscribed on behalf of its clients Members, to a Healthcare Insurance Policy with AWP Health & Life SA for the reimbursement of medical expenses.
This contract has been based on the International Expat Insurance product of Joho, previously insured by Allianz Luxembourg and reinsured by AWP Health & Life SA. In the current agreement between Henner SAS and AWP Health & Life SA, the Parties has agreed that no modifications to the benefits have been made.

The rights and obligations resulting therefrom,

- For HENNER SAS hereinafter referred to as "Policyholder " or "HENNER SAS" ;
- For the Member, who is a natural person having become a member of the Policyholder, who acquire the status of « Covered Person» or "Member" ; and
- For the insurer AWP Health & Life S.A., referred to as the « Insurer »;

are established under the terms and conditions herein which is governed by and interpreted in accordance with French law.

GENERAL CONDITIONS

PURPOSE

The present group insurance policy is governed by and interpreted in accordance with the French Insurance Code, in particular the provisions stipulated in Title IV of Book I of the Code, relating to group insurance. The statements from the Policyholder and the Covered Persons form the basis of the present contract.

The purpose the present contract is to provide all expatriate or internationally mobile client Members of the Policyholder, as defined in this policy, with the reimbursement of medical expenses
The contract consists of:

- The Membership Certificate completed and signed by the representative of the Policyholder
- A Summary Plan Description drafted by the Insurer and provided to the Policyholder specifying the benefits, effective dates, and claims procedures.

EFFECTIVE DATE, DURATION, AND RENEWAL DATE OF THE MASTER POLICY

The contract takes effect on 1st January 2022 for a period expiring on 31st December 2022.

The contract shall then be renewed subsequently by tacit agreement from 1st January of each successive year for a one-year period, unless otherwise terminated by one of the parties by registered letter sent at the latest 30th June of the current plan year.

The present contract may also be terminated on the Insurer's initiative:

- In the event of the a compulsory liquidation (or equivalent proceedings) of the Policyholder;
- in the event of non-payment of the premium in accordance with the terms defined in Title V;

The contract may also be terminated, on the initiative of the Policyholder, at any time , without fees or penalties at the expiration of a period of 1 year, starting from the first subscription.

The termination takes effect 1 month after the Insurer has received notification by registered letter, single letter, e-mail or other durable medium.

EFFECTIVE DATE, DURATION, AND RENEWAL DATE OF THE INDIVIDUAL MEMBERSHIP

For the Covered Person, the insurance membership is established by **a membership certificate signed by the Policyholder,** which includes in particular:

- the membership number,
- the effective date of the policy
- the identity of the Member and his dependants
- the geographical area of coverage
- the type and the amount of coverage

For the Covered Person, the insurance policy shall take effect on the date specified on the membership certificate.

The Membership Certificate shall then be renewed subsequently by tacit agreement for each successive year for a one-year period. The membership may be terminated, on the initiative of the Member, at any time , without fees or penalties at the expiration of a period of 1 year, starting from the first subscription.

The termination takes effect 1 month after the Insurer has received notification by registered letter, single letter, e-mail or other durable medium

The membership certificate may also be terminated in any of the following cases:

- on the date on which the Covered Person ceases to be a member of the Policyholder ,
- in case of non-payment of premium to the Policyholder ;
- following a recovery plan or a compulsory liquidation of the Policyholder
- on the date of termination of the present contract.

Withdrawal within the Cooling-off Period

The Policyholder commits to communicating the information relating to the right of withdrawal within the cooling-off period to the Covered Person.

The Covered Person may withdraw from insurance coverage within the cooling-off period of 30 calendar days from the date on which he/she is notified that the policy has been signed, by sending a registered letter with acknowledgement of receipt to:

AWP Health & Life S.A.
Client Service Relations
Eurosquare 2
7 rue Dora Maar
93400 Saint Ouen
France

The Insurer shall repay in full all sums paid by the covered Person within 30 days from the date of receipt of the registered letter.

Sample letter of Withdrawal (within the cooling-off period)

> *«I, the undersigned, Mr/Mrs/Ms. (Full name of the person concerned), residing at (Full address of the person concerned)..., withdraw from membership to the policy number. ... subscribed to by Henner with AWP Health & Life S.A., in accordance with Article L.132-5-1 of the French Insurance Code.*
>
> *I hereby certify that, on the dispatch date of this letter, I have not been aware of any claim invoking the policy coverage since the policy was concluded.*
>
> *Date:*
> *Signature:"*

COVERED PERSONS

CATEGORY OF PERSONS TO BE COVERED

All members of the Policyholder defined in the present contract shall be enrolled for benefits described herein.
All individual Expats (private persons) working abroad (and their Dependents) and Local Employees who are not eligible and not affiliated to Dutch Basic Healthcare from the age of 18 onwards of the Policyholder must be covered.

Also, retired Members who where covered by this contract at least for the past 5 years before their retirement.

ELIGIBILITY

The members of the category of Persons to be covered must, at the time of the effective date of coverage fill out and sign an Individual Application for Enrolment for Coverage consisting in:

- a medical underwriting through a health questionnaire
- an application form to be completed with :
    - the level of benefits subscribed/plan/formula; and
    - the Dependent beneficiaries defined herein of the insurance coverage.

When the Individual Application for Enrolment includes a health questionnaire, the Insurer may, if necessary, request the completion of medical formalities or production of any additional information.
The Insurer reserves the right to request any additional information it deems necessary.

Regarding Child/Children who lost their status as a dependent (by turning 28 years old or being employed), they can be enrolled as a main insured for benefits described in the present contract, on the same terms and under lighter underwriting condition as the Insurer may decide to waive medical underwriting.

The Insurer reserves the right, on the basis of the aforementioned documents and information, to limit the coverage, to reassess the policy premium indicated on the application for enrolment, or to refuse Membership.

In the event, the policy covers any Dependents, as defined herein, of the category of Persons to be covered, the Data Privacy Notice must be equally communicated by the Policyholder to the Covered Person to provide said Notice to such third parties.

The Insurer shall inform the Policyholder of the new premium rates applicable by sending it an endorsement.

The Policyholder may refuse this increase and terminate the policy by sending the Insurer a registered letter with acknowledgement of receipt within 30 (thirty) days from the date of receipt of the endorsement sent by the Insurer. The termination shall take effect on the first day of the calendar quarter following the refusal notification.

The Policyholder shall inform the Covered Person of the termination.

In the event the Policyholder fails inform the Insurer within 30 (thirty) days of its right to terminate the policy, the increase shall be deemed to have been accepted by the Policyholder.

Moreover if there any modification of the level of benefits/plan can only be taken into account every 1st January with previous written approval from the Insurer.

EFFECTIVE DATE OF COVERAGE

Once the contract has come into effect, the coverage becomes effective for each member who acquires the status of Covered Person as defined herein on the following dates:

Persons enrolled on the effective date of the policy:

- from this date

Persons enrolled after the effective date of the policy:

- on the date they join the category of Persons to be covered if their Individual Applications for Enrolment have been received within fifteen days following this date.
- otherwise, within 90 days following the date of receipt of such application.

The coverage for family members as defined herein shall take effect at the same time as the coverage for the Covered Person or, subsequently, as soon as the persons concerned meet the required conditions.

TERMINATION OR SUSPENSION OF COVERAGE

Except in the event of concealment, omission or misstatement made in bad faith, the Covered Person, once accepted, cannot be excluded from the Insurance against his/her will as long as he/she belongs to the category of Persons to be covered, subject to the provisions of Article L.141-3 of the Insurance Code.
Unless otherwise provided herein, coverage ceases in any event:

For each Covered Person:

- for each benefit, on the date on which the Covered Person ceases to belong to the category of Persons to be covered

For all Covered Persons belonging to the Category of Persons:

- upon the date of the termination of the present contract

The coverage for family members as defined herein is terminated (or suspended) at the same time as the Covered Person's coverage, except for cases mentioned hereunder.

The termination (or suspension) of the coverage results, both for the Covered Person and his/her family members, in the cancellation of entitlement to benefits for all medical care provided after the termination date, even if they have started or have been prescribed before this date.

COVERAGE AND BENEFITS

BENEFICIARIES OF COVERAGE

The beneficiaries of the coverage defined in the present contract can be **the Covered Persons and their Dependents defined hereinafter:**

Dependents
For purposes of the present contract, each reference made to the guarantees and/or the amount of the benefits herein, it shall be understood by:

Spouse/Civil Union Partner

The spouse not legally separated from the Covered Person, or his/her registered civil union partner (PACS / Civil Covenant of solidarity or local equivalent), or cohabiting partner, as registered with the appropriate regulatory authority.

Cohabitation (Common Law/Life partner)

Cohabitation means the person cohabiting with the Covered Person in a legally recognised marital/conjugal relationship and who together fulfil both of the following conditions:

- both individuals are free from matrimonial ties; and
- Cohabitation has been declared by the Covered Person to the Policyholder, who shall communicate such information to the Insurer, at the time of enrolment and the Covered Person provides a legal certificate attesting to this status.

If the cohabitation is declared subsequent to the enrolment date of the Covered Person, the person shall only be taken into account as a cohabiting partner after a 6 (six)-month period. This period is not required if a child born of this union is dependent on the Covered Person. The end of the state of cohabitation must be declared in writing by the Covered Person to the Policyholder who shall communicate this information to the Insurer.

In addition, in order to determine the lump sum in the event of death, the evidence of a marital relationship or otherwise legally recognised partnership as described hereinabove must be dated more than 1 (one year) from the date of the claim.

Only one person of the above persons shall be considered as beneficiary.

