## SUMMARY

### PART 1 - GENERAL PROVISIONS

#### CHAPTER 1 - THE POLICY

- ARTICLE 1 - DEFINITIONS
- ARTICLE 2 - PURPOSE OF THE POLICY
- ARTICLE 3 - CURRENCY OF THE POLICY
- ARTICLE 4 - ENROLMENT
- ARTICLE 5 – RIGHT OF WITHDRAWAL
- ARTICLE 6 - TERMINATION OF COVER
- ARTICLE 7 - OTHER TERMS

#### CHAPTER 2 - THE INSURED

- ARTICLE 8 - ELIGIBILITY - ACCEPTANCE INTO THE INSURANCE

#### CHAPTER 3 - PREMIUMS

- ARTICLE 9 - AMOUNT AND CALCULATION RULES
- ARTICLE 10 - NON PAYMENT OF PREMIUMS BY THE INSURED

#### CHAPTER 4 - CLAIMS

- ARTICLE 11 - CLAIMS SETTLEMENT

#### CHAPTER 5 - EXCLUSIONS

- ARTICLE 12 - GENERAL EXCLUSIONS

### PART 2 – CONDITIONS RELATED TO HEALTH COVERAGE

- ARTICLE 13 - AREAS OF COVER
- ARTICLE 14 - HEALTH AND ASSISTANCE COVERAGE
- ARTICLE 15 - WAITING PERIODS
- ARTICLE 16 - PRIOR AGREEMENT
- ARTICLE 17 - HEALTH AND ASSISTANCE COVERAGE EXCLUSIONS
- ARTICLE 18 - HEALTH COVERAGE DEFINITIONS

### PART 3 - TERMS SPECIFIC TO LIFE INSURANCE COVERAGE

- ARTICLE 20 - DEATH (ALL CAUSES) – TOTAL PERMANENT DISABILITY
- ARTICLE 21 - ACCIDENTAL DEATH
- ARTICLE 22 - LIFE INSURANCE COVERAGE EXCLUSIONS
- ARTICLE 23 - LIFE INSURANCE DEFINITIONS
- ARTICLE 24- DOCUMENTS TO PROVIDE WITH A CLAIM

### APPENDIX 1- TABLE OF BENEFITS

### APPENDIX 2- RIGHT OF WITHDRAWAL
The association LA GARANTIE MEDICALE ET CHIRURGICALE, on behalf of its Members and meeting the conditions defined in Article 8.1 of this policy, has subscribed to the policy for the coverage of Health and Life Insurance risks with HAUTEVILLE INSURANCE COMPANY LIMITED.

The resulting rights and obligations,

- For the association “La Garantie Médicale et Chirurgicale” hereafter referred to as the "Subscribing Association" or "the GMC"
- For the members of the GMC Association hereafter referred to as “the Member” or "the Insured"
- For the Insurer represented by Hauteville Insurance Company Limited, hereafter referred to as "the Insurer"

are defined by this policy which is governed by English law.

Administration is delegated to HENNER - GMC, called « HENNER - GMC » below. The insurance contract consists of general conditions and the certificate of enrolment.

I PART 1 - GENERAL PROVISIONS

CHAPTER 1 - THE POLICY

ARTICLE 1 - DEFINITIONS

The terms and expressions used in this policy have the meaning defined below (non-exhaustive list):

Expatriate
A person whose Country of Usual Residence is different from his Country of Nationality.

Country of Nationality
The country of issuance of the Insured’s passport.

Country of Usual Residence
The country in which the Insured or the Dependants reside for at least 6 consecutive months in a year.

The Country of Nationality of the Insured cannot be the same as the Country of Usual Residence. This rule does not apply to Dependants of the Insured unless their Country of Nationality is USA, Mainland China, or Switzerland.

The terms and expressions specific to each policy are defined in the corresponding parts.

Wherever the context requires, the masculine gender includes the feminine or neuter, and the singular includes the plural and conversely.

ARTICLE 2 - PURPOSE OF THE POLICY

The declarations of the Subscribing Association and the Insured are the basis of the policy.

The purpose of the Care & Health insurance policy subscribed by the GMC association is to provide its Members with the Medical Expense and Life insurance Coverage defined in parts 2 and 3 of the General Conditions.
This policy is not intended to replace mandatory Social Security types of cover in the countries where such system exist. It is the responsibility of the Members to check the conditions to be exempted from the mandatory social insurance systems in their Country of Usual Residence.

**ARTICLE 3 - CURRENCY OF THE POLICY**

The currency of this policy is the US dollar.

**ARTICLE 4 - ENROLMENT**

Enrolment to this policy by the Insured and his Dependants are effective on the date indicated on the Certificate of Enrolment, and at the earliest on the day after HENNER - GMC receives the Application Form and Health Declaration Form dully filled and signed, along with all requested additional information subject to approval by HENNER - GMC Medical Advisory Board and payment of first premium.

The effective date of enrolment cannot be prior to the date of effect of this policy.

The coverage is purchased for a period of 12 months and is tacitly renewable every year on the anniversary of its date of effect, unless termination is requested under the terms of Article 6 of this policy.

Upon application, the Insured and all of his Dependants who have reached the age of majority must complete and sign the individual Application form which includes a Health declaration form validated by the HENNER - GMC Medical Advisory Board.

For the Dependants who have not reached the age of majority at the time of application, the main Insured undertakes to sign the individual Application form and the Health Declaration in their name and on their behalf.

Depending on the Health Declaration provided, the Medical Advisory Board may request additional medical information if necessary. HENNER - GMC reserves the right, in the light of the above documents and information, to limit the coverage, to review the price or to decline the Enrolment.

The Insured shall keep a copy of his individual Application Form, General Conditions, Certificate of Enrolment and personal quotation signed with his signature preceded by the mention "read and approved".

After examining the application and the additional information that may have been requested, HENNER - GMC notifies acceptance by issuing a Certificate of Enrolment on which are mentioned the selected coverage types corresponding to the chosen Area of Cover, the coverage effective date and the list of Dependants of the policy.

**ARTICLE 5 – RIGHT OF WITHDRAWAL**

For a period of 30 calendar days following the date when the Certificate of Enrolment was sent, the Insured can exercise the right to withdraw from the policy.

This withdrawal request must be notified to HENNER - GMC by registered mail with acknowledgement of receipt.

HENNER – GMC Henner Pro Team  
137 Telok Ayer Street #07-01/02/03  
SINGAPORE 068602  
hennerpro.asia@henner.com

It can be written according to the letter template in the Appendix 2.

The termination of cover will take effect on the last day of the policy month when the registered mail is received by HENNER - GMC.

However from the moment benefit is used, a claim is submitted and reimbursed; the right to withdraw the cover within 30 days is immediately rescinded. In this case, payment of the complete premium to HENNER - GMC cannot be refunded and any premium due must be paid.
Consequences of exercising the right of withdrawal:
In the event of withdrawal, HENNER - GMC shall proceed with the refunding of the premiums within 30 days following the date of termination, after deduction of 1 month of premium from the date the subscription was in effect.

ARTICLE 6 - TERMINATION OF COVER
TERMINATION BY OPERATION OF LAW
Coverage is terminated without other formalities in one of the following cases:

- False declarations or omissions by the Insured or his Dependents cause the insurance to be null and void. The Insurer will retain paid premiums as damages, and any benefits paid shall be reimbursed.
- On the date on which the Insured or his Dependents no longer meet the insurance enrolment conditions
- On the termination date of this policy
- In the event of a change of Country of Usual Residence where the new country is outside of the Area of Cover selected, unless the Insured requests acceptance of the change from HENNER - GMC and the request is approved. This is subject to compliance with local legislation.
- The United States becomes the Country of Usual Residence of the Insured
- On permanent return to the Country of Nationality of the Insured
- On the last day of the policy month on which the Insured reaches 66 years old for all benefits
- However, if the Insured who has reached the age of 65 can prove five continuous years of insurance under the Care & Health policy then, on application, the Health coverage may be extended beyond the 66th birthday
- If health cover has been extended, on the last day of the policy month on which the Insured reached 71 years old for Assistance coverage
- At the latest on the last day of the policy month on which the Insured reached 71 years old for the Life insurance coverage exclusively, as defined in Article 20 of this policy

TERMINATION BY THE INSURED
The Insured can only terminate his membership to the Care & Health policy by sending a request to HENNER - GMC by registered letter with acknowledgement of receipt, at the latest 30 days before the subscription renewal date.

