General Conditions

2020

Allianz Insurance Luxembourg
Branch of Allianz Belgium Insurance SA.
14 boulevard Franklin Roosevelt. L-2450
Luxembourg

INTERNATIONAL EXPAT INSURANCE

Important information

JoHo Insurances has subscribed through The International Expat Insurance Package, healthcare/Life/Disability insurance contracts n° 20 000 1003 (currency: US Dollar) and n° 20 000 1001 (currency: EURO) with the Insurer Allianz Insurance Luxembourg to cover its members namely individual expatriates and companies' expatriated employees. This Policy aims to describe healthcare/life/disability cover applicable to individual expatriates and Expatriated employees.

The General Policy Provisions as set out in Chapter I, are only valid insofar as they are not contradicted by or in conflict with the provisions proper to the different types of cover as set out in Chapter II. In case of contradiction or conflict, the latter take precedence over the former. Moreover, the Special Conditions will always take precedence over the General Conditions.

1. Right of withdrawal (for individual expatriates only)

If you are not satisfied with this agreement for whatever reason, you may return it to us within a period of fourteen (14) calendar days. The period for withdrawal shall begin from the day of the conclusion of the distance contract or the day on which you receive the contractual conditions (if that is later).
We will cancel the policy and refund to you all premiums paid, on the condition that no claims have been submitted yet.

2. Change of address

Notify us immediately of any change of your address (including e-mail address) so that we can keep you informed of important information or to facilitate payment of claims.

3. General information

The Insurer: Allianz Insurance Luxembourg
Branch of Allianz Belgium Insurance SA.
14 boulevard Franklin Roosevelt, L-2450 Luxembourg

The Assistance Provider:
AWP France SAS
7 rue Dora Maar, 93 400 Saint Ouen, FRANCE,

The Administrator: Henner
14 Boulevard du Général Leclercq
CS 20058, 92527 Neuilly-sur-Seine CEDEX, FRANCE

The Supervisory Authority
Banque Nationale de Belgique
Boulevard de Berlaimont, 14, Bruxelles
Tel. (central) : +32 2 221 21 11

4. Contact

If you have any queries on your policy, kindly contact us at:
JoHo Insurances
Paviljoensgracht 18
2512 BP The Hague (Den Haag)
THE NETHERLANDS
Tel: +31 (0) 88-3214563
Email: info@johoinsurances.org

For any enquiries or complaints pertaining to any International Medical Insurance related matter on this policy you may refer to our Contact Center (24/7) at the following address:

Henner
14 Boulevard du Général Leclercq
CS 20058
92527 Neuilly-sur-Seine CEDEX
FRANCE
Tel: +33 1 40 82 44 95
Fax: +33 1 53 25 22 97
Email: joho@henner.com

Contents

Chapter I: General policy provisions

1. Order of precedence and purpose of the insurance

a) Order of precedence

The General policy provisions as set out in Chapter I, are only valid insofar as they are not contradicted by or in conflict with the provisions proper to the different types of cover as set out in Chapter II. In case of contradiction or conflict, the latter take precedence over the former.

With respect to Medical Evacuation and Assistance Services, the provisions of Chapter II take precedence over the General policy provisions of Chapter I.
Moreover, the Special Conditions will always take precedence over the General Conditions.

b) Purpose of the insurance

The International Expat Insurance Package consists of several insurance benefits, intended to offer Insured persons (namely individual expatriates companies' expatriated employees and Local employees) a social protection.

Main plan

- International Medical Insurance

The International Medical Insurance cover reimburses - up to the limits defined in this policy - Reasonable and Customary expenses for outpatient as well as for inpatient medical services, provided these expenses have been incurred because of Illness, Accident or maternity.

- Medical Evacuation and Assistance Services

Emergency Medical Evacuation and Assistance Services are included within the Main Plan.

Additional insurances

Persons insured under the Main Plan can also apply for the following Additional Insurances:

- Dental Care

This insurance can be taken out by Insured who are accepted into the Main Plan.

- Life Cover

This insurance can be taken out as an Additional Insurance to the Main Plan, and guarantees the payment of a lump sum in case of death due to any cause.

- Accidental Death and Invalidity

This insurance can be taken out as an Additional Insurance to the Main Plan, and guarantees the payment of a lump sum in case of accidental death or in case of permanent Invalidity caused by an Accident.

- Temporary Incapacity

This insurance can be taken out as an Additional Insurance on top of the Main Plan, and guarantees payment of a monthly allowance in case the Insured is totally unable to perform his/ her professional activities because of Illness or Accident.

- Permanent Disability

This insurance can only be taken out as a supplement to the Temporary Incapacity insurance and guarantees the payment of a monthly allowance to the Insured who is affected by a permanent disability caused by an Illness or Accident, prohibiting him/her from fully or partially continuing his/her professional occupation, therefore leading to a total or partial loss of income.

2. Definitions, in alphabetical order

'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.

' JoHo Insurances'
The Broker/Association that has taken out, through the International Expat Insurance Package, Healthcare/Life/Disability insurance contracts n° 20 000 1003 (currency: US Dollar) and n° 20 000 1001 (currency: EURO) with the Insurer Allianz Luxembourg for its members namely individual expatriates and companies' expatriated employees. Throughout these general conditions, JoHo Insurances is referred to as JoHo.

'The International Expat Insurance Package'
The Healthcare/Life/Disability plan proposed by JoHo to its members namely individual expatriates companies' expatriated employees and Local employees. The plan is subject to payment of premiums.

'Administrator'
The claims handler and plan Administrator: Henner - 14 Boulevard du Général Leclercq - CS 20058 - 92527 Neuilly-sur-Seine CEDEX- FRANCE, hereafter referred to as the Administrator.

'Annual Renewal Date'
For individual contracts only, 1 January. For group contracts, see Special Conditions.

'Assistance Provider'
The provider for emergency medical evacuation and assistance services.

'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.

'Complementary Medicine Practitioner'
An acupuncturist, chiropractor, homeopath or osteopath who is legally qualified and allowed to practise complementary medicine by the authorities in the country in which the Treatment is received.

'Day Care'
Treatment in a hospital or medical day-care centre, for which the patient does not have to stay overnight.

'Day Surgery'
Surgery requiring the use of a conventional operating theatre and performed on an in-and-out same-day basis without an overnight stay.

'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.

'Dentist (or Dental Surgeon)'
A person officially qualified and licensed to practise dentistry in the country where the dental Treatment is received.

'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.

'Eligible Medical Expenses'
Medically Necessary expenses incurred due to a covered Illness, Accident or maternity but not exceeding the limits in the Benefits Overview.

'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.

'Infertility Treatment'
The Treatment of infertility and all investigative procedures necessary to establish the cause(s) of infertility (e.g. hysterosalpingography, laparoscopy, hysteroscopy).

'Injury'
Bodily Injury caused solely by Accident.

'Inpatient Treatment'
Treatment for which, for medical reasons, the patient has to stay overnight in a hospital.

'Insurance Year'
A twelve (12)-month period, starting on 1st January.

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

'Insurer'
The insurance company underwriting the risks set forth in the International Expat Insurance Package: Allianz Insurance Luxembourg, branch of Allianz Belgium Insurance SA. 14 boulevard Franklin Roosevelt. L-2450 Luxembourg.

'Intensive Care Unit'
A section within a hospital that is designated as an Intensive Care Unit, and which is maintained on a twenty-four (24) hour basis solely for the Treatment of patients in critical condition and which is equipped to provide special nursing and medical services not available elsewhere in the hospital.

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

Local Employee
A person living and working in Netherland.

'MA'
Mondial Assistance, the Assistance Provider.

'Maximum Annual Reimbursement'
Benefits payable in respect of expenses incurred for Treatment provided to the Insured during the period of insurance shall be limited to overall annual limits as stated in the Benefits Overview. In the event the overall annual limit has been exhausted, no further payments shall be made for the remaining period of the Insurance Year.

'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 JoHo.

'Outpatient Treatment'
Medical Treatment for which the patient does not have to stay overnight in a hospital.

'Physician'
See definition of 'Doctor'.

'Plan Administrator and Claims Handler'
Henner - 14 Boulevard du Général Leclercq - CS 20058 - 92527 Neuilly-sur-Seine CEDEX - FRANCE is in charge with:
-enrolment, billing, claims administration, premiums collection for medical cover,
-enrolment and collection of supporting documentation for personal accidental insurance, temporary incapacity cover and permanent disability cover

'Policyholder'
The employer or the individual Expat taking out the insurance for the benefit of the Insured, having to pay the appropriate premium to the Administrator. The name of the Policyholder is mentioned in the Special Conditions.

'Policy Renewal Date'
For individual contracts, depending on the chosen policy duration. For quarterly policies, 1 January, 1 April, 1 July and 1 October. For half-yearly policies, 1 January and 1 July. For yearly policies, 1 January. For group contracts, 1 January or the Annual Renewal Date (see Special Conditions).