Child/Children

The unmarried Child/Children of the Covered Person and those of his/her spouse (or civil union partner PACS or local equivalent or cohabitating life partner), living in the household of the Covered Person, whether legitimate, recognized, adopted or taken in, those minors who are under the protection of the Covered Person under pre-adoptive care, are considered dependent, for tax purposes, on the Covered Person:

- Born alive at least 300 days after the death of the Covered Person; or
- if they are a legal minor; or
- no matter the age in the event they qualify and are officially recognised as handicapped/disabled in accordance with Article L.241-3 of the Family and Social Action Code; or
- if they fulfil the following conditions:
    - under the age of 28;
    - Financially dependent of the Member
    - benefit from a French social security system or local equivalent; and
    - unemployed but employed as a volunteer (unless, in the case of full-time schooling they pursue a temporary employment with a duration inferior of 3 months or employment for the training for their career with a monthly salary inferior to 80% of the French minimum wage).

Children are considered dependent on the Covered Person for tax purposes if they are:

- taken into account for at least a half-share in the calculation of the Covered Person's income tax payable in the year of the event invoking the coverage;
- students who have not chosen to be attached to the tax household and who receive a living allowance from the Covered Person which is deductible when calculating the Covered Person's taxes payable in the year of the event invoking the coverage; and
- recognised, adopted or taken in by the Covered Person, if they are dependent for tax purposes on his/her civil union partner (PACS or local equivalent) or cohabitating life partner.

The coverage shall be terminated for the beneficiaries as soon as they no longer fulfil the conditions defined hereinabove and, in any case, at the same date as the Covered Person.

However, if the Child/Children lose their status as a dependent (turn 28, employed etc.), they can be enrolled as a main insured for benefits described herein, on the same terms and under lighter underwriting condition as the Insurer may decide to waive medical underwritin.

The benefits are payable for medical care, treatments and hospitalisation occurring within the period during which the beneficiary belongs to the category defined hereinabove.

In case of death of the Covered Person, the **healthcare benefits** are maintained free of charge for all beneficiaries for one month.

These beneficiaries may request the Policyholder, within six months following the date of the Covered Person's death at the latest, to request the continuation of individual health coverage.

Personal data and/or other sensitive data are required for the underwriting, administration, and management of the present contract. Dependents and/or beneficiaries as defined hereinabove shall be considered "Data Subjects" for purpose of the application of the Regulation as defined herein and in the annex hereto.

BENEFITS

Scope

The guarantees granted to each Beneficiary including amounts and maximum limitations are provided in the Table of Benefit hereafter.

The benefits consist in covering the costs incurred by the Covered Person.

The benefits consist in covering the medical expenses incurred by the Covered Person.

Medical care to be covered must be recognised by the local medical authorities and provided by authorised practitioners (in compliance with the laws, regulations or other reasonable and customary relating to the practice of this profession in the country concerned).

If one of the Covered Person's beneficiaries is covered by French Social Security or equivalent, the benefits he/she receives from such organisation shall be deducted from the benefits payable under this policy.

If the spouse (or civil partner (PACS) or cohabitating partner) is employed, the benefits from the Insurer are paid in addition to any health plan he/she may personally benefit from.

Description of benefits

Eligible Medical Expenses, subject to the exclusions, limits and ceilings mentioned in this policy, are listed in the table of benefit above. The International Medical Insurance reimburses eligible Reasonable and Customary expenses for outpatient as well as inpatient medical services, provided that these expenses have been incurred because of Illness, Accident or maternity. Moreover, to qualify for reimbursement, all Treatments and procedures have to be Medically Necessary and appropriate (consistent with the diagnosis as established by a Doctor). They have to be prescribed by a Doctor, and performed by a Doctor or by a legally qualified and duly licensed medical practitioner. The reimbursement ceilings (i.e. the maximum amount of reimbursement) for certain types of medical services are - unless indicated otherwise in the table of benefit – always applicable per Insured and per Insurance Year. This means that each ceiling is applicable for a twelve-month (12-month) period of uninterrupted cover, starting on the effective date of coverage of the Insured.

- Inpatient Treatment

Prior approval as stated herein is always required except in case of emergency. Failure to comply with this prior approval requirement will lead to a reduction of the reimbursement with twenty (20)%.

- Hospital room and board

Reimbursement of the Reasonable and Customary charges for room accommodation and meals. The amount of the benefit shall be equal to the actual charges made by the hospital during the Insured's stay but in no event shall the benefit exceed, for any one (1) day, the rate of a Standard Private Room.

- Intensive Care Unit

Reimbursement of the Reasonable and Customary charges for actual room and board incurred during the Insured's stay as an inpatient in the Intensive Care Unit of the hospital. This benefit shall be payable equal to the Reasonable and Customary actual charges made by the hospital. No hospital room and board benefits shall be paid for the same hospitalisation period where the daily Intensive Care Unit benefit is payable.

- Doctor's fees
  - Surgical fees

Reimbursement of the Reasonable and Customary charges for Surgery by a Specialist within the maximum indicated in the Table of benefits.

  - Anaesthetist's fee

Reimbursement of the Reasonable and Customary charges by the anaesthetist for the administration of anaesthesia not exceeding the limits as set forth in the Table of benefits.

- Other medical expenses
  - Operating theatre

Reimbursement of the Reasonable and Customary operating and recovery room charges incidental to the surgical procedure.

  - Hospital supplies and services

Reimbursement of the Reasonable and Customary charges actually incurred for general nursing, prescribed and consumed drugs and medicines, dressings, splints, plaster casts, medical imaging (x-ray, CT, MRI, etc), medical aids, laboratory examinations, electrocardiograms, physiotherapy, logopaedic Treatment, speech therapy, occupational therapy and ergotherapy.

- Parent accommodation

Reimburses up to the limits stated in the Table of benefits the expenses for meals and lodging for accompanying an insured dependent child, aged below sixteen (16) years, in hospital.

- Hospital cash benefit

Hospital cash benefit is the daily allowance, only when room and board and Treatment are received free of charge. It amounts to 75 EUR/93.75 USD per night (Essential plan) or 100 EUR/125 USD per night (Silver , Bronze and Gold plans) with a maximum of sixty (60) nights.

- Convalescence and rehabilitation

Convalescence and rehabilitation rest/care (in a recognised centre and when the admission is medically motivated) is covered when the admission immediately follows (within five (5) days) a hospitalisation for Illness or Surgery and with a maximum of twenty-eight (28) days.

- Outpatient Treatment

This benefit provides for the reimbursement of actual expenses incurred for Outpatient Treatment subject to the stated sub-limits set forth in the Table of benefits (if applicable).

- Doctor's fees

Consultation with a legally registered General Practitioner, Family Doctor, Specialist Doctor as a result of Illness and bodily Injuries, when hospitalisation is not required.

- Diagnostic tests

Reimbursement of the Reasonable and Customary charges for tests (ECG, x-ray, laboratory tests, etc) which are performed for diagnostic purposes on account of an Injury or Illness, within the amount as set forth in the Table of benefits and which are recommended by a qualified medical practitioner.

- Prescription Drugs/Medicines

Only drugs that are prescribed by a Doctor and that are not available without prescription can be reimbursed. OTC ('over-the-counter') medicines do not qualify for reimbursement, nor do lifestyle products, dietary products, vitamins, food supplements etc. For vaccines, the special provisions of the Vaccination benefit apply.

- Preventive care and wellness benefits
  - one (1) adult physical examination per Insurance Year;
  - one (1) routine eye test per Insurance Year;
  - one (1) (bilateral) mammogram per Insurance Year for insured females as of age thirty-five (35);
  - one (1) Pap smear test per Insurance Year for insured females as of age thirty-five (35);
  - one (1) PSA test per Insurance Year for insured males as of age fifty (50);
  - well-baby care.

- Vaccinations (adults and children)
  - travel vaccinations
  - preventive vaccinations and immunisations for young children.

- Physiotherapy

Physiotherapy prescribed by a Doctor, including Mensendieck physiotherapy, is covered on condition that the medical prescription clearly mentions the need for this specific form of physiotherapy and on condition that the care provider is a certified physiotherapist.

- Treatments performed by complementary medical practitioners
  - chiropractor;
  - osteopath;
  - acupuncturist;
  - homeopath.

These Treatments have to be prescribed by a Doctor.

- Other Medical Treatment

These benefits provide for the reimbursement of actual expenses incurred subject to the overall annual limit per Insured per Insurance Year for:

- Kraamzorg

The first 8 days following the childbirth you can get kraamzorg. You need to arrange the kraamzorg yourself. Costs can be reimbursed, this cover is included in the 'Childbirth' benefit. If there is a medical reason concerning the child why you might need more than 8 days of kraamzorg you can get an extension of kraamzorg cover. See coverage overview. Pre-authorization applies on the extension of kraamzorg cover.

- Pregnancy

Costs are reimbursed according to the type of Outpatient Treatment.

- Childbirth

The covered amount includes reimbursement for Doctor's fees, hospital accommodation and other related medical expenses incurred during the hospital stay. Elective caesarean Surgery is excluded from cover.

However, if caesarean Surgery is Medically Necessary, it is covered as Inpatient Treatment. All other deliveries with complications are also covered as Inpatient Treatment.

The complications of pregnancy are the following :

- Ectopic pregnancy, medically prescribed abortion,
- Hydatidiform mole (abnormal cell growth in the womb)
- Retained placenta (afterbirth retained in the womb)
- Placenta praevia
- Eclampsia (a coma or seizure during Pregnancy and following pre-eclampsia)
- Diabetes during pregnancy
- Post partumhaemorrhage (heavy bleeding in the hours and days immediately after childbirth)
- Miscarriage requiring immediate surgical treatment

- Infertility Treatment
  - Infertility diagnosis

Investigative procedures necessary to establish the cause of infertility.