CONSEQUENCES OF TERMINATION
The termination of the membership of the Insured causes the termination of the coverage of his Dependents. In the event of termination, the coverage of the Insured and their Dependents ceases on the last day of the policy month.

The termination cannot be retroactive in any event.

In the event of termination, any outstanding requests for reimbursement under the policy must be sent to HENNER - GMC within 3 months of the occurrence of the claim. Claims lodged after that date will no longer be eligible for benefits.

ARTICLE 7- OTHER TERMS
7.1 DECLARATIONS AND COMMUNICATIONS
Declarations and communications are only effective if they have reached HENNER - GMC in writing or by email.

- Insured persons have a duty to inform HENNER - GMC in writing of any change in Country of Usual Residence, and for those that may be covered by Life Insurance, any change of professional activity
- In the absence of a notice of change, all communications shall be validly sent to the last address known by HENNER - GMC
The use of inexact or fraudulent documents or the production of any information with the purpose of misleading the Insurer on the causes, circumstances, consequences or the amount of a claim shall cause the loss of all entitlement to the insurance.

7.2 PERIOD OF PRESCRIPTION

Unless stated otherwise, the Insured’s right of action under this policy is limited to a period of 2 years from the date of the originating event. This period is extended to ten years in the event of death.

7.3 SUBROGATION

The Insurer shall have the rights of subrogation in respect of the Insured and his Dependents and initiate recourse proceedings against any liable third party. The Insurer renounces all recourse proceedings against the Subscribing Association.

7.4 GOVERNING LAW & JURIDICTION

In case of disagreement, the parties undertake to meet in order to use their best endeavours to reach an out-of-court settlement. In the absence of such a settlement, the case is brought before the court of arbitration of the Paris International Chamber of Commerce. The governing law is English law.

7.5 DATA PROTECTION

The data concerning the Subscribing Association or the Insured is used to manage the policies. They have a right of access, correction and opposition in accordance with the 1998 Data Protection Act.

7.6 INTERNATIONAL SANCTION

The Insurer shall not be deemed to provide cover and the Insurer will not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose the Insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America.

CHAPTER 2 - THE INSURED

ARTICLE 8 - ELIGIBILITY - ACCEPTANCE INTO THE INSURANCE

The persons who meet the conditions below may benefit from the coverage proposed in this policy:

8.1 TERMS OF ELIGIBILITY TO THE INSURANCE

Members of the Subscribing Association who meet all the conditions below may apply for coverage:

- To have the expatriate status as defined in Article 1 of this policy
- To be aged from 19 and up to 65 at enrolment

8.2 THE INSURED PERSONS

Insured Persons under the health and assistance coverage

The Insured Persons of the coverage are the Insured meeting the conditions in Article 8.1 and his Dependents as follows:

- The Spouse of the Insured who is aged up to 65 years, if not divorced or separated by a final court ruling (or - in the absence of a spouse and on condition of providing a certificate of a common-law union or a declaration on honor of a common law union - the partner of the Insured; or under legal partnership). Only one person shall be considered as a dependant in respect of the above.
The children of the Insured and those of his common-law partner on condition that they do not have a paid activity and are effectively dependents of the Insured:
- Aged up to 19 years of age
- Aged from 20 to 28 inclusive who are studying on a full-time basis as secondary or higher education students (a certificate proving this study is required at enrolment and will be required at the beginning of each academic year)

All the Insured Persons (the Insured, Spouse and Child) must reside in the same Area of Cover.

**Eligibility of Insured Persons of Life Insurance coverage is defined in Part 3 of this policy.**

**CHAPTER 3 - PREMIUMS**

**ARTICLE 9 - AMOUNT AND CALCULATION RULES**

9.1. PREMIUM

Premiums due by the Insured and any extra premiums are listed on his Certificate of Enrolment.

For the Dependents, the premiums are calculated as follow:

- For adults and children, the premium is calculated according to the age of each person
- For children, a discount of 10% is applicable on the 2\(\text{nd}\) child, and a discount of 20% is applicable for each child onward.

Payment frequency is defined in the Certificate of Enrolment. Premiums are payable annually, half-yearly or quarterly in advance. Premiums are always pro-rated on a monthly basis.

The Insured is solely responsible for the payment of the premiums.

The Subscribing Association collects the premiums from the Insured.

9.2. INDEXATION

Premiums are automatically revised on the 1st of April of each year, and applicable at the earliest on the anniversary date of enrolment, depending on the age of each Dependant on that date.

**ARTICLE 10 - NON PAYMENT OF PREMIUMS BY THE INSURED**

The Subscribing Association shall terminate the cover provided by this policy to an Insured if he ceases to pay due premiums. Termination of membership and thus of coverage shall take effect after a period of 40 days after a written demand of payment has been sent by the Subscribing Association by registered letter.

If the Insured has not paid the requested amount on expiry of this period, membership and coverage is terminated without further formalities.

The Subscribing Association shall inform the Insurer about the termination.

**CHAPTER 4 - CLAIMS**

**ARTICLE 11 - CLAIMS SETTLEMENT**

11.1 DOCUMENTS TO BE PROVIDED WITH A CLAIM

Documents to provide with a claim are defined in parts 2 and 3 below.

11.2 MEDICAL EXAMINATION

The doctors and experts designated by the Insurer have free access to the Insured and his Dependents for the purpose of any medical examination required or necessary under the policy.
The Insurer may refuse, suspend or reduce the right to benefits, based on the conclusions of its doctors and experts and regardless of decisions taken and payments paid by the social security or equivalent bodies, or of any other organization on which the Insured Party and his Dependants depend.

The Insured shall provide all supporting documents and accept all expert assessments or examinations requested by the Insurer, for himself or his Dependants, at risk of suspension of benefits.

Decisions made by the Insurer based on the conclusions of the Medical Advisory Board’s doctor are notified to the Insured by registered letter; the Insured may oppose the decision during the 30 days following the notification by providing a detailed medical certificate sent to the Insurer by registered letter.

In the event of a disagreement over the state of health of the Insured or his Dependants, an out-of-court expert assessment may be made in the presence of the doctor chosen by the Insured and the doctor delegated by the Insurer.

If these two doctors cannot reach a common conclusion, or if it is decided to proceed immediately to arbitration, the Insured and the Insurer choose a combined arbitrator/doctor to pronounce the decision. On failure to agree with his decision, the matter is settled through the courts.

Each party shall pay the costs and fees for their doctor, and half the costs and fees for the arbitrator/doctor.

11.3 CLAIM SUBMISSION PERIOD

Requests for claims must be presented to HENNER - GMC, within 12 months from the date the medical care has occurred. This period is reduced to 3 months if the Care & Health policy is terminated (Article 6). After this period, submission of claim will no longer be accepted.

CHAPTER 5 - EXCLUSIONS

ARTICLE 12 - GENERAL EXCLUSIONS

Benefits are not covered if they result from the following acts:

- Consequences directly or indirectly arising from taking an active part in a war, invasion, act of a foreign enemy, hostilities (whether war be declared or not), civil war, rebellion, revolution, insurrection, military or usurped power or taking part in civil commotion, popular uprisings or riot of any kind. Unless the Insured is assigned to carry out a maintenance or surveillance in order to protect the safety of persons and goods on behalf of the company
- Consequences of the disintegration of the atomic nucleus or ionizing radiation emitted suddenly and fortuitously from nuclear fuel or radioactive products or waste from the reactors, which has contaminated the area around the emission source (whether it is fixed or moving), so that, within more than a kilometer, the absorbed dose measured at ground level exceeds 0.01 Gray (or 1 rad) per hour, 24 hours after the incident. This exclusion does not apply to medical radiation required by health care
- Expenses from injuries caused intentionally and damage resulting from the participation even as an accomplice in any illegal activity or crime, offence or brawl, except in self-defence.

The exclusions specific to each coverage are defined in Articles 17 and 22 of this policy.
ARTICLE 13 - AREAS OF COVER

In order to be covered by this policy, the medical expenses of the Insured must be incurred in the selected Area of Cover.