'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.

'Prescription Drugs'
Drugs/medicines that are necessary to treat a confirmed medical diagnosis or medical condition, and which are not available without prescription by a Doctor (excluding OTC ('over-the-counter') drugs).

'Reasonable and Customary'
Medical expenses will be considered Reasonable and Customary if they correspond to the charge usually made for a similar service or supply and do not exceed the normal charge made under the best prevailing conditions for such a service or supply in the locality where the service or supply is received. If usual and prevailing charges cannot be determined because of the unusual nature of the service or supply, the Administrator will determine on behalf of the Insurer to what extent the charge is reasonable, taking into account:

- the complexity involved;
- the degree of professional skill required;
- all other pertinent factors.

'Salary'

The gross Salary being paid to an individual expatriate or expatriated employee at the commencement of his/her insurance, before deduction of any income tax. Gross Salary does not include any benefits in kind such as car, living accommodation, bonuses or overtime. In the event of a claim, satisfactory proof of income will be required.

The Salary for a self-employed person shall mean the gross average Salary during each of the three (3) years leading up to the date of the event entitling to benefits.

During the application procedure for Temporary Incapacity and Permanent Disability insurance a self employed person needs to provide official proof of income provided by an accountant or tax representative. Starting self-employed persons can opt for an insured amount of 2000 euros per month (or the equivalent in dollar) if they can prove they earned a steady income of 2500 euros per month (or the equivalent in dollar) six months prior to the date they applied for Temporary Incapacity and Permanent Disability insurance.

'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.

'Special Conditions'
A document issued with each insurance policy, stating:

- the identity of the Policyholder and of the Insured;
- the cover opted for, and the term of the policy;
- the amount of the insurance premiums;
- any particular agreement or any deviations from the General Conditions.
- The effective date of cover

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

'Standard Private Room'
A room with one bed. A Standard private room is the lowest rate (regular) private room in a hospital.

'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.

'Surgery'
Any of the following medical procedures:

- incision, excision or electrocauterisation of any organ or body part, except for dental services;
- repair, revision, or reconstruction of any organ or body part, both invasive and non-invasive;

- reduction of a fracture or dislocation by manipulation;
- use of endoscopy to remove a stone or object from the larynx, bronchus, trachea, oesophagus, stomach, intestine, urinary bladder, or urethra.

'Treatment or Medical Treatment'

Medical examinations and/or medical procedures needed to restore health, performed or prescribed by a Doctor.

3. Eligibility and acceptance into the insurance

a) Eligibility

The International Expat Insurance Package is available for individual Expats (private persons) working abroad (and their Dependents[1]) for employers to cover their expatriated employees (and their Dependents1) sent on assignment abroad and for Local Employees (and their Dependants1).

The policy must be domiciled in the European Economic Area (reference is made to the policy address).

b) Acceptance into the insurance

1/ Individual Expats ('individual cover')

A Medical questionnaire has to be completed for each Insured (including each Dependent) and has to be sent at the time of application by the candidate-Insured to the medical consultant of the Administrator. The medical consultant can define partial exclusions, total exclusion from cover (refusal of cover), or, at his discretion, propose an additional premium to waive exclusions (2).

2/ Expatriated employees ('group cover')

In case of compulsory enrolment by the employer of a group of ten (10) or more employees, the health declaration(s) for the International Medical Insurance plan may be waived at the discretion of the Insurer, meaning that there will be immediate and full acceptance into the International Medical Insurance (including the Emergency medical evacuation and Assistance services cover as well as the Dental Care plan) of both employees and Dependents. However, for the Accidental Death and Invalidity cover/Temporary Incapacity cover/ Permanent Disability cover and Life Cover, the Insurer can still define partial or total exclusion from cover, or, at his discretion, propose an additional premium to waive exclusions.

If the number of enrolled staff comes down to less than ten (10) employees, a Medical questionnaire has to be completed for each employee and each Dependent and has to be submitted by the candidate-Insured to the medical consultant of the Administrator. The medical consultant can define partial exclusions, total exclusion from cover (refusal of cover) or, at his discretion, propose an additional premium to waive exclusions.

3/ Local Employees ('individual cover')

A Medical questionnaire has to be completed for each Insured (including each Dependent) and has to be sent at the time of application by the candidate-Insured to the medical consultant of the Administrator. The medical consultant can define partial exclusions, total exclusion from cover (refusal of cover), or, at his discretion, propose an additional premium to waive exclusions (2).

[1] *For the definition of 'Dependents' see Art. I-2.; the Main Plan (including Medical Evacuation and Assistance Services) as well as the Additional Insurances Dental Care are open to the Insured's Dependents. The Additional Insurances Temporary Incapacity and Permanent Disability are not open to the Dependents. The Additional Insurance Accidental Death and Invalidity and Life Cover, however, can be taken out for the spouse (or legal partner) and dependent adult children (i.e. as from age 18) of the employee or the individual Expat, insofar as these persons are also covered by the Main Plan.*

2 For the "Essential" Plan only: the Insurer can decide not to cover a specific disease, instead of increasing a premium.

c) Addition of new Dependents into the insurance

Addition of a new-born or adopted child is possible, provided that the application is made within two (2) months following the date of birth or adoption (of a minor child).

In case the declaration of a new-born has not been made within two (2) months, a Medical questionnaire has to be completed and has to be sent to the medical consultant of the Administrator. The medical consultant can propose an additional premium to waive exclusions.

Premiums for the new-born baby are due as from the first (1st) day of enrolment.

d) Age limits for enrolment

- For individual Expats, the minimum and maximum ages for enrolment are eighteen (18) years and sixty (60) years.
- For expatriated employees, enrolled on a compulsory basis by their employer, there is no specific age limit set for enrolment into the Main Plan.
- For the Additional Insurances, reference is made to the conditions applying to each of these insurance plans.

e) Change of level of cover or geographical scope

Downgrading and upgrading of cover levels is possible, but only on the Policy Renewal Date. In case of upgrading, a new Medical questionnaire has to be completed and signed (if applicable on the initial date of acceptance).

The change of level has to be requested at least one (1) month before the Policy Renewal Date.

Changing the geographical scope (territoriality) of the cover is possible in function of the Host Country.

The change of geographical scope has to be requested at least one (1) month before the change of Host Country.

For compliance with these deadlines it is sufficient to send your notice by post, email or fax to the Administrator.

f) Individual continuation

If an expatriated employee, who was insured for at least six (6) months under the International Expat Insurance Package, decides to continue the insurance on an individual basis, and applies for cover before expiration of his/her cover under the group cover, no Medical questionnaire has to be completed and no waiting periods are applicable. However, Art. I-3.d) and I-3.e) are still applicable.

Once the former expatriated employee is accepted into the individual cover, he will be deemed as an individual expatriate.

4. Effective date of coverage

The insurance cover takes effect on the day immediately following

- the acceptance by the Administrator of the completed Application form; and
- the acceptance into the insurance of the candidate- Insured by the medical consultant, whenever such medical acceptance is required in accordance with the specific eligibility and acceptance rules of each insurance cover, as described in the different chapters of these General Conditions.

With regard to the declaration of new Dependents, reference is made to Art. I-3.c)

However, the insurance cover cannot take effect before the initial premium has been duly received by the Administrator.

5. Right of withdrawal

The consumer shall have a period of fourteen (14) calendar days to withdraw from the contract without penalty and without giving any reason. The period of withdrawal shall begin either from the day of the conclusion of the distance contract or from the day on which the consumer receives the contractual terms and conditions if that is later. The Insured will be entitled to the return of the full premium paid, on the condition that not one claim has been submitted yet.

For compliance with this deadline it is sufficient to send your notice of withdrawal by post, email or fax to the Administrator.

6. Duration and cancellation of policy

a) Period of cover and renewal

Unless otherwise agreed upon by both parties (Policyholder and the Administrator), the duration of the insurance policy is fixed atone (1) year, starting from the effective date of coverage as stipulated in Art. I-4. above.
Shorter insurance periods may sometimes apply, but those are to be discussed and decided by JoHo.

If the effective date of coverage is other than the first (1st) day of a calendar quarter, the policy will be renewed on the first (1st) day of the next calendar quarter.

b) Cancellation of the policy

The policy can be terminated by the Policyholder through notification by registered letter, delivered to JoHo or the Administrator at least one (1) month before the Policy Renewal Date.

Termination of one or more of the Additional Insurance covers (Accidental Death and Invalidity cover, Temporary Incapacity cover and Permanent Disability cover, Dental Care cover and/or Life cover), will not automatically lead to termination of the Main Plan, unless otherwise agreed upon by both parties (Policyholder and the Administrator).

c) Aggravation of the risk

Except for changes in the state of health of the Insured incurred after acceptance into the insurance, the Insured is obliged to inform the Administrator of any change in circumstances or conditions that may increase the risk of Illness or Accident (e.g. dangerous professional activity). New insurance conditions (within a period of one (1) month after having received notification of the aggravation of the risk) may then be proposed or the insurance cover, within one (1) month, may be retro-actively cancel as from the moment of the start of the aggravation of the risk.