  - Infertility Treatment

The expenses related to Infertility Treatment are covered as outpatient or inpatient expenses, subject to the following conditions:
it has to concern a primary infertility;

- maximum four (4) attempts per female Insured person and per lifetime are covered;
- maximum 4,200 EUR/5,250 USD per attempt;
- maximum age of the female Insured person of forty (40) years;
- the expenses related to the sperm/egg donation are not covered;
- the expenses related to a surrogate mother are not covered;
- prior approval of the Insurer's medical consultant is always required.

  - Expenses related to sterilisation

One (1) sterilisation per Insured and per lifetime.

  - Ceiling

For the expenses related to artificial insemination (AI) and other similar Treatments, there is no maximum number of attempts.

  - Waiting period

There is a ten-month (10-month) waiting period for all medical expenses related to Pregnancy, Childbirth and Infertility Treatment meaning that only expenses incurred as from the eleventh (11th) month after acceptance into the insurance can be eligible for reimbursement.

- Cancer Treatment

If an Insured is diagnosed with cancer as defined below, the Reasonable and Customary charges incurred for the Treatment of cancer performed at a legally registered cancer Treatment centre will be reimbursed subject to the limit specified in the Table of benefits. Such Treatment (e.g. radiotherapy or chemotherapy excluding experimental Treatment, consultation, examination tests) must be received on an inpatient or outpatient basis at a hospital or a registered cancer Treatment centre immediately following diagnosis, or discharge from hospital stay or Surgery. Cancer is defined as uncontrollable growth and spread of malignant cells and the invasion and destruction of normal tissue for which major interventionist Treatment or Surgery (excluding endoscopic procedures alone) is considered necessary. The cancer must be confirmed by histological evidence of malignancy.

- Organ transplant

Reimburses Reasonable and Customary charges incurred for transplantation Surgery for the Insured being the recipient of the transplant of an organ. Payment for this benefit is applicable whilst the policy is in force and shall be subject to the limit as set forth in the Table of benefits. The covered amount includes Doctor's fees, hospital accommodation (Standard Private Room) and other related medical expenses during the

hospital stay. Prior approval of the medical consultant of the Administrator is always required. Following expenses are excluded from cover:

- costs related to the search for a donor;
- costs for acquisition of the organ (in case a price is charged for the organ);
- costs incurred for removal of organ from the donor.

- Kidney dialysis

If an Insured is diagnosed with kidney failure as defined below, Reasonable and Customary charges incurred for the Treatment of kidney dialysis performed at a Hospital or at a legally registered dialysis centre will be reimbursed subject to the limits as specified in the Table of benefits. Such Treatment (dialysis excluding consultation, examination tests) must be received on an inpatient or outpatient basis. Kidney failure means end stage chronic renal failure which indicates the irreversible loss of the ability of both kidneys to function as a result of which renal dialysis is initiated. These benefits exclude all experimental Treatments.

- Medical aids

Reimbursement of expenses for hearing aids, orthopaedic appliances and stockings, artificial limbs, wheelchairs, etc.

- Local ambulance to the nearest hospital

Reimbursement of the Reasonable and Customary charges incurred for necessary domestic ambulance services (including attendant) to and/or from the hospital. Reimbursement is subject to the maximum limit set forth in the Table of benefits. Payment will not be made if the Insured is not hospitalised.

- Psychiatric care

Outpatient psychiatric care only reimburses care prescribed by and performed by a Doctor. The covered amount includes fees of the Doctor and/or (Treatment fees of) the medical practitioner, but does not include drugs. Drugs are covered according to the provisions for Prescription Drugs. The following expenses will also fall under the same ceiling as outpatient psychiatric care: ergotherapy, logopaedics and/or speech therapy, occupational therapy.

- Dental Treatment following Accident

Dental Surgery is only covered if required to restore damage to natural teeth as a result of an Accident.

- Palliative care

Palliative care may be as an inpatient or outpatient at home, or at a centre for controlling pain and other symptoms, and provides psychological and social support (medical and paramedical) for the patient and patient's family during the last stages of life. Palliative care is offered as an alternative to eligible hospital Treatment or nursing at home. Palliative care has to be given by an organisation providing services for patients whose Illness cannot be cured with a life expectancy of less than six (6) months.

The medical costs must have been incurred within the insurance period in one of the countries of the coverage geographical area as defined herein :

Worldwide except USA

However, during business trips or holidays, not exceeding ninety (90) days (in total) per Insurance Year, medical expenses incurred in the USA as a direct consequence of an Accident or a Medical Emergency are covered up to the limits of the policy. If the medical condition concerned already existed prior to the travel to the USA or was the objective of the travel, the medical expenses are not covered. Expenses related to pregnancy (and complications thereof) and/or childbirth will not be considered to be Accident or emergency expenses, and will therefore not be covered.

Claims for Medical Expenses

A medical expenses claim form is provided by the Insurer and must be submitted with the relevant supporting documents.

Scanned copies of original invoices sent by e-claiming for all claims up to 1 000 USD/EUR are accepted. In this case, the Covered Person has to keep the originals available for the insurer to consult for 24 months from the date of the treatment. During this period the insurer may ask the Covered Person to send these originals and if the Covered Person fail to do so it may affect his claim.

The Insurer may request, if necessary, any further documentation necessary for the application of this coverage.

The Covered Person shall be liable for any information provided by him/her or one of his/her dependents which appear to be false, forged or exaggerated, or any fraudulent or deceitful action by them and all undue payments paid by the Insurer on the basis of these incorrect data shall be recovered.

Benefit Amount

The benefit amount is determined for each itemized expense as provided for in the Table of Benefits herein and limited to reasonable and customary expenses.

The reasonable and customary nature is determined according to the medical practice which prevails in the country where the care is provided (treatment type, care and medical equipment quality, geographical area and country) and is subject to coding and rating standards of the medical procedures and treatments referenced or nomenclature in each country.

The unreasonable and uncustomary nature may lead to the denial of reimbursement or a limitation on the reimbursement amount.

Prior approval – Limitation on Actual Costs

Prior approval

The reimbursement of expenses is subject to prior approval by the Insurer, except in the event characterised as an "emergency", in the cases provided in the Table of Benefits.

Except in case of emergency, for every admission to the hospital, the Insurer must be notified at least two (2) weeks before said admission.

The Insurer's approval is deemed to be obtained if it has not responded otherwise, within 5 working days following the date of receipt of the request.

In the event that the request of prior approval has not been submitted and, subsequently, treatment becomes medically necessary, and only in this case, the Insurer shall then cover only 80% of the hospital care expenses and 50% of the amount payable for any other similar care that should have been reimbursed.

Prior approval is not necessary in case of emergency as defined in the present contract. Nevertheless, the Insurer should be notified within 48 hours following hospitalisation or, in case of force majeure, as soon as possible. The provisions relating to the reasonable and customary expenses in the country where care is provided shall apply in all cases.

Limitation on Actual Costs

Pursuant to Article 9 of the Act no. 89-1009 of 30th August 1990 and the Decree no. 90-769 of 30th August 1990, the reimbursements or payment of the expenses incurred from illness, maternity or an accident shall not exceed the amount of the expenses remaining payable by the Covered Person after the payment of the benefits of any type he/she is entitled to.

Coverage of the same nature subscribed to with several insuring bodies shall be enforceable up to the limit on each benefit, no matter the date the coverage was subscribed to. Within this limit, the policy beneficiary

of the contract may obtain supplemental compensation by submitting the detail of the reimbursement(s) paid by the other insuring body (ies).

For the purpose of the aforementioned provisions, the limitation on the amount of the expenses remaining payable by the Covered Person is determined by the Insurer for each medical act, treatment or item.

Main plan

Types of International Medical Insurance plans
There are four (4) different plans:

- Essential;
- Bronze;
- Silver *)
- Gold;

*Silver plan cannot be chosen anymore

The plan chosen by the Policyholder is mentioned in the Membership Certificate of the insurance policy. Each plan corresponds to a different level of benefits, details of which are mentioned in the table of benefits above.

International Medical Insurance
All benefits are valid per insured person, per Insurance Year (unless specifically stated).

BENEFITS	JOHO International Expat Insurance Package		
	Essential (New)	Bronze (New)	Gold
Maximum annual reimbursement per insured	€ 500 000 $ 625 000	€ 1 000 000 $ 1 250 000	€ 3 000 000 $ 3 750 000
Area of cover	Worldwide excluding USA (In case of Accident and Emergency treatment in USA, you are covered up to 90 days during each Insurance year excluding pregnancy related costs (and complications thereof) and childbirth,see conditions for more information)		
Deductible for outpatient treatment, per insured and per insurance year	N/A	€0 - $0 €100 - $125 €300 - $375 €1000 - $1250 €2500 - $2675	€0 - $0 €300 - $375 €500 - $625 €1000 - $1250 €2500 - $2675
HOSPITALISATION			
Hospital room & board	100% of semi private	100% of semi private or 80% of standard private room	100% of standard private room
Intensive care	100%	100%	100%
Doctor's fees (surgeon, anesthetist)	100%	100%	100%