The selected Area of Cover must include at least the Country of Usual Residence of the Insured and his Dependents.

The Area of Cover must be selected from one of the following areas:

- **Area of Cover 1**: Brazil, Macau, Mainland China, Hong Kong, Switzerland + countries of Areas of Cover 2, 3, 4, 5
- **Area of Cover 2**: Argentina, Australia, Belarus, Bosnia, Canada, Colombia, Ireland, Israel, Italy, Japan, Mexico, Monaco, Russia, Singapore, South Korea, Spain, United Kingdom, Venezuela + countries of Areas of Cover 3, 4, 5
- **Area of Cover 3**: Albania, Andorra, Anguilla, Antigua and Barbuda, Aruba, Austria, Bahamas, Barbados, Belgium, Belize, Bolivia, Bulgaria, Cayman Islands, Chile, Costa Rica, Croatia, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Dominican Republic, Ecuador, El Salvador, Estonia, Falkland Islands (Malvinas), Faroe Islands, Finland, France, French Guiana, Germany, Gibraltar, Greece, Grenada, Guadeloupe, Guatemala, Guernsey, Guyana, Haiti, Holy See (Vatican), Honduras, Hungary, Iceland, Isle of Man, Jamaica, Jersey, Kazakhstan, Latvia, Liechtenstein, Lithuania, Luxembourg, Macedonia, Malta, Martinique, Moldova, Montenegro, Montserrat, Netherlands, Netherlands Antilles, New Caledonia, New Zealand, Nicaragua, Norway, Panama, Paraguay, Peru, Poland, Portugal, Puerto Rico, Romania, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, San Marino, Serbia, Slovakia, Slovenia, South Africa, Suriname, Svalbard and Jan Mayen, Sweden, Trinidad and Tobago, Ukraine, Uruguay, + countries of Areas of Cover 4, 5
- **Area of Cover 4**: Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, Syria, Turkey, United Arab Emirates, Yemen, + countries of Area of Cover 5
- **Area of Cover 5**: Afghanistan, Algeria, American Samoa, Angola, Armenia, Azerbaijan, Bangladesh, Benin, Bhutan, Botswana, British Indian Ocean Territory, Brunei, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo (Democratic Republic of), Congo (Republic of), Cook Island, Djibouti, East Timor, Equatorial Guinea, Eritrea, Ethiopia, Fiji, Gabon, Gambia, Georgia, Ghana, Guam, Guinea, Guinea-Bissau, Heard and McDonald Islands, India, Indonesia, Ivory Coast, Kenya, Kiribati, Kyrgyzstan, Laos People’s Democratic Rep, Lesotho, Liberia, Libya, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Micronesia, Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nauru, Nepal, Niger, Nigeria, Niue, Norfolk Island, North Korea, Pakistan, Palau, Papua New Guinea, Philippines, Polynesia (French), Reunion, Rwanda, Saint Helena, Samoa, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, Solomon Islands, Somalia, Sri Lanka, Sudan, Swaziland, Taiwan, Tajikistan, Tanzania, Thailand, Timor Leste, Togo, Tokelau, Tonga, Tunisia, Turks and Caicos Islands, Turkmenistan, Tuvalu, Uganda, Uzbekistan, Vanuatu, Vietnam, Virgin Islands (British), Virgin Islands (U.S.), Wallis and Futuna Islands, Zambia, Zimbabwe.

Medical expenses in the United States are not covered except in an accident, unexpected illness, or an emergency as defined in Article 18.

Here above the highest Area of Cover includes the countries in the lower Areas of Cover as shown below:

- If **Area of Cover 1** is selected, the Insured and his Dependents are also covered in the countries in Areas of Cover 2, 3, 4 and 5
- If **Area of Cover 2** is selected, the Insured and his Dependents are also covered in the countries in Areas of Cover 3, 4 and 5
If Area of Cover 3 is selected, the Insured and his Dependents are also covered in the countries in Areas of Cover 4 and 5.

If Area of Cover 4 is selected, the Insured and his Dependents are also covered in the countries in Area of Cover 5.

Nevertheless coverage is provided for temporary stays outside the Area of Cover up to 90 consecutive days in a year, on condition that the expenses incurred are due to an accident, an unexpected illness or an emergency.

The coverage is no longer effective after stays of over 90 consecutive days in a year outside the Area of Cover.

13.1 MODIFICATION OF THE AREA OF COVER

The Area of Cover may only be changed on the policy renewal date. Waiting periods defined in Article 15 are applied when the Insured switches to a higher Area of Cover. The Insurer may refuse any request of modification to a higher Area of Cover.

13.2 CHANGE OF THE COUNTRY OF USUAL RESIDENCE

The change in the Country of Usual Residence in the event of relocation can be requested at all times under the following conditions:

- If the new Country of Usual Residence belongs to the same Area of Cover as the initial Country of Usual Residence, coverage continues without any interruptions and without extra costs.
- If the new Country of Usual Residence belongs to different Area of Cover than the Area of Cover of the initial Country of Usual Residence, the change is made immediately, no waiting period applies, and the premiums are readjusted.

In all cases, the Insured must inform HENNER - GMC within 30 days in order to get the new address taken into account.

ARTICLE 14 - HEALTH AND ASSISTANCE COVERAGE

14.1 TERMS COMMON TO ALL BENEFITS

Plans

The Care & Health policy offers the Insured and his Dependents the choice between several Health coverage plans (Primary, Vitality, Serenity or Prestige) to which the Insured and his Dependents can add options according to their needs.

The main cover plan and chosen options must be the same for all persons listed on the Certificate of Enrolment (except for Maternity coverage).

Modification of the plan

The cover and the premium tunings can only be changed (Article 14.4) on the policy renewal date. In the case of increased coverage:

- The waiting periods defined in Article 15 are applicable.
- The Insured will not be subject to medical underwriting unless:
  - The Insured has a Hospitalization plan only and wishes to increase his coverage to a plan composed of outpatient coverage and/or options.
  - The Insured increases his coverage plan by two levels (for example, a switch from Vitality to Prestige plan).

The previous coverage limits remain applicable during the waiting period.

The Insurer reserves the right to refuse to increase the coverage.

Benefits

The expenses taken into consideration and the amount of the benefits are determined in the Table of Benefits defined in Appendix 1 of this policy.
Benefits can be paid for expenses incurred during the coverage period (period between the effective date on the Certificate of Enrolment - subject to the waiting periods - and the date when coverage ends).

The benefit from the coverage is subject to the expiry of the waiting periods listed in Article 15 of this policy.

### 14.2 MAIN PLANS

The Insured is enrolled with the following coverage:

- Health coverage
- Assistance, repatriation and evacuation

The terms of this coverage for the Insured and his Dependents are specified below.

#### 14.2.1 HEALTH COVERAGE

Health coverage is defined in the Table of Benefits in Appendix 1.

The purpose of the policy is to ensure the refund of the medical and surgical expenses incurred following an illness or an accident. The amount of benefits depends on the plan chosen by the Insured. This choice is detailed on the Certificate of Enrolment.

The coverage plan chosen must be the same for all the Insured Persons of the same family insured simultaneously under the same policy.

Upon application, the Insured has the option to reduce the level of coverage under the conditions defined in Article 14.4 “Premium Tunings”.

All benefits under the policy are expressed in US dollars.

#### LIMITATION TO ACTUAL COSTS - REASONABLE AND CUSTOMARY

The benefits due under the Care & Health policy are always limited to actual costs that are reasonable and customary. Medical expenses will be considered reasonable and customary if they correspond to the charge usually made for a similar service.

Reimbursements cannot exceed the amount of the medical expenses incurred by the Insured. This is inclusive but not limited to any reimbursement the Insured is entitled to.

If the Insured and/or his Dependents has or should have any other insurance policy providing cover for the same loss, damage or liability under the policy except for any excess beyond the amount that is or would have been payable under those policies (including local Social Security). For the application of the above terms, the limitation to the amount of the remaining expenses for the Insured is determined by the Insurer for each act or item of expense.