7. Termination of cover

a) For the Insured, the insurance under this policy shall automatically terminate on the following events and in the following events:

- if any premium on this policy is not paid on the due date or within the grace period;
- if the dependent is the spouse or legal partner, upon the date of divorce or legal separation from the Insured, or as from the end of the legal partnership;
- upon the death of the Insured,
-

b) Suspension of cover and cancellation of the insurance because of non-payment of premium

In case of failure by the Policyholder to pay the premium on the due date, The Administrator on behalf of the Insurer has the right to suspend or cancel the insurance policy.

The Administrator on behalf of the Insurer will first notify the Policyholder by means of a registered letter, reminding the Policyholder of the amount of the premium that has to be paid, and informing him of the consequences of non-payment. If the premium shall then not have been paid within fifteen (15) days following service or posting of the registered letter, the insurance cover will be suspended automatically. Payment by the Policyholder of the premiums due shall terminate suspension.

The Administrator on behalf of the Insurer may cancel the policy during the period of suspension. In this case, cancellation shall take effect on the expiry of the period of fifteen (15) days, starting from the first day of suspension.

Claims incurred during the period of suspension are not covered.

8. Premium and premium increase

a) Amount and payment of the premium

The amount of the insurance premium is mentioned in the Special Conditions.

The premium is payable by the Policyholder to the Administrator on quarterly, half-yearly or yearly basis in advance, unless otherwise agreed upon between both the Policyholder and the Insurer.

Taxes and charges as established by the applicable laws will be added to the amount of the premium, and have to be paid in full by the Policyholder.

The premium payment frequency can be altered:

- from quarterly to half-yearly to yearly (frequency decrease), on the Policy Renewal Date;
- from yearly to half-yearly to quarterly (frequency increase), on the Annual Renewal Date only.

b) Annual premium increase

The Insurer may increase premiums depending on technical results (e.g. medical expenses, claims experience…) of the International Expat Insurance Package. If so, the Insurer will warn JoHo of the increase. In case the Insurer increases the premium rate, he will notify the Policyholder, in writing, of said increase and of the date as from which the new premium will become effective. This notification will be sent to the Policyholder, in writing, at the latest on

- for individual policies, the thirtieth (30th) of November of the expiring calendar year;
- for group contracts, two (2) months prior to the Annual Renewal Date, unless otherwise agreed upon between the Policyholder and the Insurer.

The new premium rates will become effective as from

- for individual policies, first (1st) of January of the next calendar year;
- for group contracts, the next Annual Renewal Date (on or after first (1st) of January of the next calendar year).

If the Policyholder does not agree with the new premium conditions, he can terminate the policy through notification of cancellation to the Insurer by registered letter, email or fax delivered to the Insurer or the Administrator:

- for individual policies before fifteenth (15th) of December;
- for group contracts at least one (1) month before the Annual Renewal Date of the policy.

Alternatively and exceptionally for individual contracts, we accept an upgrade or a downgrade of cover level or territorial scope on 1st January. This exceptional change has to be requested the thirtieth (30th) of November at the latest through notification to the Insurer by registered letter, email or fax delivered to the Insurer or the Administrator.

There will be no notification in the event of a premium increase due to a change of age band. The new premium rates will become effective as from the next Policy Renewal Date. There is no possibility to terminate the contract due to an age band related premium increase.

c) Waiver of premiums

For the Insured benefiting from the Coverage in the event of incapacity or disability as provided for in the present contract, the Insurer will waive premium payments. The waiver of premiums will be based on the percentage of disability.

9. Return to the Home Country

When the Insured returns to live and/or to work in his/her Home Country, thereby ending the period of expatriation abroad, the insured or the Policyholder have to notify the Administrator in writing of the exact date of relocation to the Home Country. The insurance will remain in force until the end of the quarter of return to the Home Country, at which date it will be automatically terminated.
The Policyholder can nevertheless request - in writing and before the termination date - cover for one additional three (3)-month period (without interruption of cover), at the conditions prevailing on the first day of this additional three (3)-month period. During this period the Insured (or the Policyholder) can apply for affiliation to a local social security scheme or look for another private insurance.

Failure to notify JoHo of the relocation to the Home Country, shall result in suspension of cover for the duration of the Insured's return to the Home Country.

The Return to the Home Country does not impact the entitlement to indemnity in relation to an event which took place before the Insured's final return to the Home Country.

10. Currency

The International Expat Insurance Package can be taken out in EURO (€ or EUR) or in US Dollar ($ or USD).
The choice of currency has to be made (by the Policyholder) before the cover takes effect, and can only be changed on the Annual Renewal Date.

The change of currency has to be requested at least one (1) month before the Annual Renewal Date.

Premiums and claims shall be payable in EUR or USD, according to the currency in which the policy has been concluded.

With respect to medical expenses incurred in another currency than the currency of the policy, the conversion will be based on the European Central Bank daily rate of exchange in effect on the date the medical service has been billed.

The Administrator may settle medical bills in another currency (than the currency of the insurance policy), viz in the original currency, especially in case of direct payment to hospitals insofar as allowed under the local legislation of the country concerned.

11. General exclusions[1]

The cover described in this policy does not extend to:

- consequences of a voluntary or intentional act committed by the Insured or his/her beneficiary;
- consequences of any sport for professional purposes, even as a secondary profession;
- consequences of hazardous competitions;
  - rugby;
  - winter sports competitions and races;
  - aerial sports (except ballooning);
  - hunting big game (including safari);
  - speleology and cave diving;
  - alpinism, if not on official paths;
  - motor vehicle racing on land and water (except non-competitive recreative jet-ski, recreative water ski, or tourist rallies for which no time or speed imperatives have been imposed);
  - rafting, canyoning, bungee jumping and similar sports.
- consequences of insurrections or riots if by taking part the Insured or his/her beneficiary has broken the applicable laws;
- consequences of brawls, fights and all kinds of disturbances and measures taken to combat them, except in case of self-defence;
- consequences of the preparation of or participation in crimes or misdemeanours;
- consequences of drug addiction and alcoholism;
- direct or indirect consequences of any action relating to what is commonly designated as 'Nuclear risk'. This exclusion is not applicable to medical radiations required by covered Medical Treatment;
- events related to bets or challenges;
- expenses resulting from any kind of competition with motor vehicles;
- flight risk: the insurance covers the use, as a passenger, of all planes, hydro-planes or helicopters duly authorised to transport persons, as long as the Insured is not a member of the crew and does not exercise in the course of the flight a professional or other activity, in relation with the plane or the flight. However, this exclusion is not applicable to the International Medical Insurance plan and Dental Care;
- consequences of taking an active part in a War or acts of War and Terrorism, to the extent mentioned in Art. I-12. Hereafter.

<u>Important remark</u>:

[1] The exclusions relating to the evacuation are listed in the Chapter II 2.

For the additional specific exclusions relating to each separate cover of the International Expat Insurance Package, reference is explicitly made to the provisions proper to the different types of cover (see Chapter II).

12. War and Terrorism

a) Definitions

'War'

- armed conflict, declared or undeclared, between one State and another, an invasion or a state of siege.
- also considered as acts of War are: all similar actions, the use of military force by a sovereign nation to achieve certain economic, geographic, nationalistic, political, racial, religious or other ends.
- civil War: armed conflict between two (2) or several parties belonging to one and the same state, the members of which are of different ethnic origin, religion or ideology.
- also considered as acts of civil War are: an armed rebellion, a revolution, a sedition, an insurrection, a coup d'état, the consequences of martial law and border closings ordered by a government or by local authorities.

'Terrorism'

- any actual or threatened use of force or violence directed at or causing damage, Injury, harm or disruption;
- commission of an act dangerous to human life or property, against any individual, property or government, with the stated or unstated objective of pursuing economic, ethnic, nationalistic, political, racial or religious interests, whether such interests are declared or not;
- robberies or other criminal acts, primarily committed for personal gain and acts arising primarily from prior personal relationships between perpetrator(s) and victim(s) shall not be considered terrorists acts.

Terrorism shall include any act that is verified or recognised by the (relevant) government as an act of Terrorism.

b) Description of benefits

Medical and dental cover:
In case the Insured is victim of acts of War and Terrorism without any active involvement on behalf of the Insured or his/her beneficiaries in these acts, the Insured persons is covered within the limits and the ceilings of the cover.