Physician and therapist fees	100%	100%	100%
Medical devices and prostheses	100%	100%	100%
Other medical expenses (medical imaging, drugs and dressings, use of operating room, etc.)	100%	100%	100%
Hospital accommodation in intensive care unit (ICU)	100%	100%	100%
Organ transplant (excluding costs for donor)	100% up to € 100.000 $ 125.000	100% up to € 100.000 $ 125.000	100% up to € 150.000 $ 187.500
Kidney dialysis (excluding experimental treatments)	100%	100%	100%
Cancer treatment (excluding experimental treatments) : . Hospitalization and chemo- or radiotherapy · Other costs	100%	100%	100%
AIDS / HIV Treatment	100% Up to € 50.000 $ 62.500	100%	100%
Parent accommodation of one parent for child < 16	100% up to € 1.500 per stay / $ 1.875 per stay	100% up to € 1.500 per stay / $ 1.875 per stay	100% up to € 1.500 per stay / $ 1.875 per stay
Out-patient surgery	100%	100%	100%
Nursing at home	80% up to € 160 / $ 200 per day (maximum 60 days)	80% up to € 160 / $ 200 per day (maximum 60 days)	100% up to € 200 / $ 250 per day (maximum 100 days)
Local ambulance (to nearest hospital)	100% up to € 1.500 / $ 1,875	100% up to € 1.500 / $ 1,875	100% up to € 4.500 / $ 5,625
Complications of pregnancy	Not covered	100%	100%
Accident related dental Treatment · Emergency dental Treatment · Dental Surgery	100%	100%	100%
Palliative care	80% up to € 40.000 / $ 50.000	80% up to € 40.000 / $ 50.000	100% up to € 50.000 / $ 62.500
Chronic and pre-existing conditions	Not covered	Covered [1]	Covered [1]
Rehabilitation and convalescence rest/care (when the admission	Not covered	Not covered	100% (max. 28 days)

immediately follows hospitalisation)			
Psychiatric care	Not covered	Not covered	100% up to € 20.000 / $ 25.000
New born [2]	Not covered	100% if the childbirth is covered under this policy	100% if the childbirth is covered under this policy
PREGNANCY AND CHILDBIRTH (a waiting period of 10 months is applied)			
Pregnancy	Not covered	Reimbursement according to type of outpatient treatment	Reimbursement according to type of outpatient treatment
Infertility treatment and sterilization (IVF, ICSI, AI and all similar treatments) (limit per lifetime)		Not covered	100 % up to max. € 16 800 / $ 21.000 (4 x € 4.200 / $ 5.250)
Childbirth (without complications)		80% up to € 7.500 / $ 9.375	100% up to € 10.000 / $ 12.500
Childbirth (with complications)		Covered under "Complications of Pregnancy" Benefit in the Hospitalisation Plan	Covered under "Complications of Pregnancy" Benefit in the Hospitalisation Plan
Kraamzorg, from the 9th day following the childbirth.The first 8 days are included in your "Childbirth" benefit		80% up to €160/day (maximum 60 days)	80% up to €160/day (maximum 60 days)
OUTPATIENT TREATMENT			
Doctor's fees (generalist, specialist)	Not covered	100%	100%
Diagnostic tests, lab tests, medical imaging (x-ray, MRI- and CT- scans)		100%	100%
Prescribed drugs		100%	100%
Physiotherapy		100% up to €1.000 / $1.250	100% up to €3.000 / $3.750
Preventive care & well-being benefit: · Check-up · Eye test · Mammogram		100% up to €300 / $375	100% up to €1.000 / $1.250

· Pap-smear test · PSA-test			
Vaccinations		100% up to €200 / $250	100% up to €600 / $750
Alternative medicines such as homeopathy, acupuncture, chiropractry and osteopathy		100% up to €500 / $625	100% up to €3.000 / $3.750
Therapy: · Ergotherapy · Logopaedics and/or Speech therapy · Psychiatric outpatient care		Not covered	50% up to €2.000 / $2.500
HIV / AIDS treatment		100%	100%
Psychiatric care		Not covered	see Outpatient Treatment Therapies
PROSTHESES			
Medical aids (e.g. hearing aids and orthopedic appliances)	Not covered	100% up to € 1.500 / $ 1.875	100% up to € 3.000 / $ 3.750
VISION			
Vision care (glasses, frames, contact lenses)	Not covered	100% up to € 100 / $ 125	100% up to € 300 / $ 375

1. Acceptance of your application is subject to a medical questionnaire and approval by our Medical Advisory Board.
2. Enrolment of newborns

- Essential plan: Newborn children can be enrolled subject to the completion of a medical questionnaire and approval by our Medical Advisory Board.
- Bronze and Gold Plans: Newborns whose birth is covered under this policy can be enrolled if registered within 2 months of delivery. For all other cases, enrolment is subject to the completion of a medical questionnaire and approval by our Medical Advisory Board.

Additional Insurances : Dental Care

DENTAL	Dental 1	Dental 2
Maximum annual reimbursement per insured	€3.000 / $3.750	€5.000 / $6.250

Basic dental care (check-ups, basic treatments	80% up to € 1.500 / $ 1.875	100% up to € 2.500 / $ 3.125
Major dentistry (orthodontic, prostheses, bridges, implants) Orthodontic Treatment is only covered if started before age 15. A waiting period of 12 months applies to all major dentistry for individuals.	60% up to € 1.500 / $ 1.875	80% up to € 2.500 / $ 3.125

Eligibility

Dental Care is only open to Insured who are accepted into the International Medical Insurance plan. The choice for taking out the Dental Care insurance has to be made on a family level in that sense that all members of the same family, i.e. the Insured and his/her insured Dependents who are accepted into the International Medical Insurance plan, have to

- take out Dental Care or not (i.e. all family members or none);
- opt for the same Dental Care cover (Basic or Comprehensive).

If the Dental Care cover has been subscribed, it has to be maintained for at least one (1) year (unless the contract is terminated). Children of less than two (2) years old do not pay premium and thus are not covered for Dental Care.

Territorial scope of the insurance

With respect to the Main Plan and the additional Dental care insurance, the territorial scope on the insurance is worldwide cover with exception of medical expenses incurred in the United States of America (USA). However, during business trips or holidays, not exceeding in total ninety (90) days per Insurance Year, medical expenses incurred in the USA as a direct consequence of an Accident or a Medical Emergency are covered up to the limits of the policy and up to ninety (90) days per Insurance Year. If the medical condition concerned already existed prior to the travel to the USA and was the objective of the travel, the medical expenses are not covered.

Benefits

Only expenses that are Reasonable and Customary can qualify for reimbursement, subject to the limits and ceilings as mentioned in the Benefits Overview above.

1. Basic Dental Care - Basic Dental Care includes up to two (2) periodic check-ups per year, prophylactic Treatments, fillings, root canal Treatment, extraction, paradental Treatment, Treatment of parodontosis, Treatment of gums, etc.
2. Major dentistry - Major dentistry covers bridges, implants, orthodontic Treatment and dental prostheses (dentures, crowns, inlays). The amount covered includes the fees of the Dentist (or dental surgeon). Dental Surgery is included under major dentistry.

Waiting period and age limit

A waiting period of twelve (12) months applies for all major dentistry. Orthodontic Treatment is only covered if started before age fifteen (15).

Other provisions

Apart from the general policy provisions as set out in Chapter I of the General Conditions, the provisions of Art. II-1.h). up to and including II-1.j). also apply to the Dental Care cover.

EXCLUSIONS

FORFEITURE OF THE RIGHT TO A BENEFIT

The Covered Person is deprived of all rights to the benefits of a claim in the event the Covered Person voluntarily makes a false declaration about that claim including the date, nature, causes, circumstances and/or consequences and/or amount of the loss.

The forfeiture of this right also applies in the event the Covered Person knowingly uses inaccurate documents as supporting documents for that claim.

EXCLUDED RISKS

Any costs resulting from the following events are not covered by the Insurer:

- A claim arising directly or indirectly from the decay of an atomic nucleus,
- the consequences of a civil or non-civil war, an insurrection, a riot, an attack, a commotion or acts of terrorism, whatever the place of these events and their protagonists, except if the covered person does not take an active part in such event or if he/she is called upon to perform a maintenance or monitoring mission in order to ensure the security of people and goods for the Company.

The Insurer reserves the possibility of modifying the coverage for one or several specific territories, subject to a fifteen days prior notice sent to the Company. This one may refuse this modification and terminate the policy by sending the Insurer a registered letter with acknowledgement of receipt within 30 days from the date of receipt of the endorsement submitted by the Insurer. The termination shall take effect on the first day of the calendar quarter following the refusal notification.

EXCLUDED BENEFITS

The following benefits are not covered by the present contract, unless otherwise stipulated or to the exclusion of the benefits specified as being covered in the Table of Benefits hereinabove:

- Treatments provided outside the geographical area of the coverage as set out in the membership Certificate , except as provided for in Article 10.1.4,
- Any form of experimental or uncontrolled treatment which does not follow customary or traditional, commonly accepted medical practices, unless the Insurer has given its specific consent, and any form of treatment non recognized by the medical authorities where the treatment took place, or in the country of origin of the covered person ;
- Any preventive treatment, excepted the mandatory vaccination requested on the country of expatriation, health check-up, as well as screenings,
- Ancillary or "comfort" costs in case of hospitalisation (telephone, television, hotel, Internet)
- Medical cares or treatments for drug addiction or alcoholism,
- Disintoxication treatments,
- Any surgery or treatment relating to a gender reassignment,
- Medical checks, studies, treatments, consultations and complications relating to sterility, sterilization, sexual dysfunctions, contraception including insertion or removal of contraceptive devices, induced termination of pregnancy, except in the case of an interruption of pregnancy medically necessary and performed in compliance with local legislation,
- The sterility, the diagnostics, treatments or complications arising from the sterilisation, the sexual dysfunction and the contraception, including the introduction or extraction of contraceptive device and any other contraceptive's methods, even if prescribed, unless mentioned in the Table of Benefit
- Any elective/voluntary surgery and/or plastic/aesthetic surgery,
- Aesthetic treatments and consultations, rejuvenation cures, slimming cures,

- Thermal cures,
- transportation and accommodation costs relating to thermal cures,
- Medical costs relating to a stay in thalassotherapy centre or fitness centre, even if this stay is medically prescribed,
- Medical costs relating to a stay in a rest home or a convalescent home, except if this stay results from an hospitalisation or a severe surgery assessed by the Insurer's doctor, for the Essential and Bronze pan only
- Outpatient consultations of psychotherapy, psychoanalysis and the relevant treatments,
- Consultations, treatments and complications relating to hair loss or hair transplantation, unless this treatment results from a hair loss caused by a serious illness,
- Treatments to modify the refraction of an eye or both eyes (laser eye correction), including refractive keratotomy (RK) and photorefractive keratotomy (PRK),
- Non-prescription medicines and non-prescribed para-pharmacy.
- participation in any sport as a professional or under contract providing remuneration, as well as any preparatory training.
- elective caesarean delivery expenses;
- remedial teaching;
- expenses resulting from maternity and childbirth during the first ten (10) months - except pregnancy with complications - after the individual inception date of cover unless explicitly waived in his membership certificate;
- OTC ('over-the-counter') medicines; lifestyle products, dietary products, vitamins, food supplements and food products, baby food, mineral waters, tonics, cosmetic products etc;
- sunglasses and orthoptic Treatment;

DEFINITIONS

'Accident'
A sudden, unexpected event, the cause of which is situated outside the victim's body, which results in bodily Injury. Following events are also considered to be Accidents:

- a rescue attempt of persons or goods in peril;
- gas or vapour inhalation and the absorption of poisonous or corrosive substances;
- dislocations, distortions, ruptures and muscular lacerations provoked by a sudden effort;
- freezing;
- drowning.