The reasonable and customary nature is assessed depending on current medical practices in the country in which the care is provided (type of treatment, quality of care and equipment, geographical area and country) and is subject to the coding and pricing standards for acts and treatments referenced or part of nomenclatures in each country.

An unreasonable and uncustomary nature can therefore lead to a refusal to cover or a limitation of the refunded amount.

#### HEALTH BENEFITS DEFINITIONS

Expenses are covered when they are incurred for authorized practitioners exercising their profession in accordance with applicable regulations. All entitlements below are subject to the limits as per the chosen plan and options.

### Hospitalization

The "Hospitalization" item covers hospital expenses for surgery or general treatment, internal or external, in a public or private establishment.

It gives entitlement to the following reimbursement:

- Doctors’ fees (surgeon, anesthetist)
- Surgery and possible operating room fees
Private or semi-private room
Accompanying bed for parent when staying with their insured child under 16 year old
Daily cash benefit
All medical acts: radiology, imagery, pharmacy, examinations, laboratory analyses and general practitioner/specialist consultations
Rehabilitation/Physical therapy expenses incurred during the days following hospitalization
Reconstructive surgery
Home nursing following hospitalization
Palliative care
Medically justified Land ambulance transport related to hospitalization at the time of admission to or departure from the hospital
Treatment of addictions related to alcohol and substance abuse
Psychiatric treatment
Organ transplants: operating expenses for bone marrow grafts, cornea, heart, liver, kidney and lung transplants
Hospital expenses related to cancer treatment (treatment given for cancer received as an In-Patient, Day-Patient or Out-Patient which includes oncologist fees, surgery, radiotherapy and chemotherapy, alone or in combination, from the point of diagnosis)
Hospital expenses related to AIDS treatment
Emergency dental treatment following an accident
Hospital equipment charges: crutches, appliances, wheelchair
Renal dialysis

Outpatient services
Generalist and specialist consultations and visits
Acts of medical biology,
Diagnostic and laboratory test: the costs of medically necessary outpatient diagnostic and laboratory tests where prescribed by a health professional.
Radiology/internal investigations and scans: the charges relating to medically necessary outpatient internal investigations inclusive of X-rays, MRI and ultrasound scans, where prescribed by a General Practitioner or Specialist.
Vaccination against diphtheria and tetanus, poliomyelitis and yellow fever. As well as recommended vaccinations against whooping cough, rubella, measles, mumps, chicken pox, invasive infections, hepatitis A and B but also the mandatory vaccinations in the Country of Usual Residence of the Insured
Prescription medicines prescribed by a General Practitioner or Specialist, and dispensed by an authorized provider.
The purchase expenses for additional drugs prescribed by the doctor such as vitamins or dietary supplements
Prescribed complementary therapies and medicines (registered speech therapist, orthoptist, chiropractor, oстеopathes, homeopathes, podiatrists, Traditional Chinese Medicine practitioner (and any medication they may prescribe), acupuncturists, physiotherapists)
Paramedical practitioners (nurses)
Psychological treatments by an licensed psychologist
Psychiatric treatments by an licensed psychiatrist
Hormone replacement therapy
Medical check-up (for adults and children): Urine analysis, blood samples (diabetes, cholesterol, etc.), hearing test, biometric assessment (size, weight, BMI measurement), sight test, electrocardiogram at rest, memory test, lung capacity measurement, interview with a dietician, dental examination, gynecological examination (breast and cervical cancer tests), “hemoccult” test, HIV test, additional medical examination
Consultations and outpatient expenses related to cancer treatment
Consultations and outpatient expenses related to AIDS treatment

Medical prostheses
Orthoses
Hearing aids
Orthopedic prostheses
Non-orthopedic, non-dental prostheses
Equipment and appliances
14.2.2 ASSISTANCE, REPATRIATION AND EVACUATION

Assistance, repatriation and evacuation coverage is described in the Table of Benefits in Appendix 1. The organization of this coverage has been delegated to AXA Assistance by the Insurer.

DEFINITIONS FOR ASSISTANCE, REPATRIATION AND EVACUATION COVERAGE

The terms and expressions used in this article have the meaning defined below:

Close relation of the Insured
Any private person named by the Insured or one of his Dependents domiciled in the same country as the Insured.

Members of the family
Ascendants and descendants, spouse or common-law partner, brothers, sisters, parents-in-law, brothers-in-law, sisters-in-law of the Insured.

Serious bodily harm
Physical accident or sudden illness of which the nature would be likely to cause a major deterioration in the condition of the Insured at short notice if adequate care is not provided quickly.

DESCRIPTION OF THE ASSISTANCE, REPATRIATION AND EVACUATION

The Insured is covered in the event of a medical evacuation or an emergency medical repatriation.

The Assistance Organization shall assess the seriousness of the medical condition and decide on a possible country to which evacuate or repatriate the Insured. Only the assistance expenses organized and approved by AXA Assistance are covered under the plan.

1. Emergency evacuation and repatriation

In the event of serious bodily harm, the AXA Assistance doctors will contact the attending doctors at the location. They will then make the most suitable decision for the condition of the Insured according to the information collected and exclusively medical requirements.

If the AXA Assistance medical team recommends that the Insured should be evacuated, AXA Assistance will organize and carry out the evacuation to the closest and most suitable hospital centre solely depending on the medical requirements defined by its medical team.

Evacuation destination and the resources used is the exclusive decision of the AXA Assistance medical team.

Repatriation destination is:

- The nearest Hospital from home in the Country of Usual Residence or in a country that belongs to the Area of Cover selected by the Insured
- or home in the Country of Usual Residence or in a country that belongs to the Area of Cover selected by the Insured

The means used for repatriation can be a light medical vehicle, an ambulance, a train, a regular airline flight, or an air ambulance.

The final choice of the hospitalization location, the date and the need to accompany an Insured as well as the resources used are decisions taken exclusively by the medical team.

Any refusal of the solution proposed by the AXA Assistance medical team voids the personal assistance coverage.

AXA Assistance may ask the Insured to use his travel ticket if it can be used or modified. If this is not the case, when AXA Assistance pays for the return, the Insured has a duty to send AXA Assistance his original unused travel tickets or the sum that is refunded to the Insured by any authorized body.
2- Round-trip airfare for next of kin
If the condition of the Insured does not allow or does not require repatriation, and if local hospitalization lasts longer than 5 consecutive days, AXA Assistance shall provide return economy class air tickets or 1st class train tickets for a member of the family or a close relation to the place of hospitalization.

If necessary, AXA Assistance will also organize and pay for accommodation (room and breakfast only) for a maximum of 10 consecutive nights for up to USD 120 per night.

This coverage is only available if there is no member of the family of legal age present at the place of hospitalization.

*All other temporary accommodation solutions are not covered and will not be reimbursed.*

3- Repatriation of mortal remains
AXA Assistance organizes and pays for the repatriation of the Insured’s body or ashes from the place of death to the place of burial in the Country of Nationality in agreement with the deceased’s family.

AXA Assistance pays for the post mortem, casketing and transport arrangements.

The fees related to the casket thus organized shall be paid up to USD 4000.

The funeral, ceremony, local convoy, burial or cremation costs remain at the expense of the Insured’s family.

*The choice of companies used for the repatriation process is made exclusively by AXA Assistance.*

4- Compassionate visit in the event of death of a direct family member
AXA Assistance provides the travelling Insured with a return economy class plane ticket or a 1st class return train ticket in the event of the death of a direct ascendant or descendant (mother, father, or child) in the Country of Nationality or Country of Usual Residence.

The journey must take place within 8 days following the date of death.

AXA Assistance reserves the right to request the necessary supporting documents (death certificate, etc.) before providing its services.

5- Second medical opinion
If the insured wishes to have a second medical opinion, AXA Assistance puts him in contact with a doctor from its medical team. This doctor will be able to answer or direct him to one or more specialists located close to his home in the Country of Usual Residence.

6- Dispatch of medicines unavailable locally
Should it be impossible to obtain essential drugs or their equivalent on site that were prescribed before departure by the attending doctor in the Country of Usual Residence, AXA Assistance will look for them in France.

If they are available, they will be sent as soon as possible, depending on local statutory constraints and the available means of transport.

This service is available for occasional requests. It cannot, under any circumstances, be provided in the context of long-term treatments that would require regular shipments or for vaccination requests.