AD&D, Life, TI & PD covers:
However, These insurance covers are not valid when the Insured (or covered Dependent) is travelling to or from or is residing in a country or a part of a country publicly known to be in state of War or civil War at the time damages (bodily Injury, or death) to the Insured or his/her covered Dependents happen. In case of a dispute about whether a given country is known to be in state of

War or civil War, the list of countries for which the UK Foreign and Commonwealth Office (FCO) advises not to travel to ('advise against all travel to these countries/parts of these countries'), as published on its official website (www.fco.gov. uk), will be decisive.

In the event the Insured, whilst abroad or is residing in a country, is faced with the sudden, unanticipated occurrence of a new (outbreak of) War or warlike situations and acts, these insurance cover remains valid for fourteen (14) days starting from the beginning of the hostilities.

13. Data protection

Data on employers and insured persons is used to administrate the insurance plan. Employers and insured persons have the right to access, amend and object to data held about them, pursuant to provisions set out in Luxemburg Law of 2 August, 2002 relating to data freedom.

However, when data are handled by the Plan Administrator or the claims handler in France, the following provisions shall be applicable: data on employers and insured persons are only used in the purpose of the Policy's management. Employers and Insured Persons are allowed to have access, to modify and to object to those information in accordance with French regulation on Data Protection n° 78-17 dated January 6th, 1978.

14. Subrogation

The Insurer has full rights of subrogation for any benefits paid within the framework of the International Expat Insurance Package.
Therefore, when asked to confirm this right to the Insurer in order to assist the Insurer in recovering from a third party any amount paid or which will be paid by the Insurer to the Insured or expenses made on behalf of the Insured, the Insured shall be obliged to provide this confirmation in writing to the Insurer.

15. Defence

Any defence inherent in the insurance contract which the Insurer may raise against the Policyholder may also be raised against the Insured, whoever he/she may be.

16. Complaints procedure

If an Insured has any complaint regarding the standard of service received under this insurance contract, the following procedure is available to restore the situation:

- In first instance, the Insured should write to JoHo Insurances - Paviljoensgracht 18 - 2512 BP The Hague (Den Haag) - THE NETHERLANDS.
- If not satisfied, the Insured should then write to Henner - 14 Boulevard du Général Leclercq CS 20058 - 92527 Neuilly-sur-Seine CEDEX - FRANCE.

- If still not satisfied, the Insured should finally write to Allianz Insurance Luxembourg, branch of Allianz Belgium Insurance SA. 14 boulevard Franklin Roosevelt. L-2450 Luxembourg.

In case of disagreement with the Insurer or insurance intermediary, the Ombudsman will try to arrange a friendly settlement.
Ombudsman (Luxembourg) - 36, Rue du Marché-aux-Herbes - L-1728 Luxembourg- Phone +352 26 27 01 01.

17. Governing Law

This contract shall be governed and construed in accordance with Luxembourg Law. All and any documents issued pursuant to this contract will be written in English. The English version of this contract is leading.

18. Dispute settlement

Non-medical disputes

Before resorting to arbitration, the parties shall attempt to settle in good faith all disputes or differences which arise between them out of or in connection with this insurance policy, by negotiation between them in good faith, and, in the event of failure of such negotiations, the parties may, if they so agree, attempt to resolve any such dispute or difference by the use of a procedure known as Alternative Dispute Resolution (i.e. mediation, conciliation, expert determination or mini-trial).

Medical disputes

In case the Insured does not agree with decisions of the Medical Consultant of the Insurer, he/she can call upon his/her own treating doctor to assist him/her, and both the doctors of the Insurer and the Doctor of the Insured will try to reach agreement on the issue. If both Doctors fail to reach an agreement, they can jointly appoint a third Doctor to settle the dispute. If the two Doctors cannot agree on the choice of a third Doctor, he/she will be appointed by the "Chambre nationale d'Arbitrage des médecins" whose address is as follows: 180 Boulevard Haussmann, 75008 Paris - FRANCE. Each party has to pay the fees of their own Doctor, the fees of the third Doctor to be paid half by each of the parties.

Chapter II: Benefits and provisions proper to the different types of cover

Main plan

19. International Medical Insurance

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

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 costs on pregnancy (and complications thereof) and childbirth.

BENEFITS	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.)		
Deductible for outpatient treatment, per insured and per calendar year	N/A	€ 0 - $ 0 € 100 - $ 125 € 300 - $ 375 € 1000 - $ 1250	€ 0 - $ 0 € 300 - $ 375 € 500 - $ 625 € 1000 - $ 1250

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%
Surgical appliances 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 chem- or radiotherapy · Other costs	100%	100%	100%
AIDS / HIV Treatment	100% Up to € 50,000 Up to $ 62,500	100%	100%
Parent accommodation of one parent for child < 16	100% up to € 1.500 per stay 100% up to $ 1.875 per stay	100% up to € 1.500 per stay 100% up to $ 1.875 per stay	100% up to € 1.500 per stay 100% up to $ 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 € 1.500 100% up to $ 1.875	100% up to € 1.500 100% up to $ 1.875	100% up to € 4.500 100% up to $ 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 80% up to $ 50.000	80% up to € 40.000 80% up to $ 50.000	100% up to € 50.000 100% up to $ 62.500
Chronic and pre-existing conditions	Not covered [1]	Covered [2]	Covered [2]
Rehabilitation and convalescence rest/care (when the admission immediately follows hospitalisation)	Not covered	Not covered	100% (max. 28 days)
Psychiatric care	Not covered	Not covered	100% up to € 20.000 100% up to $ 25.000
New born [4]	100% Up to € 100,000 per delivery Up to $ 125,000 per delivery	100%	100%

EVACUATION IN THE EVENT OF ACCIDENT, ILLNESS AND UNEXPECTED EVENTS			
Evacuation assistance - Organisation and handling/taking care of return of Beneficiary or transportation towards a hospital - Reimbursement of accommodation costs and those incurred by an insured person accompanying the latter - Organisation and handling/ taking care of return for an insured person accompanying the Beneficiary	Actual costs In the limit, per day and per insured person, of € 104 / $ 130 for 7 days maximum Actual costs, in the limit of a ticket (1st class train ticket and/or economy class plane)		
Hospitalisation in situ 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	Shipping costs		
Assistance for early return 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)		
Emergency hospitalisation fees in case hospitalization of over 3 days abroad - 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		
Assistance in case of death of an insured person - Transportation of body - Funeral costs	Actual cost In the limit per insured person of € 2.390 / $ 2.987		

PREGNANCY AND CHILDBIRTH (a waiting period of 10 months is applied) [3]			
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 80% up to $ 9.375	100% up to € 10.000 100% up to $ 12.500
Childbirth with complications (No waiting period)		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 € 1.000 100% up to $ 1.250	100% up to € 3.000 100% up to $ 3.750
Preventive care & well-being benefit: · Check-up · Eye test		100% up to €300 100% up to $375	100% up to € 1.000 100% up to $ 1.250
Vaccinations		100% up to € 200 100% up to $ 250	100% up to € 600 100% up to $ 750
homeopathy, acupuncture, chiropractry and osteopathy		100% up to € 500 100% up to $ 625	100% up to € 3.000 100% up to $ 3.750
Therapy: · Ergotherapy · Logopaedics and/or Speech therapy · Psychiatric outpatient care		Not covered	50% up to € 2.000 50% up to $ 2.500
AIDS / HIV Treatment		100%	100%
Psychiatric care		Not covered	see Outpatient Treatment Therapies

Additional Insurances

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 80% up to $ 1.875	100% up to € 2.500 100% up to $ 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 60% up to $ 1.875	80% up to € 2.500 80% up to $ 3.125

1 No medical underwriting will be requested but members will still have to fill in a Medical questionnaire in order for the Medical Advisory Board to be able to list the chronic and pre-existing conditions that will be specified in the special conditions as not covered
2 Acceptance of your application is subject to a Medical questionnaire and approval by our Medical Advisory Board. For companies with more than 10 insured employees, medical history may be disregarded
3 For individuals and companies without MHD (Medical History Disregarded)
"4 New Born Child can be enrolled without waiting periods if registered within 2 months of delivery.
The limit on Essential plan applies from the 1st to the 90th day of the child's life if she/he has been registered in the plan."

a) Purpose

The International Medical Insurance reimburses - up to the limits defined in the present General Conditions - Reasonable and Customary expenses for outpatient (when relevant) as well as for inpatient medical services, provided these expenses have been incurred because of Illness, Accident or maternity.

b) Eligibility and acceptance

With respect to eligibility and acceptance into the insurance, reference is made to conditions as set out in Art. I-3.

c) Types of International Medical Insurance plans

There are Four (4) different plans:

- Essential;
- Bronze;
- Gold;
- Silver[2].

The plan chosen by the Policyholder is mentioned in the Special Conditions of the insurance policy. Each plan corresponds to a different level of benefits, details of which are mentioned in the Benefits Overview above. With regard to the change of level of cover, reference is made to Art. I-3.e).