'The International Expat Insurance Life Insurance'
The Life/Disability plan proposed by Henner SAS to its members namely individual expatriates . The plan is subject to payment of premiums.

'Annual Renewal Date'
For individual contracts only, 1 January..

'Chronic Conditions'
Illness or Injury which has one or more of the following characteristics:

- is recurrent in nature;
- is without a known, generally recognised cure;
- is not generally deemed to respond well to Treatment;
- requires palliative Treatment;
- requires prolonged supervision or monitoring;
- leads to permanent Invalidity.

'Deductible'

The (first) part of the (eligible) medical expenses, not reimbursed by the Insurer and deducted from the amount (of Eligible Medical Expenses) on which the reimbursement is calculated.

'Dependent'
The legal spouse (or legal partner) and/or unmarried children, until the thirty-first (31st) of December of the year of the twenty-eighth (28th) birthday of the insured child, who are financially dependent on the Insured.

'Doctor'
A person who graduated from a recognised medical school as listed in the WHO World directory of medical schools and who is licensed to practise medicine in the country where the Treatment is received.

'Expat (or Expatriated person)'
A person living and working abroad (outside his/her Home Country).

'Family Doctor or GP (General Practitioner)'
A Doctor providing Medical Treatment not requiring a specialist Doctor's training.

'GP (General Practitioner)'
See definition of 'Family Doctor'.

'Home Country'
The country where the Insured normally resides or used to reside and out of which he/she is expatriated to another country (as declared in the Application form). If the Home Country cannot be named according to this definition, it is the country of which the Insured has the nationality and is holding a passport from.

'Host Country'
The country where the Insured is expatriated to, as declared in the Application form.

'Illness'
A condition marked by a pathological deviation from the normal healthy state confirmed by a Doctor.

'Injury'
Bodily Injury caused solely by Accident.

'Insurance Year'
A twelve (12)-month period, starting on the1st January and terminating 31st December of each year.

'Insured'
The person(s) covered by the International Expat Insurance Package and whose name(s) is(are) mentioned in the Membership Certificate.

'Insurer'
The insurance company underwriting the risks set forth in the International Expat Insurance : AWP Health & Life SA

'Invalidity'
Incapacity of permanent nature, caused by a chronic Illness or Injury.

'Local employee'
A person living and working in the Netherlands who is not eligible and not affiliated to Dutch Basic Healthcare.

'Medical Emergency'

An accidental Injury or a sudden and unexpected onset of a change in a person's physical or mental condition which, if the procedure or Treatment was not performed immediately could reasonably be expected to result in loss of life or limb or significant impairment to bodily function or permanent dysfunction of a body part, as determined by the Doctor in attendance.

'Medically Necessary'
A medical service which is:

- consistent with the diagnosis and customary Medical Treatment for a covered Illness or Injury;
- in accordance with standards of good medical practice, consistent with current standard of professional medical care, and of proven medical benefits;
- not for the convenience of the Insured or the Physician, and unable to be reasonably rendered out of hospital (if admitted as an inpatient);
- not of an experimental, investigational or research nature, preventive or screening nature;
- for which the charges are fair and reasonable for the Treatment.

'Member' is the expatriate individual or the company that has been accepted as a member of HENNER SAS.

'Physician'
See definition of 'Doctor'.

'Policy Renewal Date'
1st January of each year

'Pre-existing Conditions'
Medical conditions or any related conditions, for which symptom(s) has/have been shown at some point during the five (5) years prior to commencement of cover, irrespective of whether any Medical Treatment or advice was sought. Any such condition or related condition, about which the Insured or his/her Dependents know, knew or could reasonably have been assumed to have known, will be deemed to be pre-existing.

'Self-employed person'
A person who owns a company and works for him/herself rather than for an employer.

'Sickness, disease or illness'
shall mean a condition marked by a pathological deviation from the normal healthy state confirmed by a doctor.

'Specialist Doctor'
A Doctor having a specialised qualification in the field of, or expertise in, the Treatment of the Illness or Injury.

'Starting self-employed person'
A person who owns a company for less than three years and works for him/herself rather than for an employer.

FORMALITIES IN THE EVENT OF A CLAIM

In case of hospitalisation

- The hospitalisation supporting documents (invoices, notes of fees),

In case of illness

- the detailed invoices,

In case of home childbirth

- a copy of the child's birth certificate,

The Insurer reserves the right to request any other supporting documentation necessary process the claim.

Assessment of the Claims

Within the context of reviewing the claim, that the Insurer's advising medical expert may request any other supporting documentation necessary to process the claim. Insofar as the documentation listed herein to be submitted is incomplete, gives rise to doubt, or the Insurer is unable to investigate thoroughly its obligation to pay the claim, the Insurer's advising medical expert is entitled to request data from the following organisations and persons subject to Article 5.8 hereinabove and as defined in the Data Privacy Notice

- Doctors,
- Hospitals,
- Other medical institutions,
- Care homes,
- Caregivers,
- Other personal insurance providers,
- Statutory health insurance bodies,
- Occupational insurance organisations and
- Official bodies

In the event the members of the category of covered persons, including dependents, where applicable, as defined herein, , explicitly reject concrete data collection in the context of claims processing or revoke consent the benefit may not become due if the Insurer is unable to determine whether and to what extent the Insurer is liable for payment of the claim.

The Insurer shall not otherwise be held liable by the Policyholder for the impossibility of performing the services under the present contract.

Any fraud, misstatement or concealment in relation to any matter affecting the insurance or in connection with any claim shall render the cover of a Covered Person null and void and have the result that all claims there under are forfeited as provided herein.

OTHER PROVISIONS

Scope of coverage

Unless otherwise stipulated in this policy, the coverage may be invoked 24 hours a day, both in professional and private life in the event of illness or accident and in the geographical area as indicated in herein (Article 11.1.4.)

Claims

Any event that may give entitlement to benefits must occur during the effective period of the coverage concerned and be declared within the periods stipulated therein or, if no period is stipulated, within six months following the event.

Except in the event of force majeure, illnesses or accidents not declared within six months following the beginning of the sick leave shall be excluded from the coverage and therefore be not subject to compensation, provided that the absence or delay in declaring the claim has resulted in prejudice to the Insurer.

The Summary Plan Description given to each Covered Person by the Policyholder lists the supporting documents required to be submitted to the Insurer.

LIMITATION ON ACTIONS

The provisions relating to the statute of limitations on actions arising from the insurance contract are established by Articles L.114-1 - L.114-3 of the French Insurance Code indicated hereafter:

Article L.114-1 of the French Insurance Code
All actions arising from an insurance contract are limited to two years after the incident giving rise thereto. However, this statute of limitations only applies:

1° In case of concealment, omission, false or inaccurate declaration of the risk involved, from the day on which the insurer had knowledge thereof;
2° In the event of a claim of damages, from the day on which the parties involved became aware thereof, if they prove that they were unaware of it until then.
When the action of the Insured Party against the Insurer is due to the action of a third party, the statute of limitations only starts to run from the day on which the third party initiated legal proceedings against the Insured Party or was compensated by him.
The limitation is extended to ten years in life insurance contracts when the beneficiary is a person distinct from the policyholder and, in accident insurance contracts affecting people, when the beneficiaries are the beneficiaries of the deceased insured party.
For life insurance contracts, notwithstanding the provisions of Item 2, the actions of beneficiaries are limited to thirty years after the death of the Insured Party.

Article L. 114-2 of the Insurance Code The running of the statute of limitations is interrupted by one of the ordinary causes of interruption and by the appointment of experts following an incident. The interruption of the statute of limitations of the action can furthermore result from the sending of a registered letter with return receipt requested sent by the Insurer to the Insured Party regarding the action for the payment of the premium and by the Insured Party to the Insurer for the payment of the compensation.

Article L. 114-3 of the Insurance Code
As an exception to article 2254 of the French Civil Code, the parties to the insurance contract cannot, even by joint agreement, modify the duration of the statute of limitations, nor add to the causes of its suspension or interruption.

Additional Information:
The ordinary causes of interruption of the statute of limitations are mentioned in Article 2240 and in accordance with the Civil Code; among the latter include notably: the questioning of one of the joint debtors by a judicial action or by an act of compulsory execution or the acknowledgement by the debtor of the right of the person against whom he applied the statute of limitations. For the exhaustive list of the ordinary causes of interruption of the statute of limitations refer to the aforementioned articles of the Civil Code hereinabove.