*The cost of the drugs remains at the Insured’s expense. He undertakes to refund the amount plus any customs fees within a maximum of 30 days calculated from the shipping date.*

14.3 OPTIONAL BENEFITS

In addition to the Main Plan, the Insured and dependants can select the following options: Maternity, Dental and/or Vision optional benefits. This coverage is defined in the Table of Benefits in Appendix 1.

*Definition*

These options must be chosen as an addition to the main plan and must correspond to the same coverage plan.
14.3.1 MATERNITY
This option is available with Vitality, Serenity and Prestige only.
The following benefits are covered within the limits of the plan selected by the Insured:

- Pre- and post-natal costs
- Natural delivery and non-elective caesarean delivery
- Elective cesarean delivery
- Private or semi-private room
- Treatments related to infertility, artificial insemination and in vitro fertilization, for patients aged under 40 attempting to give birth to their first child (Serenity and Prestige plans only)

In the event of major medical complications, medical expenses are paid under the hospitalization main plan according to the selected maximum annual reimbursement limit.

In case the Maternity option has not been purchased, treatment for the following major medical complications is still paid for as hospitalization according to the selected maximum annual reimbursement limit:

- 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-partum hemorrhage (heavy bleeding in the hours and days immediately after childbirth)
- Miscarriage requiring immediate surgical treatment
- And any other medical complications that threaten the life of the insured mother

14.3.2. DENTAL
This option is available with Vitality, Serenity and Prestige only.
The following benefits are covered within the limits of the plan selected by the Insured:

- Routine dental treatment (annual check-up, fillings related to tooth decay, devitalisation and annual descaling)
- Fixed prostheses: crowns and bridges (metal, ceramic-metal and ceramic)
- Removable prostheses: metal chassis, partial resin prosthesis and complete prosthesis
- Prostheses on implants
- Periodontal treatments
- Children’s orthodontic treatment on condition that the child is under 16 years of age
- Adult orthodontic treatment beginning at 16 years of age (Prestige plan only)
- Teeth whitening, only if the whitening is carried out by the Insured’s dentist. Any whitening techniques other than those used by a health professional are not covered (Prestige plan only)

14.3.3. VISION
This option is available as an addition to the Dental option with Serenity and Prestige plans.
The following benefits are covered within the limits of the plan selected by the Insured:

- Ophthalmological consultations and visits
- Spectacles and frames (excluding sunglasses)
- Corrective contact lenses whether disposable or not
- Lasik surgery and contact lens implants (Prestige plan only)

14.4 PREMIUM TUNINGS
Upon application, the Insured can opt for the reduced coverage defined below.
This reduced coverage is applicable to the coverage of the Insured and his Dependents.
These reductions impact the level of premiums.
14.4.1 MAXIMUM ANNUAL LIMIT

When applying, the Insured chooses the maximum annual limit applicable to his reimbursements. This limit only applies to the main plans. According to the plan selected, the Insured can choose one of the following limits:

- **Primary**: US$ 200,000; US$ 300,000; US$ 500,000; US$ 4,500,000
- **Vitality**: US$ 200,000; US$ 300,000; US$ 500,000; US$ 4,500,000
- **Serenity**: US$ 300,000; US$ 500,000; US$ 4,500,000
- **Prestige**: US$ 300,000; US$ 500,000; US$ 4,500,000

14.4.2 LEVEL OF REIMBURSEMENT

The level of reimbursement represents the part covered by the Insurer. The Insured has the choice between the following reimbursement levels:

- 80%
- 90%
- 100%

The choice of reimbursement level only applies to outpatient, medical prostheses and options (Maternity, Dental and Vision) and is the same for all.

**ARTICLE 15 - WAITING PERIODS**

Waiting periods correspond to periods during which the Insured and his Dependents cannot claim under the Care & Health policy coverage.

These waiting periods are defined as follows:

- **6 months**: for prostheses, dental and vision expenses
- **12 months**: for maternity and maternity related expenses
- **24 months**: for expenses related to infertility, medical check-ups and AIDS treatment
- **24 months**: for expenses related to adult orthodontic work, teeth whitening, laser surgery, lens implants, and treatments for alcohol or substance abuse

Waiting periods are applicable to the Insured and his Dependents:

- At enrolment
- When increasing coverage, a 6-month period is applicable for prostheses, dental coverage and vision, and a 10-month period for maternity coverage
- When switching to a higher Area of Cover (without changing the Country of Usual Residence)
- When adding a Dependant (waiting period for the dependant only).

The 6-month waiting period can be waived under certain conditions:

- If the Insured can prove that he had equivalent health coverage at the date of enrolment. A Certificate of the Insured’s previous health insurance dated less than a month at the time of his Care & Health enrolment, proving the continuity of insurance cover
- In the event of an accident, a sudden illness or an emergency occurring after the enrolment date
- In the event of marriage when the request to add the spouse is made during the 90 days following the date of marriage
- In the event of the enrolment of a new born child within one month of the birth of the child,
- If the change to the Area of Cover is due to the move by the Insured to a new Country of Usual Residence
ARTICLE 16 - PRIOR AGREEMENT

Prior agreement is requested for all the expenses listed below, except in the case of an emergency as defined in this policy. This means that the Insured must obtain pre-authorization from the Medical Advisory Board prior to medical care being extended to him and/or his Dependents.

In an emergency, a temporary emergency agreement will be issued within 2 hours for the first 3 days of hospitalization. A medical report and a quote must be submitted within 3 days in order to enable the issuing of the final coverage agreement.

Should the prior agreement procedure not be followed, the reimbursement of the care expenses may be limited or refused.

Hospitalization or Maternity

The patient or the selected hospital must provide HENNER - GMC with a Prior Agreement at least 10 days before the planned hospitalization date, except in emergencies, at the number indicated on the back of the Insured's insurance card.

In the event of an emergency, a temporary emergency agreement will be issued within 2 hours for the first 3 days of hospitalization. A medical report and a quote must be submitted within 3 days in order to enable the issuing of the final Guarantee of Payment.

The prior agreement application must be sent to HENNER - GMC within the 48 hours following admission to the hospital, stating the urgent nature of the hospitalization.

After examination and agreement by the Medical Advisory Board’s doctor, a final Guarantee of Payment will be sent to the hospital.

For all extensions of hospitalization, the prior agreement application must be renewed before the expiry of the approved period.

For all changes to the hospital or unplanned transfers of medical or surgical services, a new prior agreement application must be provided within 48 hours following the change.

Outpatient services

For all series of medical treatments (e.g. chemotherapy, dialysis, nursing treatment, radiotherapy), a Prior Agreement application must be submitted indicating the pathology and foreseeable length of treatment. The form should be completed and signed by the prescribing doctor, be accompanied by a prescription and be submitted at least 10 days before the start of the treatment.

The following treatments are subject to prior agreement as well: outpatient surgery, cancer treatment, HIV/AIDS treatment.

Dental care

The patient must send the prior agreement application form filled in and signed by the practitioner to HENNER - GMC at least 10 days before the start of the treatment for the following dental treatments:

- Core inlays
- Inlays, onlays
- Periodontal treatments
- Dental prostheses
- Child orthodontics (the treatment must begin before the child is 16 years old)
- Adult orthodontic treatment (beginning at 16 years of age)
- Dental implants

A panoramic dental X-Ray may be requested in some cases indicated on the prior agreement application form.
Vision

The prior agreement application must be provided to HENNER - GMC at least 10 days before the intervention in the case of laser myopia treatment and contact lens implants.

Medical appliance prostheses

The prior agreement procedure is required in all cases.