[2] If you are covered by the Silver plan, please refer to the General Conditions 2013. **As of start date 01/01/2018, please note that the "Out-Of-Pocket" amount applied for Outpatient Treatment is reduced from €2500 to €1500 in this Silver plan.**

d) Territorial scope of the insurance

The territorial scope of 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 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.

e) Benefits

1/ Definitions

Reference is made to Art. I-2.

2/ Description of benefits

Eligible Medical Expenses, subject to the exclusions, limits and ceilings mentioned in this policy, are listed in the Benefits Overview 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 Benefits Overview – 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 1st January.

- Inpatient Treatment

Pre-certification as stated in Art. II-1.f) below is always required except in case of emergency. Failure to comply with this pre-certification requirement will lead to a reduction of the reimbursement with twenty-five (25)%.

- 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 Benefits Overview.

  - 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 Benefits Overview.

- 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 Benefits Overview 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[3], 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 Benefits Overview (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

[3] If you are covered by the Silver plan, please refer to the General Conditions 2013.

amount as set forth in the Benefits Overview 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. This waiting period can be waived for groups. Such waiver is only valid if explicitly mentioned in the Special Conditions of the group contract in question.

- 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 Benefits Overview. 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 Benefits Overview. 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 Benefits Overview. 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 Benefits Overview. 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.

f) Pre-certification requirement

All inpatient Medical Treatments (except emergency hospital admissions), as well as Day Surgery and Day Care are subject to pre-certification. This means that in case of non-emergency hospitalisation, Day Surgery or Day Care, for which the diagnosis of the medical condition has been established more than five (5) days before actual admission into hospital (or before the start of the Day Care or Day Surgery), the Claims handler has to be informed - in writing - at the latest five (5) days before the Treatment will be performed (in case of childbirth, five (5) days before the delivery will take place). The following information is required:

- diagnosis;
- description of the required Medical Treatment;
- name and address of the hospital where the Treatment will be given;
- expected length of stay in the hospital;
- estimated cost of the Treatment.

In case of an emergency hospitalisation, the Claims handler has to be informed as soon as possible (normally within forty-eight (48) hours) and at the latest before discharge from the hospital.

g) Restrictions and exclusions

In addition to the exclusions mentioned in Art. I-11., the following items or services are excluded from cover:

- Treatment that is considered experimental/investigative according to accepted professional medical standards and Treatment that is not medically indicated;
- non-prescribed Medical Treatments;
- complementary (and or alternative) Medical Treatments other than those explicitly mentioned in the Benefits Overview;
- rejuvenation and spa cures, cosmetic Treatments and convalescent rest;
- facilities for the aged, primarily giving custodial, educational and rehabilitory care;
- 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 the Special Conditions;
- non-Prescription Drugs;
- OTC ('over-the-counter') medicines; lifestyle products, dietary products, vitamins, food supplements and food products, baby food, mineral waters, tonics, cosmetic products etc;
- expenses related to sterilisation, unless explicitly mentioned in the schedule of benefits;
- contraceptive and birth control drugs, even if prescribed by a Physician;
- costs related to abortion except in case of absolute medical necessity;
- cosmetic/aesthetic Treatment except restorative Treatment following Accident;
- surgical procedures costs related to corrective eye Surgery (keratectomy and keratotomy, including LASIK and LASEK procedures), except in case of refractive Illness of the cornea in which case they are covered as any other surgical expenses;
- remedial teaching;
- elective caesarean delivery expenses;
- sex change operations and related Treatment expenses;
- sunglasses and orthoptic Treatment;
- participation in any sport as a professional or under contract providing remuneration, as well as any preparatory training.

h) Claims procedure/Coordination of benefits - other insurance/Claims payment

1/ Claims procedure

Each claim has to be submitted to the Administrator, in writing - using the special claim forms made available by the Administrator - as soon as possible after the event giving rise to the claim has occurred. The claim has to be accompanied by the original supporting documentation including all relevant invoices, and proof of payment whenever requested. Moreover, in case of Accident, the Insured has to provide following additional information:

- date and detailed description of circumstances and place of the Accident;
- identity of persons involved, as well as of witnesses and persons possibly liable;

- official report from local authorities (police or other).

2/ Coordination of benefits - other insurance

If the Insured is entitled to a reimbursement by another Insurer or social security system, the cover - in accordance with the provisions of Art. II-1.e) - will be applied on the difference between the Eligible Medical Expenses and the reimbursement made by the other Insurer. However, in case the International Expat Insurance Package is offered as a supplementary Insurance (and this is reflected in the premium rates), the amount reimbursed by the other insurance will be deducted from the amount of reimbursement as determined in accordance with the provisions of Art. II-1.e). In any case, the Insured has to attach (to his/her claim) copies of the pertaining medical bills and the original settlement notes (with details of the amount reimbursed) provided by the other Insurer or the social security system concerned. Total reimbursement for any given claim will never exceed the total amount of expenses actually incurred by the Insured.

3/ Claims payment

The Administrator shall effect reimbursement of the covered Reasonable and Customary medical expenses (up to the limits defined in these General Conditions) following the receipt of the claim form and the relevant and complete written evidence of the medical expenses (original invoices of medical service providers, etc).
Reimbursements shall be made to the Insured, but if the Insured has deceased, payment shall be made at the sole discretion of the Insurer, or to any person submitting satisfactory evidence that he/she is entitled to such payment. Benefits may be directly assigned to hospitals.

i) Medical information and examination

Whenever required for the smooth settlement of claims related to the insurance cover provided by the insurance policy, and in accordance with Belgian legislation concerning the protection of personal data, the Insured is obliged to provide (directly or through his/her Doctor) all the necessary medical information requested by the Insurer through the Administrator. Confidential information may be forwarded under sealed envelope to the Administrator's medical consultant. Whenever deemed necessary for the assessment of a claim, the Administrator is allowed to request a medical examination of the Insured, performed by a Doctor appointed by the Insurer, at the Insurer's expense. The Insured can ask for his/her own Doctor to be present at this examination, the costs for the own Doctor to be borne by the Insured himself/ herself. In case the Insured and/or the Insured's Dependents do not comply with above obligations to provide the requested medical information or examination, the Insurer can refuse payment of benefits.

j) Time limitation

Claims should be reported to the Administrator as soon as possible after their occurrence. For some Treatments, precertification is required (Art. II-1.f)).
In any case, claims have to be received by the Administrator no later than two (2) years after the event giving rise to the claim occurred. Beyond this maximum term of two (2) years, no claim will qualify for payment by the Insurer.

20. 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, on e 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 authorisation 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 **$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 **$130** for **7 days maximum**	
• **Dispatch of medication (1.3)**	Shipping costs	N/A

• Assistance for early return (1.4) - 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)	N/A
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: $39 N/A
ASSISTANCE IN CASE OF DEATH		
• Assistance in case of death of an insured person (1.7) - Transportation of body - Funeral costs	 Actual cost In the limit per insured person of $2,987	N/A

21. Dental Care

Dental care	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 80% up to $ 1.875	100% up to € 2.500 100% up to $ 3.125
Major dentistry *(orthodontic, prostheses, bridges, implants)*[3] 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 60% up to $ 1.875	80% up to € 2.500 80% up to $ 3.125

a) 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.

b) 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.

c) 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.

d) Waiting period and age limit

A waiting period of twelve (12) months applies for all major dentistry. The waiting period can be waived for groups. Such waiver is only valid if explicitly mentioned in the Special Conditions. Orthodontic Treatment is only covered if started before age fifteen (15).

e) 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.

22. Life Cover

This Additional Insurance can only be taken out if your policy is domiciled (policy address) in one of the following EEA countries: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Spain, Sweden and the United Kingdom.

a) Purpose and eligibility

The purpose of the Life Cover is to guarantee payment of a lump sum in case of death due to any cause.

The Life Cover can be taken out for or by the expatriated person as well as by his/her adult spouse insofar as this person is also accepted in and covered by the International Medical Insurance and maximum up to sixty (60) years of age.

b) Period of reflection

If you are not satisfied with the agreement of the Life Cover for whatever reason, you may return it to us within thirty (30) days from the date of delivery. We will cancel the insurance and refund to you all premiums paid, on the condition that no claims were reimbursed yet.

c) Benefits payment

A lump sum payment will be effected to the designated beneficiaries of the deceased Insured as indicated on the Nomination of beneficiaries form.

Benefits will be paid insofar as the Insured's decease occurs before the day of his/her sixty-sixth (66th) birthday. If the policy ends before the decease of the Insured, no payments will be effected.

d) Amount of the sum insured

The amount of the sum insured is specified in the Special Conditions. However, the minimum sum insured shall be 50,000 EUR/65,000 USD and can be increased up to a maximum sum insured of 500,000 EUR/625,000 USD. Premiums and benefits (lump sum) are calculated on the basis of the sum insured.

e) Additional exclusions

In addition to the general exclusions mentioned under Art. I-11. and I.12., following exclusions shall apply to the Life Cover:

- the consequences of suicide or of suicide attempts;
- death caused by a state of drunkenness or under the influence of non-prescribed drugs;
- death caused by ionising radiations other than the medical radiations required by covered Medical Treatment;

f) Obligation of the Insured

At the inception of the policy, the Policyholder has to provide the Claims Handler with the Nomination of beneficiaries form, duly filled out and signed by the Insured.