SUBROGATION

Pursuant to the French Insurance Code, the Insurer may be subrogated to the right of the person entitled to benefits in order to exercise any recourse proceedings against any liable third party.
The Insurer waives its right of recourse proceedings against the Policyholder .

COMPLAINT

In the event of a disagreement with the Insurer, the Policyholder and/or the Covered Person shall first contact their representative at AWP Health & Life S.A.

If the proposed solution does not meet the expectations of the Policyholder and/or these of the Covered Person, a complaint may be submitted by ordinary letter or email to:

AWP Health & Life S.A.
Client relations
Eurosquare 2
7 rue Dora Maar
93400 Saint Ouen
France
Email: client.care@allianzworldwidecare.com

AWP Health & Life SA is a signatory to the mediation charter of the French Federation of Insurance Companies. Therefore, in the event of a persistent and definitive disagreement, the Policyholder and/or Covered Person have the option, after exhausting all other possible amicable remedies, to opt for the **Mediator of the French Federation of Insurance Companies**, without prejudice to other possible legal action, who can be contacted at the following address:

La Médiation de l'Assurance
TSA 50 110
75 441 Paris Cedex 09
https://www.mediation-assurance.org/

DATA PROTECTION

Personal data concerning the Parties to the present contract , the category of members to be covered, their Dependents and/or beneficiaries as applicable, and/or any identified or identifiable natural living person to whom personal data relates hereto, herein referred to as **"Data Subject(s)"**including the signatories to the contractual agreements and the various schedules, exhibits, attachments and other documents referenced or incorporated herein and/or endorsements, amendments or addendums hereto, are used for the sole purpose of the management thereof, whether or not by automated means, such as collection, processing, recording, organization, purpose limitation and data minimization, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transfer, dissemination or otherwise making available, alignment or combination, security, relating to the collection and processing of personal data, including but not limited to the privacy and security thereof, in accordance with the Amended French Data Protection Act no. 78-17 of 06.01.1978 on Information Technology, Data Files and Civil Liberties and all applicable laws and regulations relating to the protection and processing of Personal Data, including the General Data Protection Regulation (Regulation (EU) 2016/679) of the European Parliament and of the Council of 27 April 2016, hereinafter referred to as the **"Regulation",** sector-specific laws and applicable guidance and codes of practice issued by supervisory authorities and as stipulated in the Data Privacy Notice at www.allianzcare.com/fr/pages/privacy/france.html

The Data Subjects have the rights to request access to, rectification, deletion of their personal data, restriction of processing concerning their data, objection to processing, and data portability as defined in the Data Privacy Notice.

In addition, in accordance with the performance of the contract, personal data may be subject to an extra-European transfer due to specific needs linked to the policy. This transfer occurs in full compliance with the Regulation, sector-specific laws and applicable guidance and codes of practice issued by supervisory authorities relating to the personal data transfers.

The terms used herein shall have the meaning given in the Regulation, as stipulated in the **Definitions** section of the Data Privacy Notice on the protection of natural persons with regard to the processing of personal data and on the free movement of such data as a result of, or in connection with the present contract. "Personal Data" shall be any personal and/or sensitive data in relation to Data Subjects.

Any and all necessary endorsements, where applicable, to existing contractual agreements, all relevant Data Protection Agreements with third-parties, and Data Transfer Agreements relating to the collection, processing, use, storage, and/or transfer of any personably identifiable data are concluded in application of all aspects of data protection and information security regulations as stipulated in the Data Privacy Notice and in application of the Regulation.

In the event the Data Subject wishes to exercise his/her rights in relation to the present contract, a request may be sent to:

AWP Health & Life S.A.
Information Technology and Civil Liberties
Eurosquare 2
7 rue Dora Maar
93400 Saint Ouen
France
Email : informatique.libertes@allianzworldwidecare.com

The Insurer will assess the corresponding requests under the scope of the Regulation, and will respond by justifying meeting the request or denial thereof.

The Data Subjects have as well the right to lodge a complaint with the Data Protection Supervisory Authority as provided hereunder if they consider the processing of their data is not lawful or do not agree with the conclusions resulting from their requests for exercising their rights.

In the event the Data Subject has any queries about how the personal and/or sensitive data is used in relation to the present contract, the Data Subject may contact the Insurer as follows:

AWP Health & Life S.A.
Data Protection Officer
Eurosquare 2
7 rue Dora Maar
93400 Saint Ouen
France
Email: AWC.DataPrivacyOfficer@allianz.com

Data Protection Supervisory Authority
Pursuant to Article 51 of the Regulation, the independent public authority established by a Member State is concerned by the processing of personal data:

- the controller or processor is established on the territory of the Member State of that supervisory authority;
- data subjects residing in the Member State of that supervisory authority are substantially affected or likely to be substantially affected by the processing; or
- a complaint has been lodged with that supervisory authority.

Obligations of the Parties

The present contract implements the regulations and requirements on the protection of Personal Data and on the collection, processing and use of Personal Data in the performance and management of the present contract.

In relation to all Personal Data, each Party warrants and undertakes the following as relevant:

- To process Personal Data only as necessary to perform its obligations herein;
- To process Personal Data in compliance with its obligations under applicable data protection law, including the Regulation;
- To implement and maintain appropriate technical and organizational security measures giving due regard to the risks inherent in the processing and nature of the personal data concerned to protect against accidental or unlawful destruction, loss, alteration, unauthorized disclosure of, or access to the Personal Data and which provide a level of security appropriate to the risk represented by the processing and the nature of the data to be protected as stipulated hereunder;
- The Policyholder shall provide appropriate notice to the category of members to be covered, their dependents and/or beneficiaries where applicable whose personal data is processed in a timely manner and in accordance with applicable data protection law, including the Regulation and as stipulated herein;
- To have in place procedures so that any third party or service provider authorized have access to Personal Data, will respect and maintain the confidentiality and security of the Personal Data. Any person authorized to have access to Personal Data shall be obligated to process the Personal Data in accordance with applicable data protection law, including the Regulation and, where the recipient is a data controller in their own right, subject to terms no less onerous than those set out in this section;
- Personal data may be processed both inside and outside of the European Economic Area (EEA) subject to contractual restrictions regarding confidentiality and security in line with applicable data protection laws and regulations. No personal and/or sensitive data may be disclosed to parties who are not authorized to process them.

In the event of a transfer personal and/or sensitive data outside of the EEA, such transfers shall be done in application of the terms and conditions stipulated in Data Transfer Agreements in conjunction with the rules of the Regulation, sector-specific laws and applicable guidance and codes of practice issued by supervisory authorities. Full and accurate records of any transfer of Personal Data outside the European Economic Area shall be kept and such records shall be made available to upon request;

- To delete (and procure that third-party data processors delete or return to the relevant Party for deletion) Personal Data of a Data Subject where such Data Subject ceases to be a Data Subject for purposes of the present contract, unless and until the Parties no longer need to retain such Personal Data under applicable data protection law, including the Regulation;
- In the event a Data Subject has exercised his/her rights by sending a request directly to one of the parties, the other Party is responsible for immediately informing the other party of said request and to immediately inform the party responsible for assessing the request and responding to the request.
- To promptly notify the other Party if a Party becomes aware of any unauthorized or unlawful processing or breaches of security relating to the Personal Data:
  - In case of suspected data protection infringements, data breaches, data losses or any other material discrepancies, the Party shall without undue delay and within the **immediate 24 following hours**, inform the Data Protection Officer of the other Party.

- Except where prohibited to do so by law, notify the other Party of any request by a law enforcement authority for Personal Data in advance of providing such data; and

- Upon reasonable request of one of the Parties, as applicable, the requested Party agrees to submit its data processing facilities, data files and documentation needed for processing Personal Data to reviewing, auditing and/or certifying by the requesting Party (or any independent or impartial inspection agents or auditors, selected by the requesting Party and not reasonably objected to by the Insurer) to ascertain compliance with applicable data protection law including the Regulation and this section, with reasonable notice and during regular business hours.

Upon written request and no more than once a year the Parties may, as applicable:
- meet with the each other's security team to discuss security questions that they may have; or
- complete a questionnaire regarding compliance with applicable data protection law, including the Regulation.

Confidentiality

Each Party undertakes that it shall not at any time disclose to any person and shall treat as confidential all information of a confidential nature received or obtained directly or indirectly as a result of entering into or performing the present contract except as expressly permitted in writing by the other party.

Each party may disclose Confidential Information:

- to its employees, officers, external auditors, professional advisers, consultants who need to know such information for the purposes of enabling the party to perform its obligations under the contract. The party shall use all reasonable endeavors to ensure that its employees, officers, external auditors, professional advisers, consultants to whom it discloses Confidential Information comply with this section.
- where required by law, court order or any governmental or regulatory authority provided that, subject to any legal or regulatory obligations that apply to the receiving party, the receiving party shall give notice to the other party that it proposes to disclose the Confidential Information;
- where the Confidential Information is now in or comes into the public domain otherwise than as a result of a breach of the present section.
- where the Confidential Information is already known by the party in circumstances when it was not bound by any form of confidentiality obligation.

Furthermore, the Parties undertake to treat as strictly confidential all matters not generally known in the public domain and in particular the business and company secrets of the other Party, only to use such information within the scope of the Parties' relationship and – to the extent not required in order to achieve the purpose of the present contract– not to record, disclose or make use of such information.

In the event of a breach or a suspected breach of its obligations under this Section the party must notify the other party promptly as stipulated hereinabove and use all reasonable endeavors, at their own cost, to remedy or mitigate the effects of such a breach.

Each Party shall ensure that its personnel engaged in the processing of personal data are informed of the confidential nature of such Personal Data, have received appropriate training of their responsibilities and have executed confidentiality agreements. The parties shall ensure that such confidentiality obligations survive the termination of the employment term with said personnel.