ARTICLE 17 - HEALTH AND ASSISTANCE COVERAGE EXCLUSIONS

In addition to “ARTICLE 12 - GENERAL EXCLUSIONS”, unless the Certificate of Enrolment or the Table of Benefits of the Insured states otherwise, this policy does not cover the following:

17.1 Health

- Expenses relating to accidents or illnesses prior to the effective date and not declared to the Insurer
- Treatments costs incurred outside the period of cover and/or the selected Area of Cover
- Expenses incurred for non-authorized practitioners or those not exercising their profession in accordance with applicable regulations
- Expenses in excess of Reasonable and Customary charges
- All forms of experimental treatment or uncontrolled treatment which do not follow commonly accepted, customary or traditional medical practice, unless the Insurer explicitly agrees
- Preventive treatments, health check-ups and screening examinations
- Personal and comfort items expenses such as telephone charges, TV, alcoholic beverages, and visitor's meal in the event of hospitalization or day surgery. In addition, health comfort items or generally available medical equipment for the home, including but not limited to blood pressure measuring devices, thermometers, inhalators, sun lamps, massage devices, heating pads, cold pads, software programs, bedding, or learning aids.
- Treatments related to drug addiction
- Rehabilitation treatment
- Expenses incurred when acquiring an organ
- All operations or treatment related to a sex change
- Verifications, studies, treatments, consultations and complications related to sterility, sterilization, sexual disorders, contraception including the fitting and removal of contraceptive devices, abortion, except in the case of a medically justified abortion in accordance with local legislation
- All elective/voluntary and/or plastic/aesthetic surgery and its consequences
- Beauty consultations and treatments, youth cures, slimming cures and its consequences.
- Spa treatments inclusive of any transport and accommodation expenses
- Medical expenses related to a stay in a thalassotherapy centre and fitness centre, even if the stay is medically prescribed
- Medical expenses related to a stay in a rest home and convalescent home unless the stay immediately follows hospitalization or major surgery as assessed by the Insurer's doctor
- Outpatient consultations for psychotherapy, psychoanalysis and the related treatments
- Consultations, treatments and complications related to the loss or the implanting of hair unless the treatment is related to hair loss caused by a serious illness
- Treatments to modify the refraction of an eye or eyes (laser eye correction), including refractive keratotomy (RK) and photo-refractive keratotomy (PRK)
- Non-prescription drugs and non-medical common products such as medical alcohol, absorbent cotton, sun lotion, dental hygiene products, dressings, shampoos, vitamins, supplements, nasal wash/rinse, moisturizers, hand creams, etc.
- Competitive sports other than those in which the Insured Person participates purely as an amateur
- Procedures requiring Prior Approval and for which Prior Approval was not requested or granted.
Dependants eligible to the policy as children cannot benefit from the Maternity option.

Expenses related to complications or conditions arising from excluded conditions or treatments

17.2 Assistance, repatriation and evacuation

Any expense incurred for more than one emergency transportation for any single serious medical condition of the Insured during the term of the Care and Health Plan and in the case where the Insured had not taken all the necessary actions to prevent the occurrence or aggravation of the serious medical condition.

Any cost or expense following an emergency medical transportation not expressly approved in advance and in writing by AXA Assistance and/or not arranged by AXA Assistance. This exception shall not apply to Emergency Medical Evacuation from remote or primitive areas when AXA Assistance cannot be contacted in advance and delay might reasonably be expected in loss of life or harm to the Insured.

Any expense for Insured Persons, contrary to the advice of a medical practitioner, related to non-urgent treatment, or for treatments that where known in advance.

Any expense for the Insured that is not suffering from a Serious Medical Condition, and/or in the opinion of the AXA Assistance physician, the Insured can be adequately treated locally, or treatment can be reasonably delayed until the Insured returns to his Country of Residence.

Any cost or expense related to convalescence and disorders (illness, accident) undergoing treatment or not completely healed

Any expenses related to consequences of a chronic illness not consolidated and to consecutive illness. This exclusion shall not apply for first manifestation of symptoms of this nature or during a sudden and unexpected aggravation putting in danger the vital prognosis at a short term and requiring an immediate hospitalization in a specialized facility.

Any expense for medical transportation where the Insured, can travel as an ordinary passenger on a commercial carrier without a medical escort.

Trips made with the purpose of obtaining a diagnosis and/or undergoing treatment

Any treatment or expense related to childbirth, miscarriage or pregnancy. This exception shall not apply to any abnormal pregnancy or vital complication of pregnancy which endangers the life of the mother and/or unborn child during the first twenty-eight (28) weeks of pregnancy.

The direct or indirect consequences of alcoholism or abuse of alcohol, dependence on or abuse of drugs and narcotics even when medically prescribed ('abuse' means exceeding legally authorized levels in the Country of Usual Residence).

Accident and first Emergency expenses, research expenses, primary transport expenses

Accident or injury occurring while the Insured Person is engaged in dangerous sports such as parachuting, free-fall bungee jumping, deep sea diving using a diving suit, automobile rally's and 4 wheel drive accidents, or participating as a competitor or professional in sports competitions, gambles, matches, contests.

Accident or injury occurring while the Insured Person is engaged in practice of high risk sports, such as caving, mountaineering or climbing necessitating the use of ropes, rock-climbing, air-ballooning, paragliding, martial arts, racing of all kinds other than by foot. This exception is not applicable if the Insured Person is accompanied by a monitor or professional guide which is recognized by an international federation, or if the Insured Person has certified qualifications which allow him to practice and is practicing this activity in an independent way in the measure that they are practiced on a regular and reasonable way.

Any expense related to the Insured person engaging in any form of aerial flight except as a passenger on a scheduled airline flight or licensed charter aircraft declared.

Any expense incurred for the Insured person transportation from ship, platform or offshore oil drilling rig, towards land after an accident that occurred offshore.
Any expenses incurred consecutively to a serious and intentional act, contrary to the basic elements of safety, health and security or resulting from the non-compliance to the medical recommendations or treatment, in which case it constitutes a self-inflicted injury dangers situation.

All expenses incurred in any action initiated and organized at state level, or between states, by any governmental or nongovernmental authority or organisation.

ARTICLE 18 - HEALTH COVERAGE DEFINITIONS

The terms and expressions used in this part of this document have the meaning defined below:

**Accident**
All bodily injuries not intended by the Insured, caused by the violent, sudden and unexpected action of an external cause, not including severe or chronic illness.

**Accidental Damage to teeth**
Dental work provided during a hospital stay and within 72 hours of the accident for which the Insured required hospitalization, to restore teeth damaged by that accident. Mastication is not considered as an accident.

**Accommodation**
The cost of the hospital room stay charged (shared ward or standard single room only). This does not include Deluxe, VIP suites, etc.

**Area of Cover**
Defines the countries in which the Insured and the Dependents can be treated.

**Daily cash benefit**
The insurer will pay a daily sum, as noted in the Table of Benefits, for each full night in hospital, if the Insured does not lodge a claim to the insurer for usual benefits under the policy (for example, because they are claiming treatment costs under another insurance policy).

**Delivery expenses**
Medical expenses incurred in relation to a natural delivery or an elective or emergency caesarean. All costs in relation to medical complications, as well as a private room are covered by the “hospitalization” coverage.

**Dental prosthesis**
Prosthetic care, including crowns, inlays, incrustations, and implants as well as all required treatments, including the reimbursement of laboratory and component expenses.

**Emergency**
Term used in the event of an accident, a natural disaster, the beginning or sudden downturn of a serious illness requiring immediate measures and medical treatment of the Insured or of one of his Dependents. Only a medical treatment by a doctor, whether a general practitioner or a specialist, and hospitalization within the twenty four (24) hours following the direct cause of the emergency are considered to be conditions required for reimbursement.

**Health declaration**
Document tracing the medical history used by the Insurer’s Medical Advisory Board to assess the health risk that a future Insured represents (valid three months prior to the effective date of coverage).

**Home nursing**
The cost of nursing care at the Insured’s home, where it is prescribed by the attending doctor as medically necessary and in lieu of an extended inpatient stay, limited to 60 days per policy year.

**Hospital**
Any legally authorized establishment having the title of medical or surgical hospital in the country where it is located. The establishment must offer its patients permanent surveillance by a doctor. Rest and care homes, spas, cure and fitness centres are not considered to be hospitals.

**Hospitalization (or inpatient)**
A medically necessary admission into a hospital involving an overnight stay.
Maternity
The period covering the first diagnosis up to giving birth.

Maximum annual reimbursement limit
The maximum annual amount of expenses in excess of which the Insurer no longer has a duty to reimburse the expenses incurred.

Medical prostheses
Hearing aid, phonation appliances (electronic larynx), wheelchair and personal movement assistance, artificial limb, stoma products, hernia support, abdominal bandage, elastic compression stockings, orthopaedic soles and all other medically prescribed appliances.