In case of death the Insurer will pay the lump sum insured to the Insured's designated beneficiaries or the lawful heir(s) in case no beneficiaries have been declared on the said form, within a month of receiving:

- copy of the birth certificate of the deceased or a certificate of civil status, and
- an original death certificate;
- a medical certificate, established by a Doctor, stating the cause of death;
- the Special Conditions of the insured's policy.

The burden of proof lies with the beneficiaries.

23. Accidental Death and Invalidity

a) Purpose and eligibility

The Accidental Death and Invalidity cover guarantees:

- the payment of a lump sum in case of accidental death or;
- the payment of a lump sum in case of permanent Invalidity of at least 20%, caused by an Accident.

The Accidental Death and Invalidity cover can be taken out for or by the Expat, as well as for or by his/her adult Dependents as defined in Chapter I.

b) Definition of Accident

For the definition of Accident, reference is made to article 2 of the General Policy Provisions.

c) Time limits for the declaration of the Accident, claim assessment and benefits payment

1/ Time limit for the declaration of the Accident

Any Accident resulting in - or which may result in – permanent Invalidity or death of the Insured, has to be declared in writing to the Insurer or the Administrator within a fortnight after the Accident occurred.

The declaration of the Accident should contain detailed information relating to the cause of the Accident and the nature of the Injuries.

2/ Time limit for claim assessment and benefits payment

In case of accidental death, which has to occur within twelve (12) months after the date of the Accident causing the decease, a lump sum payment will be effected to the designated beneficiaries of the deceased Insured as indicated on the Nomination of beneficiaries form.

In case of permanent Invalidity, the Invalidity must be medically recognised at the latest one (1) year after the date of the Accident. However, if the Insured's condition has not entirely stabilised within two (2) years after the date of the Accident, the degree of permanent Invalidity will be assessed on the basis of the Insured's state of health at the end of that two (2)-year period.

d) Amount of the sum insured

The amount of the sum insured is specified in the Special Conditions. However, the minimum sum insured shall be 50,000 EUR/62,500 USD and can be increased up to a maximum sum insured of 500,000 EUR/625,000 USD. Premiums and benefits (lump sum) are calculated on the basis of the sum insured.

For group insurance plans, benefits under the Accidental Death cover deriving from One Single Event shall be limited to € 4,000,000 / $ 5,000,000. If this limit is met, the € 4,000,000 will be apportioned between the beneficiaries.

e) Insured benefits

1/ Accidental death

In case of death of the Insured, caused by an Accident, the lump sum payable by the Insurer (to the beneficiaries of the Insured) will be equal to hundred (100)% of the sum insured, the amount of which is mentioned in the Special Conditions.

2/ Accidental Invalidity

In case of permanent Invalidity of the Insured caused by an Accident, the lump sum payable by the Insurer (to the Insured) will be equal to the amount of the sum insured (as mentioned in the Special Conditions) multiplied by the degree of Invalidity (percentage), the latter being determined in accordance with the Table of Invalidity hereafter. Permanent Invalidity of a degree of less than twenty (20)% will not qualify for payment of any benefit. If the permanent Invalidity caused by the Accident amounts to twenty (20)% or more than 20% according to the Table of Invalidity hereafter, the benefit amounts to the corresponding percentage of the sum insured.

f) Assessment of the degree of permanent Invalidity and use of the Table of Invalidity

1/ Table of Invalidity

The following Table of Invalidity will be used to determine the degree of Invalidity:

Table of Invalidity		
Total paralysis		100%
Total blindness		100%
Incurable and total mental disability		100%
Amputation or the permanent loss of the use of:		
a) both arms or both hands		100%
b) both legs or both feet		100%
c) one arm or hand and one leg or foot		100%
Total loss of sight of one eye with removal of the eye		50%
Total loss of sight of one eye		45%
Loss of bone of the skull forming a hole in the skull over:		
a) an area of at least 6 cm^2		40%
b) an area of 3 to 6 cm^2		20%
c) an area of less than 3 cm^2		10%
Incurable total loss of hearing in both ears		100%
Incurable total loss of hearing in one ear		50%
Amputation of the lower jaw		
a) total		70%
b) partial (upright branch plus the whole or half of the up toillary bone)		40%
Loss of top and bottom teeth and their sockets		
a) impossibility of fitting dental prosthesis		10 to 30%
b) In the case of possible prosthesis with established functional improvement		1 to 10%
	Right	**Left**
Loss of arm or hand	75%	60%
Total paralysis of an upper limb	65%	55ù
Total paralysis of the circumflex nerve	20%	15%
Total paralysis of the median nerve	45%	35%

Total paralysis of the cubital nerve at the elbow	30%	25%
Total paralysis of the nerve of the hand	20%	15%
Total paralysis of the radial nerve above the triceps	40%	30%
Complete ankylosis of the shoulder:		
a) with immobilisation of the shoulder-blade	65%	55%
b) with mobility of the shoulder-blade	35%	25%
Non-consolidated fracture of the upper arm: *(constitution of pseudoarthrosis)*	30%	25%
Total loss of movement of the elbow:		
a) in an unfavourable position	40%	35%
b) in a favourable position	25%	25%
Non-consolidated fracture of the fore-arm: *(constitution of pseudo-arthrosis)*		
a) both bones	25%	20%
b) a single bone	10%	8%
Total loss of movement of the wrist		
a) in an unfavourable position *(flexion, forced extensions or supination)*	40%	30%
b) in a favourable position *(straight or prone)*	20%	15%
Amputation of a thumb		
a) total	20%	18%
b) partial (ungual phalanx)	10%	8%
Ankylosis of a thumb		
a) total	15%	12%
b) partial (ungual phalanx)	10%	8%
Amputation of index-finger		
a) total	16%	14%
b) two phalanxes	12%	10%
c) one phalanx	6%	5%
Amputation of second finger	12%	10%
Amputation of third finger	10%	8%
Amputation of fourth finger	8%	6%
Total paralysis of a lower limb		60%
Complete paralysis of the internal popliteal sciatic nerve		30%
Complete paralysis of the external popliteal sciatic nerve		30%
Complete paralysis of both popliteal sciatic nerves		40%
Shortening of a lower limb		
a) at least 5 cm		30%
b) from 3 to 5 cm		20%
c) from 1 to 3 cm		10%
Complete ankylosis of the hip:		
a) in a bad position *(flexion, adduction or abduction)*		60%
b) in a straight position		40%
Amputation of the thigh:		
a) upper half and leg		60%
b) lower half and leg		50%
Non-consolidated fracture of the thigh or both bones of the leg *(constitution of pseudoarthrosis)*		50%
Complete ankylosis of the knee:		
a) in flexion (from 130 degrees)		50%
b) straight or almost straight		25%
Chronic gonarthrosis according to the degree of muscular atrophy		3 to 20%
Non-consolidated fracture of the knee-cap with wide separation of the fragments and considerable difficulty in extension of the leg from the thigh		40%
Amputation of a leg		50%
Tibio-tarsian ankylosis		15%
Amputation of a foot:		
a) total (tibio-tarsian disarticulation)		50%

b) sub-astragalian c) media-tarian d) tarso-metatarsian	40% 35% 30%
Amputation of all toes	20%
Amputation of big toe	10%
Amputation of a toe other than big toe	3%
Ankylosis of the big toe	3,5%

2/ Permanent nature of the Invalidity

In order to qualify for payment of the insured benefit, the Invalidity has to be of a permanent nature, meaning that it has been medically determined that continuation of the Medical Treatment will not lead to any significant improvement of the person's state of health, and that the Invalidity will therefore be definitive and irreversible.

3/ Pre-existing state of infirmity

A pre-existing state of infirmity of limbs or organs, cannot be taken into account for the assessment of the Injuries that are caused by the Accident.

4/ Maximum degree of Invalidity

The degree of permanent Invalidity can never exceed 100%. Under no circumstances the sum payable by the Insurer will exceed 100% of the sum insured.

5/ Several Injuries affecting the same limb

In case of several Injuries or infirmities resulting from the same Accident or from successive Accidents, each Injury or infirmity will be assessed separately, but the sum of Injuries or infirmities affecting a limb may not lead to a degree of Invalidity exceeding the degree of Invalidity corresponding to the full loss of the limb concerned.

6/ Events or infirmities not listed in the table of Invalidity

For events or infirmities not listed in the Table of Invalidity, the degree of Invalidity shall be determined by reference to the listed events or infirmities: the Table of Invalidity will be used as a guide to assess the degree of Invalidity by analogy with listed items. The sum payable will in no case be less than the amount payable for any reasonably analogous event or infirmity, listed in the Table of Invalidity.