The Parties shall therefore only deploy employees for conducting any collections of processing activity of Personal Data, who have received adequate training and who are subject to an individual obligation to maintain data secrecy. Compliance with such obligation must be verified by the Parties on request by means of a signed declaration form.

The Parties shall ensure that authorized third-party contractors and their relevant authorized sub-contractors commit their personnel to the same scope of secrecy and confidentiality and shall verify such commitment to the relevant Party upon request.

Information Security

Each Party hereto agrees to guarantee compliance with adequate technical and organizational security measures necessary to properly protect and secure the Personal Data collected, processed and used by the Party and/or by third-party data processors. Any authorized third parties shall audit compliance with these measures regularly and provide the Party with sufficient documentation thereof as applicable.

Each Party must implement and/or ensure any authorized third-party processing or controlling data on behalf of a Party implements the following minimum security measures:

- prevent unauthorized persons from gaining access to data processing systems for processing or using personal data (access control);
- prevent data processing systems from being used without authorization (access control);
- ensure that persons authorized to use a data processing system have access only to those data they are authorized to access, and that personal data cannot be read, copied, altered or removed without authorization during processing, use and after recording (access control);
- ensure that personal data cannot be read, copied, altered or removed without authorization during electronic transfer or transport or while being recorded onto data storage media, and that it is possible to ascertain and check which bodies are to be transferred personal data using data transmission facilities (disclosure control);
- ensure that it is possible after the fact to check and ascertain whether personal data have been entered into, altered or removed from data processing systems and if so, by whom (input control);
- ensure that personal data processed on behalf of others are processed strictly in compliance with the Data Controller's instructions (job control);
- ensure that personal data are protected against accidental destruction or loss (availability control),
- ensure that data collected for different purposes can be processed separately.

Each Party guarantees that compliance with these technical and organizational security measures will be assured notwithstanding the location in which the processing activity of Personal Data actually takes place.

All appropriate security measures necessary to properly protect and secure the Personal Data and Sensitive data collected, processed and used shall be in application the Amended French Data Protection Act no. 78-17 of 06.01.1978 on Information Technology, Data Files and Civil Liberties and the laws and regulations relating to the protection and processing of Personal Data, and, in particular pertaining to Sensitive data, as applicable, the implementation of confidentiality relating to medical data processing in accordance with the Regulation, the French AERAS Agreement (Insurance and Loans with an Increased Health Risk), effective 2006, revised on 1 February 2011 and 2 February 2015 and the Code of Conduct appended to it as well as the French Code of Medical Ethics.

SANCTION LIMITATION AND EXCLUSION CLAUSE

Sanction Limitation and Exclusion Clause

Cover is not provided if any element of the cover, benefit, activity, business or underlying business violates any applicable sanction law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction law or regulations.

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ANNEX 1 - Medical Evacuation and Assistance Services

DEFINITION

DEFINITION OF PARTIES TO THE AGREEMENT

ASSISTOR: Mondial Assistance
BENEFICIARY: Policyholder of the present Agreement

- DEFINITION OF ASSISTANCE TERMS

ACCIDENT: any sudden, unexpected event or event outside the control of the victim or the damaged item or person, constituting the cause of the damage. Food poisoning shall be considered as an accident.
EMPOWERED MEDICAL AUTHORITY / DOCTOR: any person holding a qualification which is legally recognised in the country where same person usually practices.
RESIDENCE: primary residence located in the country of expatriation, outside of the country of origin
FOREIGN: any country with the exception of the country of origin
DEDUCTIBLE: the share of the prejudice left to be paid by the beneficiary in the claim. Deductible amounts relating to each guarantee are indicated in the table of amounts of benefits and deductibles.
COUNTRY OF ORIGIN: native country of the beneficiary as indicated in the passport thereof
PERIOD OF LIMITATION: the period beyond which no claim shall be admissible, namely following a period of 2 years after the corresponding event.
CLAIM: all harmful consequences leading to application of one of the subscribed guarantees. All prejudice and damage resulting from a single initial cause shall constitute a single claim.
SUBROGATION: action via which Mondial Assistance subrogates the rights and actions of Beneficiary against any liability for damages suffered by Beneficiary in order to receive compensation of amounts which Mondial Assistance paid to Beneficiary following the claim.

- With regard to the « Expatriate evacuation » insurance coverage:

ACCOMMODATION COSTS: additional hotel and telephone costs for Mondial Assistance, following any covered incident, with the exclusion of all sustenance costs.
FUNERAL COSTS: fees for initial conservation, handling, casket costs, special travel provisions, conservation costs incurred by legislative provisions, preparation and simple coffin costs required for transportation and which comply with local legislation in force, with the exclusion of all burial, dressing and ceremony costs.
MEDICAL COSTS: pharmaceutical, surgery, consultation and hospital fees medically required, following a diagnosis and treatment of an urgent pathology.
EMERGENCY HOSPITALISATION: any stay exceeding 48 consecutive hours in a public or private hospital, for any emergency procedure, namely any procedure which was unplanned and cannot be delayed.
PLANNED HOSPITALISATION: any stay exceeding 48 consecutive hours in a public or private hospital, for any procedure planned at least fifteen days in advance.
ILLNESS: any change in the health condition of the Beneficiary observed by a duly qualified medical authority.
TRIP: an itinerary travelled up to the place of destination indicated on the ticket or travel registration, whatever the amount of flights used, whether the outward or return journey.
MEDICAL EMERGENCY: any unplanned medical incident.

JURISDICTION OF AGREEMENT

Coverage provided by the Agreement shall be applicable across the entire world.
Beneficiary shall be covered for all personal or professional travel.

EXCLUSIONS COMMON TO ALL EVACUATION BENEFITS

In addition to special exclusions applicable to each benefit, Mondial Assistance never covers the consequences of the following circumstances and events:

1. Voluntary participation by Beneficiary in betting, crime or riots, except in case of legitimate self-defence;
2. Any nuclear incident caused by any source of ionising radiation;
3. Intentional or misleading actions by Beneficiary, including suicide and attempted suicide;
4. Any consumption or use by Beneficiary of alcohol, drugs and any narcotic substance indicated in the French Public Health Code, not prescribed by a doctor.

EVACUATION BENEFITS

ASSISTANCE FOR EXPATRIATE

1. OBJECT OF COVERAGE

Insofar as Beneficiary calls upon the assistance of Mondial Assistance, all decisions pertaining to the nature, opportunity and organisation of measures to be taken shall belong exclusively to the Assistance Department at Mondial Assistance.

➢ MEDICAL INFORMATION

Mondial Assistance provides Beneficiary with a medical assistance telephone hotline available 24 hours a day. By making a simple call to this number, one of the doctors at Mondial Assistance will respond to medical questions and may indicate addresses of doctors or specialist clinics or those which are not likely to be acceptable.

➢ ACCIDENT, ILLNESS AND UNEXPECTED INCIDENT ASSISTANCE

1.1. Evacuation Assistance

In such instance as the health condition of Beneficiary requires evacuation, Mondial Assistance shall provide assistance as follows.

- **Organisation and handling/taking care of the return transportation of Beneficiary towards a hospital**
  Mondial Assistance shall organise and handle return to the country of origin or residence of Beneficiary and transportation to the closest hospital and/or the most suitable to provide the care required by the health condition of the Beneficiary.
  In the latter instance, if Beneficiary wishes, Mondial Assistance may subsequently organise, as long as the health condition of Beneficiary allows, a return to the country of residence or of origin.
- **Reimbursement of accommodation costs incurred by Beneficiary and those of an accompanying person**
  Mondial Assistance shall reimburse, upon presentation of justification documents and within the limitations appearing under table of amounts of benefits and deductibles, all additional accommodation costs incurred by Beneficiary and those incurred by a person accompanying the latter.
- **Organisation and handling/ taking care of the return of an accompanying person. Mondial Assistance** shall additionally organise and handle, following agreement by the Mondial Assistance's Medical Team, the journey for a person accompanying the Beneficiary in situ so as to allow said person to accompany Beneficiary.

IMPORTANT:

Decisions are taken in consideration of the best medical interests of Beneficiary, and shall belong exclusively to Mondial Assistance's doctors in agreement/ in line with local practitioners.

Doctors at Mondial Assistance shall contact medical structures in situ and, where appropriate, the usual medical practitioner of Beneficiary, in order to collect all information required so as to take the most suitable decisions in light of the health condition of Beneficiary.

Repatriation of Beneficiary shall be decided and managed by a medical authority holding a legally recognised qualification in the country in which same person usually practices.
In such instance as Beneficiary refuses to follow the decisions taken by the Medical Team at Mondial Assistance, Beneficiary hereby relinquishes Mondial Assistance from all liability concerning the consequences of such a decision and shall lose all entitlements to services and compensation from Mondial Assistance.

Moreover, Mondial Assistance may not under any circumstances whatsoever stand as replacement for local emergency services, nor accept costs incurred in this regard.

Pregnant women: Due to risks which may endanger women during an advanced stage of their pregnancy, airline companies apply strict restrictions, different according to the airline company, which are subject to modification without notice: medical examination at most 48 hours prior to departure, presentation of a medical certificate, request for medical consent by the airline company, etc. Where required, and subject to those conditions outlined above, Mondial Assistance shall organise air transportation for Beneficiary under the express condition that doctors and/or airline companies do not object thereunto.

1.2. Hospitalisation in situ

- Handling/Bearing costs for a family member of Beneficiary to visit the latter
  If Beneficiary is hospitalised in situ for over 8 days
  - Mondial Assistance shall fund a return journey of a family member of Beneficiary to visit Beneficiary during this time;
  - Mondial Assistance shall reimburse, upon presentation of justification document and within the limitation of the total amount appearing in the table of amounts of benefits and deductibles, all accommodation costs incurred by the latter.