New Born Child
A new born child whom one of the parents is insured under the plan. Enrolment comes without waiting periods according to the parent’s plan and if the child has been registered within 30 days of birth. A new born child is subject to medical underwriting unless the maternity option has been selected, the 10-month waiting period has been fulfilled, and the delivery has been covered under the Care & Health plan.

Orthodontics
The use of appliances to correct a malocclusion and to reposition teeth so that they function and are aligned correctly.

Outpatient surgery
Operative procedures performed on members who are admitted to and discharged from a hospital on the same day.

Palliative Care
The cost of care by an accredited palliative care team when care related to a life threatening, incurable condition that would otherwise be eligible for inpatient benefits under the Policy if the Insured was instead admitted into an accredited hospital, up to the limit noted in the Insurance Policy.

Parent accommodation in hospital
The price of a hospital room for a parent during the admission of the insured child under 16 years of age to the hospital for treatment. If a hospital bed is not available, the Insurer shall pay for the equivalent of a room up to the limits indicated. Various expenses such as meals, telephone calls or newspapers are not covered.

Periodontal treatment
Treatment of bacterial infections that affect and destroy the tissues that surround and support the teeth. The tissues concerned are the gums, the attaching fibres (ligament or periodontal ligaments) and the bone that supports the teeth.

Prescribed medicines
They cover the drugs of which the sale and use are subject to a medical prescription. Products that are possible to purchase without a prescription are excluded from this definition.

Unexpected illness
A sudden and unforeseeable illness confirmed by a doctor, or an unexpected aggravation requiring medical care that if not provided within 24 hours could result in permanent injury, incapacity, or in death.

ARTICLE 19 - DOCUMENTS TO PROVIDE WITH A CLAIM

19.1 HEALTH EXPENSES

If expenses have been incurred in the Country of Usual Residence or in a country in the selected Area of Cover, the Insured must send HENNER - GMC the following justifying documents:

- The claim form duly filled in and including the contact details for the Insured and his Dependants
- A copy of the medical prescription
- Original detailed itemized invoices and original proof of payment.
- Any other documents requested by HENNER-GMC to assess the claim submitted.
If expenses have been incurred in a country outside the selected Area of Cover:

- In addition to the documents mentioned above, any documents proving that the medical expenses concern an accident, unexpected illness or emergency as defined in this policy

Payment is made to the Insured, or to a dependant expressly designated by the Insured, for all accepted claims.

Exceptionally, requests for reimbursement of invoices for amounts not more than USD$300 can be submitted by email. In this case, the Insured must keep the original documents for 24 months and must present them to HENNER - GMC within 30 working days of a request to do so by HENNER - GMC.

From the date of treatment, the Insured has a 12 month period to submit his claims. This delay is reduced to 3 month in case of termination of the insurance policy.

19.2 ASSISTANCE

All requests to implement the Assistance service must be made directly by telephone + 65 6322 2523.
PART 3 - TERMS SPECIFIC TO LIFE INSURANCE COVERAGE

As stand-alone or as an add-on option to the Main Plan defined in Part 2 of this policy, the Insured can purchase the following Life Insurance coverage:

- Death (all causes) or Total Permanent Disability
- Optional double benefit when Death is caused by Accident (available in addition to Death all causes or Total Permanent Disability)

The spouse who wishes to be covered for the Life Insurance risk must fill in a separate Life Insurance Application Form.

**Area of Cover:**

The following countries are excluded from the Life Insurance coverage:

- Afghanistan
- Angola
- Belarus
- Burundi
- Chad
- Cuba
- Democratic Republic of Congo (ex-Zaire)
- Eastern Timor
- Indian provinces: Jammu, Kashmir, Punjab, Rajasthan, Gujarat
- Iran
- Iraq
- Ivory Coast
- Kosovo
- Liberia
- Libya
- Mali
- Mauritania
- Myanmar
- Nigeria
- North Korea
- Pakistan
- Palestine, Gaza, West Bank
- Rwanda
- Sierra Leone
- Somalia
- Sudan
- Sudan (Republic of South Sudan)
- Syria
- Yemen
- Zimbabwe

The Insured cannot purchase Life Insurance in these countries and he will only be covered in these countries for travels not exceeding 49 days per year.

**ARTICLE 20 - DEATH (ALL CAUSES) OR TOTAL PERMANENT DISABILITY**

20.1 DEFINITION

In the event of the death of the Insured, the Death (all causes) coverage allows the payment of a lump sum to the Insured’s designated beneficiaries named under the conditions defined in Article 23. However, in the event of a Total Permanent Disability (TPD), this lump sum is paid in advance to the Insured.

**Total Permanent Disability is defined as:**

The complete and continuous inability of the Insured at that time and at all times thereafter to engage in any business or occupation or perform any work of any kind for remuneration exceeding one third of the remuneration prior to the total and permanent disability earned in the same region by workers in the same professional category as the Insured.

The Insured must also require, due to his condition to be assisted by a third party to carry out normal everyday acts - i.e. eating, dressing, bathing, having incontinence issues moving (from a bed to a chair, and indoors in areas without multiple floors).
The date on which the Total Permanent disability benefit is fixed is the day on which the condition is accepted by the Insurer.

Upon payment of the lump sum due to Total Permanent Disability, the Insured will no longer be covered under the life insurance benefit.

20.2 LUMP SUM BENEFIT

Upon application, the Insured selects the lump sum amount in the table of benefits (see Appendix 1). In all circumstances, the life insurance benefit paid is limited to 3 times the gross annual income of the last 12 months preceding the enrolment.

20.3 EXTENSION OF DEATH (ALL CAUSES) OR TPD TO 70 YEARS OF AGE

This coverage can be extended up to the age of 70. The amount of the Death benefit remains equal to the sum defined above.

Premiums are calculated as follows:

- From 65 to 66 years of age: add 20% to the premium
- From 66 to 67 years of age: add 40% to the premium
- From 67 to 68 years of age: add 60% to the premium
- From 68 to 69 years of age: add 80% to the premium
- From 69 to 70 years of age: add 80% to the premium
- On the day prior to the 71st birthday of the Insured: the Death (all causes) and Total Permanent disability ceases.

ARTICLE 21 - ACCIDENTAL DEATH

21.1 DEFINITION

Accidental Death coverage can only be purchased by the Insured in addition to the Death (all causes) coverage defined above.

When the death of the Insured results from an accident, provided that death occurs within one year after the date of the accident, an additional lump sum is paid to the beneficiary(ies) named under the conditions defined in Article 23.

The Accidental Death coverage is excluded from the extension of coverage as mentioned in article 20.3 of this policy and will end at the latest on the day prior to the 66th birthday of the Insured.

21.2 LUMP SUM AMOUNT

The amount of the Accidental Death lump sum is equal to 100% of the Death (all causes) or TPD lump sum.

The Accidental Death lump sum paid is limited to 3 times the gross annual income of the last 12 months preceding enrolment.

The Accidental death lump sum comes on top of the lump sum in case of death all causes. The total amount shall not in any circumstances exceed a total of 6 times the gross annual income of the Insured.

ARTICLE 22 - LIFE INSURANCE COVERAGE EXCLUSIONS

In addition to “ARTICLE 12 - GENERAL EXCLUSIONS”, the following are excluded from the Life Insurance coverage:

- Illnesses and bodily harm, including suicide, inflicted intentionally by the Insured, his Dependents or Beneficiary(ies). Suicide is covered however, if the Insured has been covered one year under the life insurance plan
The coverage ceases to benefit the Beneficiary if he has deliberately caused the death of the Insured. The lump sum covered is then carried over to the next Beneficiary in the designated order unless the said Beneficiary is convicted as the murderer or accomplice in the murder of the Insured.

The unnecessary exposure to danger, except to save a human life, an animal or property.

The consequences of participating in a brawl, assault, riot or popular movement, as well as the actions taken to stop them, except in cases of self-defence.

The direct or indirect consequences of alcoholism, dependence on or abuse of drugs and narcotics even when medically prescribed (‘abuse’ means exceeding legally authorized levels in the Country of Usual Residence).

The consequences of claims occurring during travel undertaken against medical advice.