7/ Total loss of use of a limb

Total loss of use of a limb will be considered being equal to the loss of the limb itself.

8/ Left-handed persons

Left-handed persons, upon declaration of left-handedness in the place indicated on the declaration of state of health, shall receive scaled benefits related to the upper right limb instead of upper left limb, and vice versa.

9/ Aggravating facts

In the case of aggravation of the consequences of an Accident as a result of infirmities, Illness or circumstances independent of the accidental cause, the degree of Invalidity cannot be superior to the one that would have been determined if the Accident had struck a healthy organism.

g) Additional exclusions

In addition to the general exclusions mentioned under Art. I-11. and I-12., following exclusions shall apply to the Accidental Death and Invalidity cover:

- Accidents resulting from obviously foolhardy and/or reckless acts by the Insured, or Accidents he/she has intentionally caused or provoked;
- the consequences of suicide or of suicide attempts;
- Accidents occurring in a state of drunkenness or under the influence of non-Prescription Drugs except if it is established by the Insured or his/her beneficiaries that such state was not the cause of the Accident;
- Accidents provoked by ionising radiations other than the medical radiations required by covered Medical Treatment;
- Invalidity and/or death resulting from an Illness.

h) Obligations to be fulfilled by the Insured

1/ Declaration of Accident

Any Accident that leads or that could lead to Invalidity or death must be declared in writing to the Insurer (through the Administrator) within a fortnight after the Accident occurred. The declaration must contain all information relating to the Accident, including:

- place, date and detailed circumstances of the Accident;
- names and addresses of persons involved;
- names and addresses of witnesses and of persons possibly liable;
- the official report from the local authorities (e.g. police report or other relevant documents).

A medical certificate must be attached to this declaration, indicating the nature and extent of the Injuries of the Insured and the probable duration of the Invalidity.

2/ Changes to the extent of the Invalidity

Any changes to the extent of the Invalidity must be communicated by the Insured to the Insurer (through the Administrator) within one (1) month. In the absence of such communication, any amount unduly paid to the Insured will have to be refunded by him/her to the Insurer.

3/ Medical information

The Insured shall authorise his/her attending Physician to communicate all relevant information concerning the Insured's state of health to the Insurer's medical consultant.

4/ Force majeure

There shall be no loss of cover if the Insured can prove that the obligations, as stipulated by this article, have not been fulfilled as a result of circumstances totally beyond his/her control ('force majeure'), or if the good faith of the Insured cannot be called into question.

i) Payment of the benefit

At the inception of the policy, the Policyholder has to provide the Administrator with the duly completed and signed Nomination of beneficiaries form. In case of death caused by an Accident,

the Insurer will pay the lump sum insured to the Insured's designated beneficiaries (or the lawful heir(s) in case no beneficiaries have been declared on the said form) within one (1) month of receiving:

- the documents mentioned under Art. II-5.g)1/;
- copy of the birth certificate of the deceased or a certificate of civil status;
- an original death certificate;
- a detailed medical certificate, established by a Doctor, stating the cause of death.

Before the claim can be paid, the causal link between the Accident and death should have been established. The burden of proof lies with the beneficiaries. In case of permanent Invalidity caused by an Accident, the Insurer will pay the lump sum insured to the Insured. Following documents have to be provided to the Administrator:

- the documents mentioned under Art. II-5.g)1/;
- copy of the birth certificate of the Insured concerned or a certificate of civil status;
- a detailed medical certificate, established by the attending Physician, stating the cause of the Invalidity, accompanied by all relevant documents needed to accurately assess the Invalidity (Art. II-5.e)).

After all documents have been received by the Administrator and the condition of the Insured concerned has sufficiently stabilised to allow the Insurer's medical consultant to assess the degree of Invalidity (according to the provisions as set out in Art. II-5.e)), payment of the insured sum due will be made within one (1) month.

24. Temporary Incapacity

a) Purpose and eligibility

The purpose of the Temporary Incapacity cover is to guarantee to the Insured, after the waiting period as defined hereafter, the payment of a monthly allowance during a maximum period of two (2) years, in case the Insured is totally unable to perform his/her professional occupation.
The Temporary Incapacity cover can be taken out for or by an individual expatriate or expatriated employee and is also extended to the expatriated spouse or legal partner of the individual expatriate or expatriated employee provided the spouse or legal partner occupies a remunerated occupation. The Temporary Incapacity is not available to the insured's child and housewife.

b) Medical acceptance into the insurance

Joining the Temporary Incapacity cover is subject to the acceptance of the candidate-Insured into the insurance by the Insurer's medical consultant. If one subscribes to the Temporary Incapacity cover on a later date than the International Medical Insurance cover, a new Medical questionnaire has to be completed and signed.

c) Temporary Incapacity benefit

The Temporary Incapacity cover provides for a monthly allowance in case the Insured - further to an Illness or an Accident - is totally unable to perform his/her own professional occupation (i.e. the usual professional occupation at the time the incapacity started).

d) Waiting period

The allowance is payable after a waiting period of ninety (90) days (for which no benefits are due) of uninterrupted total incapacity to perform the own professional occupation. The waiting period shall commence on the starting date of the incapacity, as determined by the treating Physician.

e) Assessment of the incapacity

The incapacity has to be supported by sufficient medical evidence, to be presented by the Insured or his/her Physician to the medical consultant of the Insurer. The Insurer's medical consultant has the right to ask for relevant additional information and/or have the Insured medically examined to assess the incapacity.

f) Amount and duration of the benefit

The amount of the monthly allowance in case of total incapacity of the Insured to perform his/her own professional occupation is mentioned in the Special Conditions. The minimum amount to be insured is 1,000 EUR/1,250 USD (monthly allowance). The amount insured cannot exceed 80% of the gross (monthly) Salary of the Insured, nor can it exceed an amount of 10,000 EUR/12,500 USD per month. The Policyholder shall submit to the Administrator a copy of the latest Salary statement of the Insured. After the waiting period of ninety (90) days, the allowance will be paid as long as

the Insured is totally unable to perform his/her occupation, limited however to a maximum period of two (2) years.

g) Partial resumption of work

Persons who (after the ninety (90)-day waiting period) are benefiting from the monthly allowance and whose condition is improving to such an extent that they are capable of partially resuming work, may continue (within the limits of the maximum period of two (2) years after the waiting period) to receive an allowance. The amount of this allowance will however be reduced, and will be calculated by multiplying the (total monthly) sum insured by the percentage of the (remaining) incapacity. In case the incapacity would become less than thirty (30)%, the allowance will be discontinued.

h) Relapse

In the event of a relapse, the payment of the allowance shall be resumed without application of a new waiting period. By 'relapse' is meant: the incapacity to work, which arises within three (3) months of the end of incapacity covered by this insurance policy, and which is caused by the same Illness or the same Accident. Any additional incapacity resulting from another cause shall be subject to a new waiting period of ninety (90) days.

i) Benefit payment

The incapacity allowance shall be payable to the Insured, at the end of each month, and for the first time at the end of the month following the expiration of the waiting period. If the incapacity to work comes to an end in the course of a month, the allowance shall be proportional to the number of days lapsed in that month. Payments shall cease at the event of one of the following occasions:

- when the degree of incapacity becomes less than 30%;
- on the death of the Insured;
- at the end of the period of two (2) years of payment of the allowances;
- in the event of the insurance policy being terminated for the non-payment of the premium;
- on the renewal date after the sixty-fifth (65th) birthday of the Insured;
- when the Insured fully resumes work.

j) Additional exclusions

In addition to the general exclusions mentioned in Art. I-11. and I-12., the following exclusions apply to the Temporary Incapacity cover:

1/ Maternity leave and childbirth

Maternity leave and incapacity to work because of childbirth are not covered. They will not be taken into account for the calculation of any waiting period and will not give rise to any benefits. In case the Insured would, however, be in receipt of benefits for Temporary Incapacity for other reasons (than childbirth or maternity leave) during which period the maternity leave would start, the payment of benefits will be suspended to resume only after the end of the maternity leave, and

only in case if the Insured is then still unable to resume work. If on the expiry date of the normal maternity leave of a female Insured, a health condition exists which prevents the Insured from fully resuming her usual professional occupation (total inability to work), the waiting period will start as from that date.

2/ Mental or nervous disorders[4]

There shall be no cover for mental or nervous disorders except when they result from a serious accident (i.e causing at least a 21 days Temporary Incapacity).