1.3. Sending medication

In such instance as Beneficiary requires medication not available in situ:

- Subject to a prescription by the local practitioner dealing with Beneficiary corresponding to the date of request, Mondial Assistance shall handle the dispatch of medication which is not available in situ, if these are essential for curing the given problem, on the condition that no equivalent medication may be prescribed and that national and international health and customs regulations do not oppose such a measure;
- Mondial Assistance shall send this medication to Beneficiary as soon as possible. However, Mondial Assistance shall not be held liable for any delays attributable to shipping agents used nor any potential lack of availability of medication.

Beneficiary hereby undertakes to reimburse to Mondial Assistance for this medication within a period of three months following receipt thereof. Beyond this period, Mondial Assistance shall be entitled to request, moreover, costs for the proceedings launched to recover this amount in addition to legal interest as set out by decree following the issue of a first recorded delivery letter.

1.4. Assistance for early return

Mondial Assistance shall organise and handle, insofar as the resources for which provision was initially made for return to the country of origin of Beneficiary cannot be used, for the outward/return journey.
Beneficiary shall be entitled to this service in the following instances:

- In the event of illness or accident, leading to emergency hospitalisation, beginning during the stay and seriously affecting the health condition according to the Medical Team at Mondial Assistance, of a spouse or partner, of any minor offspring or disable offspring, living in the country of origin ;
- In order to provide assistance for funeral following death of a spouse or partner, of any direct ascendants or descendants, siblings, legal guardian, or the person placed under the guardianship of Beneficiary.

➢ HOSPITALISATION FEES (INCLUDING GIVING BIRTH) ABROAD

1.5. Emergency hospitalisation fees abroad

Within the limitation of the amounts for which provision is made by the Group agreement as well as deductible amounts, as annexed herewith under the same table

- Control of the nature of hospital fees in case of hospitalization of over 3 days
  Beneficiary shall be bound, prior to any hospitalisation, to contact Mondial Assistance. Following contact with the doctor in situ, Mondial Assistance shall decide if necessary to direct the Beneficiary

towards any hospital of its choice so as the nature of hospital fees incurred by and covered by the health insurer may be controlled by Mondial Assistance.

- Advance payment of hospital fees in case of hospitalization of over 3 days
  In the event of hospitalisation exceeding 3 days, Mondial Assistance may pay fees in advance, directly to the hospital, within the limitation of the ceiling costs indicated in the table of amounts of benefits and deductibles. Only those fees incurred under the control of Mondial Assistance shall be paid in advance.
- Advance payment of fees shall stop the day on which the Medical Team believes that repatriation of Beneficiary is possible.
  In all instances, Beneficiary hereby undertakes to present its request for reimbursement from its basic social security body, mutual health insurance body or any insurance or providence body from which the Beneficiary may make a claim.

1.6. Fees for hospitalisation planned abroad

For any planned hospitalisation, Beneficiary is bound to contact, in first instance, the manager of its healthcare insurance policy who may, where applicable, redirect the Beneficiary to Mondial Assistance.

➢ ASSISTANCE IN THE CASE OF DEATH

1.7. Assistance in the case of death of a policyholder

In the event of death of a policyholder, Mondial Assistance organises and handles:

- Transportation of the body from the place where it is placed in the casket to the place of burial in the country or origin or in the country of expatriation of Beneficiary
- Funeral expenses, within the limit of the ceiling price indicated in the table of amounts of benefits and dedcutibles.

2. EXCLUSIONS

In addition to exclusions common to all benefits, the following shall additionally be excluded from coverage:

With regard to « Accident, illness and unexpected incident assistance » and « Assistance in case of death » :

2.1. All fees incurred without the prior consent of Mondial Assistance;
2.2. The consequences of incidents or benign injuries which may be treated in situ ;
2.3. An abortion, aside for those instances where an abortion was medically necessary within respect of local legislation, giving birth, in vitro fertilisation and the consequences thereof in addition to pregnancies leading to hospitalisation within 6 months prior to the request for assistance;
2.4. Psychiatry;
2.5. Involvement by Beneficiary in any sport undertaken professionally under a paid contract, in addition to all preparatory training;
2.6. Default by Beneficiary in observing official prohibitions, in addition to default in respect of official safety rules, pertaining to the performance of any sporting activities;
2.7. the consequences of any accident arising when Beneficiary is performing any air sports (including gliding, paragliding, hand gliding) or any of the following sports: skeleton, bobsleigh, ski jumping, mountain climbing using ropes, rock-climbing, underwater diving below forty meters with autonomous breathing device, caving, bungee jumping, parachuting;
2.8. All costs not expressly indicated as leading to reimbursement, in addition to sustenance costs and any expenses or costs for which Beneficiary is unable to provide justification.

With regard to « Medical and emergency hospitalisation costs abroad », the following are also excluded:

2.9. Costs for thermal therapy, heliotherapy, weight reduction, aesthetic therapy or any « comfort » cure or aesthetic therapy, physiotherapy costs;
2.10. Costs for implants, prosthesis, devices or eyewear;
2.11. Vaccination costs;
2.12. Costs resulting for care or treatment which was not a medical emergency;
2.13. Costs resulting for care or treatment which of which the therapeutic nature is not recognised by French legislation.

3. BENEFICIARY OBLIGATIONS IN THE EVENT OF MAKING A CLAIM

3.1. To request assistance

Beneficiary should contact Mondial Assistance or have the latter contacted by a third party as soon as the situation leads it to believe that it will be necessary for an early return or that additional costs will be incurred falling within the scope of insurance coverage.
Mondial Assistance teams are at your disposal 24/7:

By telephone on (+) 33 1 40 25 50 87

Beneficiary will immediately be issued a case number and Mondial Assistance will ask Beneficiary to:

- Indicate the assistance agreement number: 611 792,
- The insurance contract number or name of employer where applicable,
- The name of the healthcare insurance agreement manager,
- Indicate an address and contact telephone number, as well as the details of people caring or looking after Beneficiary,
- Allow doctors to access all medical information concerning Beneficiary, or which concern the person requiring assistance.

3.2. To claim reimbursement

In order to claim reimbursement of costs incurred by Beneficiary with the consent of Mondial Assistance, Beneficiary should communicate to Mondial Assistance all justifications allowing/ that enable the well-founded nature of the claim to be established.
Any services which were not requested in advance or which were not organised by the teams at Mondial Assistance, shall not be reimbursed nor reclaimed.

3.3. For handling/the taking care of transportation

Where Mondial Assistance organises and handles transportation in the framework of the present coverage, this shall be done via first class for train travel and/or economy class for air travel or by taxi, as decided by Mondial Assistance.
In this instance, Mondial Assistance shall become owner of the tickers and Beneficiary hereby undertakes to return these to Mondial Assistance or to reimburse the amount which Beneficiary received as compensation for the issuer of these tickets.
Where Beneficiary does not hold the return ticket, Mondial Assistance request reimbursement from Beneficiary of all costs incurred, in all instances, for return, on the basis of a first class train ticket and/or economy class air ticket, at the moment of early return by Beneficiary, with the same company having been used for the outward journey.

4. SCOPE OF EVACUATION

Mondial Assistance shall assist within the framework of national and international laws and regulations and the services of Mondial Assistance shall be subject to receiving the prior authorization from competent administrative authorities.
Moreover, Mondial Assistance may not be held liable for any failings or delays in the performance of its obligations as resulting from any case of force majeure or events such as civil or foreign war, revolutions, popular uprising, riots, strikes, compulsory garnishment by the police, official prohibitions, acts of piracy, mechanical explosions, nuclear or radioactive incidents, hindrance caused by serious meteorological conditions and any natural and unpredictable events. However, Mondial Assistance shall make every effort to assist Beneficiary in such instances.

TABLE OF AMOUNTS OF BENEFITS AND DEDUCTIBLES

COVERAGE	AMOUNTS AND LIMITATION OF BENEFITS	DEDUCTIBLES AMOUNTS OR THRESHOLD OF EVACUATION
EVACUATION IN THE EVENT OF ACCIDENT, ILLNESS AND UNEXPECTED EVENTS		
• **Evacuation assistance (1.1)**		N/A
- Organisation and handling/taking care of return of Beneficiaryor transportation towards a hospital	Actual costs	
- Reimbursement of accommodation costs and those incurred by an insured person accompanying the latter	In the limit, per day and per insured person, of €104 / **$130** for **7 days maximum**	
- organisation and handling/ taking care of return for an insured person accompanying the Beneficiary	Actual costs, in the limit of a ticket (1st class train ticket and/or economy class plane)	
• **Hospitalisation in situ (1.2)**		N/A
- Payment of costs allowing/enabling a family member of Beneficiary to visit the latter: · Return journey · Accommodation costs up until repatriation of Beneficiary	Actual costs, in the limit of a ticket (1st class train ticket and/or economy class plane) In the limit, per day, of €104 / **$130** for **7 days maximum**	
• **Dispatch of medication (1.3)**	Shipping costs	N/A
• **Assistance for early return (1.4)**		N/A

- organisation and handling/taking care of transportation costs	Actual costs, in the limit of a ticket (1st class train ticket and/or economy class plane)	
MEDICAL AND EMERGENCY HOSPITALISATION COSTS ABROAD		
• **Emergency hospitalisation fees in case hospitalization of over 3 days abroad (1.5)** - Advance payment of hospital costs	In aforementioned limits, per insured person and per insurance period: In the limits of costs guaranteed by the insurer Allianz, costs which are incurred exclusively under the control of Mondial Assistance	Per claim: €37,50 / **$39** N/A
ASSISTANCE IN CASE OF DEATH		
• **Assistance in case of death of an insured person (1.7)**		N/A
- Transportation of body	Actual cost	
- Funeral costs	In the limit per insured person of €2,390 / **$2,987**	