3/ Dangerous sports

- incapacity resulting from any sport for professional purposes, even as a secondary profession;
- or any remunerated participation in sports competitions;
- or any unremunerated practice of sports reputed to be rash and hazardous, such as:
  - rugby;
  - winter sports competitions and races;
  - aerial sports (except ballooning);
  - hunting big game (including safari);
  - speleology and cave diving;
  - alpinism, if not on official paths;
  - motor vehicle racing on land and water (except noncompetitive recreative jet-ski, recreative water ski, or tourist rallies for which no time or speed imperatives have been imposed);
  - rafting, canyoning, bungee jumping and similar sports.

k) Obligations to be fulfilled by the Insured and/or the Policyholder

1/ Notification of incapacity

In case of incapacity to perform the usual professional occupation because of Illness or Accident, such incapacity has to be notified by the Policyholder to the Administrator in writing as soon as possible and at the latest on the ninety-first (91st) day of the incapacity. At the same time, a medical report, established by the treating Physician of the incapacitated person, indicating the nature and extent of the incapacity of the Insured as well as the probable duration of the incapacity, has to be forwarded to the Administrator, for the attention of the Insurer's medical consultant. Furthermore, a proof of income has to be provided.

2/ Changes to the extent of the incapacity

Any changes to the extent of the incapacity must be communicated by the Insured or his/her Doctor to the Insurer's medical consultant (through the Administrator) within a month. In the absence of such communication, any amount unduly paid to the Insured will have to be refunded by him/her to the Insurer.

3/ Medical information

[4] This exclusion only applies on Permanent Disability insurances with a start date of 1 January 2018

The Insured shall authorise his/her attending Physician to communicate all relevant information concerning the Insured's state of health to the Insurer's medical consultant.

4/ Force majeure

There shall be no loss of cover if the Insured can prove that the obligations, as stipulated by this article, have not been fulfilled as a result of circumstances totally beyond his/her control ('force majeure'), or if the good faith of the Insured cannot be called into question.

25. Permanent Disability

a) Purpose and eligibility

1/ Purpose

The purpose of the Permanent Disability cover is to guarantee payment of a monthly Disability allowance, (maximum up to age of sixty-five (65)) to the Insured who is affected by a Permanent Disability caused by an Illness or Accident, prohibiting him/her from fully or partially continuing his/her professional occupation, therefore leading to a total or partial loss of income.
The insurance covers Permanent Disability caused by an Illness or Accident and amounting to a degree exceeding thirty-three point thirty-three (33.33)%. Moreover, in case the degree of Disability exceeds sixty-six point sixty-seven (66.67)%, and if the Insured needs the assistance of a third person to perform the basic activities of daily living, the insurance guarantees an additional lump sum benefit, in accordance with the provisions as set out below.

2/ Eligibility

The Permanent Disability cover can only be taken out as an Additional Insurance (supplement) to the Temporary Incapacity cover. The Permanent Disability cover can be taken out for or by an individual expatriate or expatriated employee and is also extended to the expatriated spouse or legal partner of the individual expatriate or expatriated employee, provided the spouse or legal partner occupies a remunerated occupation. The Permanent Disability is not available to the insured's child and housewife.

b) Medical acceptance into the insurance

Joining the Permanent Disability cover is subject to the acceptance of the candidate-Insured into the insurance by the Insurer's medical consultant.

c) Definition of Permanent Disability (resulting from an Illness or Accident)

1/ Disability

An Insured is considered to be disabled because of Illness or Accident, if:

- his/her ability to work, i.e. the ability to perform his/her normal professional occupation (occupation at the time the Disability started) or any other gainful occupation for which he/she is reasonably fitted by training, education or experience has been reduced;

and

- his/her ability to function in general has been reduced because of the Illness or Accident concerned. In order to qualify for the insured benefits, it has to be medically determined that the Insured's Disability is of a permanent nature and that the degree of (the combination of both) occupational and functional Disability exceeds 33.33% according to the Table of Disability hereafter (Art. II-7.e)).

2/ Permanent Disability

Permanent Disability means that the continuation of the Medical Treatment will not lead to any significant improvement of the person's state of health, and that the Disability will therefore be definitive and irreversible.

d) Waiting period

The Permanent Disability cover is a supplement to the Temporary Incapacity cover. Benefit payment will therefore start at the earliest after the allowances paid by the Insurer within the framework of the Temporary Incapacity cover have come to an end.

e) Assessment of Disability

The degree of Permanent Disability will be determined by means of a medical examination. To this end, the Insurer will designate a Doctor to determine the degree of Disability in accordance with the Table of Disability hereafter.

	Degree of functional disability					
Degree of occupational disability	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**
10%						36,59
20%				36,94	41,60	46,10
30%			36,54	42,17	47,62	52,78
40%			40,00	46,2	52,42	58,09
50%		35,57	43,09	50,00	56,46	62,57
60%		37,80	45,79	53,13	60,00	66,49
70%		39,79	48,20	55,93	63,16	70,00

f) Amount and duration of the benefit

1/ Calculation of the amount of the monthly Disability allowance

- Insured allowance

The amount of the insured allowance is mentioned in the Special Conditions. In no event, the amount of the insured allowance shall be higher than the monthly allowance of the Temporary Incapacity cover.

- Degree of Permanent Disability of less than 33.33%

No benefits will be due for Disabilities of less than thirty-three point thirty-three (33.33)% (=1/3).

- Degree of Permanent Disability between 33.33% (= 1/3) and 66.67% (=2/3)

If the degree of Disability, as determined in accordance with the stipulations of Art. II-7.c) and II-7.e) above, is situated between thirty-three point thirty-three (33.33)% and 6 sixty-six point sixty-seven (66.67)%, then the amount of the Disability allowance will be calculated as follows: ((3 x n) – 1) x insured allowance, 'n' being the degree of Disability (%).

- Degree of Permanent Disability exceeding 66.67% (=2/3)

If the degree of Disability, as determined in accordance with the stipulations of Art. II-7.c) and II-7.e) above, exceeds sixty-six point sixty-seven (66.67)%, then the amount of the Disability allowance will be equal to the amount of the insured allowance (hundred (100)%).

2/ Additional lump sum benefit in case of need of assistance of a third person

If from the start of the Disability (i.e. as from the start of the payment of the Disability allowance) the degree of Permanent Disability exceeds sixty-six point sixty-seven (66.67)%, and if the Insured, as from the start of the Disability, needs the assistance of a third person to be able to perform the following activities of daily living:

- feeding oneself (taking and eating prepared food);
- dressing oneself;
- washing oneself;
- using the toilet or bedside commode;
- moving around (transferring from a bed to a chair or vice versa, and ability to move on level surfaces);

then the Insurer will pay a once-only additional benefit of 25,000 EUR/ /31,250 USD (single lump sum) to the Insured.

3/ Yearly adjustment of Disability allowance (indexation)

The monthly Disability allowance, paid under temporary incapacity cover or permanent disability cover, shall be subject to an annual increase of two (2)%. This adjustment will be applied for the first time at the end of the first month of the first (1st) calendar year following the first (1st) benefit entitlement.

4/ Duration of benefit

Benefits will be paid at the latest till the end of the month in which the Insured:

- reaches the age of sixty-five (65);
- deceases;
- resumes work full time;

whichever event occurs first.

g) Benefit payment

The Disability allowance shall be payable on a monthly basis, at the end of each month. Before any payment can be made, the Administrator should have received a copy of the Insured's birth certificate or a certificate of civil status.

h) Additional exclusions

In addition to the general exclusions mentioned in Art. I-11. and I-12., the following exclusion applies to the Permanent Disability cover:

1/ Mental or nervous disorders[5]

[5] This exclusion only applies on Permanent Disability insurances with a startdate of 1 January 2018

There shall be no cover for mental or nervous disorders except when they result from a serious accident (i.e causing at least a 21 days Temporary Incapacity).

2/ Dangerous sports

Disability resulting from any sport for professional purposes, even as a secondary profession, or any remunerated participation in sports competitions, or any unremunerated practice of sports reputed to be rash and hazardous, such as:

- rugby;
- winter sports competitions and races;
- aerial sports (except ballooning);
- hunting big game (including safari);
- speleology and cave diving;
- alpinism, if not on official paths;
- motor vehicle racing on land and water (except noncompetitive recreative jet-ski, recreative water ski, or tourist rallies without time or speed imperatives);
- rafting, canyoning, bungee jumping and similar sports.

i) Obligations to be fulfilled by the Insured

1/ Assessment of Disability – medical information

The Disability has to be supported by sufficient medical evidence, to be presented by the Insured or his/her Physician to the medical consultant of the Insurer.
The Insured shall authorise his/her attending Physician to communicate all relevant information concerning the Insured's state of health to the Insurer's medical consultant. The Insurer's medical consultant has the right to ask for relevant additional information and/or have the Insured medically examined to assess the Disability. Furthermore, a proof of income has to be provided.

2/ Changes to the extent of the Disability

Any changes to the extent of the Disability must be communicated by the Insured to the Insurer (through the Administrator) within one (1) month. In the absence of such communication, any amount unduly paid to the Insured will have to be refunded by him/her to the Insurer.