The consequences of a flight in a plane after the 28th week of pregnancy.

Accidents occurring in aerial activities, except if the Insured is a passenger in an aircraft, hovercraft or helicopter for which the owner and pilot have the authorizations and licenses required to transport passengers and when the Insured is not exercising a professional activity in relation to the aircraft or the flight. Further, the aircraft used must:

- Be suitable for travel according to regulatory technical requirements
- Have a flight certificate
- Have the necessary valid authorizations to transport passengers from the relevant authorities.

The consequences of the professional activity of the Insured if they conduct an activity underwater, on water, underground or in the air.

The consequences of the practice of a competitive sport activity, except for the events in which the Insured participates as an amateur.

The practice by the Insured of a sports activity not represented by a sports federation or not in accordance with the elementary safety rules recommended by public authorities or by the sports federation corresponding to the activity.

Traumas or illnesses resulting from the practice of any extreme sport (except for private skiing), such as bob-sleigh, bungee jumps, potholing, contact sports and martial arts, sand sailing, gliding, U.L.M. flying, mountaineering, paragliding, rafting or the use of jet skis, ski jumping, sports using motor vehicles on land, at sea or in the air.

Traumas or illnesses resulting from attempts to beat records.

The consequences of participation in bets or challenges.

The consequences of a trip to a country or geographical area to which the Insured has received instructions from the Insurer not to travel.

The consequences of taking an active part in acts of terrorism, including but not limited to the use or threat of the use of force or violence by any person or group of persons, acting alone or in collaboration with an organization or organizations, or a government or governments, committed for a political, religious, ideological or similar reason or with the intention of influencing a government and/or to create fear in the population or any part of the population. Unless the Insured is in charge of the protection of the safety of property or persons.

The consequences of holding, possessing or handling illegal arms or war machines on the site of the Accident by the Insured.

The consequences of surgery required due to an accident excluded from the coverage.
ARTICLE 23 - LIFE INSURANCE DEFINITIONS

The terms and expressions used in this part have the meaning defined below:

Accident

Whenever referred to in the context of the cover or amount of benefits, accident should be understood to mean any physical injury beyond the Insured Party’s control, resulting from an abrupt, sudden and unexpected action, excluding an acute or chronic illness.

Beneficiaries in the event of the death of the Insured:

The lump sums covered on the death of the Insured are paid, in order of preference:

- To the surviving spouse unless legally separated,
- Otherwise in equal shares to his children born or to be born, the share of a deceased child going to his own children or to his brothers and sisters,
- Otherwise in equal shares to the surviving parents,
- Otherwise to the Insured’s heirs

The Insured can at all times change the above order and name any private person or legal entity or entities of his choice by private agreement or by an authentic instrument. The Insured shall inform HENNER - GMC in writing of the named beneficiary(ies).

Changes in the choice of beneficiaries must be notified to the Insurer in writing. The beneficiaries’ designation clause can also be modified when it is no longer appropriate.

When the beneficiary is specifically named, the Insured must state the beneficiary(ies)’s address for use by HENNER - GMC in the event of the death of the Insured.

The nomination of a beneficiary becomes irrevocable on acceptance of the nomination by the said beneficiary. Acceptance is accomplished by an authentic instrument or private agreement, signed by the Insured and the named beneficiary. The acceptance has no effect on the Insurer unless it has been notified to the Insurer in writing.

When the personal nomination is deemed null and void, the standard nomination above is applicable.

ARTICLE 24- DOCUMENTS TO PROVIDE WITH A CLAIM

The justifying documents to provide in the event of a claim for the payment of the Life Insurance coverage are:

IN THE EVENT OF DEATH

- The completed death declaration form as provided by the Insurer
- A medical certificate of death by natural causes drawn up by the doctor who pronounced the death
- A complete photocopy of the family documents; or a certificate of legal partnership; or a certificate of common-law union justifying life in common
- A complete copy of the birth certificate of the deceased Insured
- An excerpt from the birth certificate of the Dependant designated beneficiaries of the life insurance lump sum
- The last tax return if there are Dependants
- Bank account details

IN THE EVENT OF ACCIDENTAL DEATH

- In addition to the documents listed above, a photocopy of the police report
IN THE EVENT OF TOTAL PERMANENT DISABILITY

- A copy of the Birth Certificate of the Insured
- The last tax return
- The medical certificate attesting to the Total Permanent Disability addressed to the Advisory Doctor of the Insurer, in an envelope marked “Medical confidentiality”

The Insurer reserves the right to request any other proof or documentation needed to assess the case and complete the file.
## APPENDIX 1 - TABLE OF BENEFITS

### PLAN

<table>
<thead>
<tr>
<th></th>
<th>Primary</th>
<th>Vitality</th>
<th>Serenity</th>
<th>Prestige</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum annual limit</strong></td>
<td><code>US$ 200,000, US$ 300,000 or US$ 500,000</code></td>
<td><code>US$ 200,000, US$ 300,000 or US$ 500,000</code></td>
<td><code>US$ 300,000, US$ 500,000 or US$ 1,000,000</code></td>
<td><code>US$ 300,000, US$ 500,000 or US$ 1,000,000</code></td>
</tr>
<tr>
<td><strong>HOSPITALIZATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Settlement for Inpatient services within the HENNER - GMC medical network</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Inpatient treatment charges</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Hospital Accommodation</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Hospital Accommodation private or semi-private room</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Parent Hospital Accommodation when staying with an insured patient under 16 years of age</td>
<td>100% up to 30 days Max US$ 60 / day after</td>
<td>100% up to 30 days Max US$ 60 / day after</td>
<td>100% up to 30 days Max US$ 120 / day after</td>
<td>100% up to 30 days Max US$ 120 / day after</td>
</tr>
<tr>
<td>Daily Cash Benefit paid to you if you receive hospital inpatient treatment for a covered condition but will not be lodging a claim.</td>
<td>100% up to 30 days Max US$ 200 / day</td>
<td>100% up to 30 days Max US$ 200 / day</td>
<td>100% up to 30 days Max US$ 200 / day</td>
<td>100% up to 30 days Max US$ 200 / day</td>
</tr>
<tr>
<td>Post Hospital Outpatient Services</td>
<td>Up to 90 days from discharge</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>100% while in hospital Up to 90 days post hospitalization</td>
<td>100% while in hospital Up to 90 days post hospitalization</td>
<td>100% while in hospital Up to 90 days post hospitalization</td>
<td>100% while in hospital Up to 90 days post hospitalization</td>
</tr>
<tr>
<td>Home nursing in lieu of an extended hospital stay</td>
<td>100% up to 60 days</td>
<td>100% up to 60 days</td>
<td>100% up to 60 days</td>
<td>100% up to 60 days</td>
</tr>
<tr>
<td>Palliative Care with a Palliative Care team</td>
<td>100% up to US$ 25,000 Lifetime limit</td>
<td>100% up to US$ 50,000 Lifetime limit</td>
<td>100% up to US$ 100,000 Lifetime limit</td>
<td>100% up to US$ 200,000 Lifetime limit</td>
</tr>
<tr>
<td>Land Ambulance where medically necessary</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Treatment for alcohol or substance abuse in recognized treatment facilities for the condition.</td>
<td>-</td>
<td>100% Up to US$ 15,000 Lifetime limit</td>
<td>100% Up to US$ 25,000 Lifetime limit</td>
<td>100% Up to US$ 50,000 Lifetime limit</td>
</tr>
<tr>
<td>Inpatient Psychiatric Treatment in a registered psychiatric unit of a Hospital and with a registered psychiatrist.</td>
<td>-</td>
<td>-</td>
<td>100% up to 30 days After 2 years 100% up to US$11,000</td>
<td>100% up to 30 days After 2 years 100% up to US$11,000</td>
</tr>
<tr>
<td>Accidental Damage to Teeth</td>
<td>100% Up to US$ 550</td>
<td>100% Up to US$ 550</td>
<td>100% Up to US$ 1,400</td>
<td>100% Up to US$ 2,500</td>
</tr>
<tr>
<td>Equipment Charges rental of crutches, braces or wheelchairs,</td>
<td>100% up to 90 days following treatment as an Inpatient</td>
<td>100% up to 90 days following treatment as an Inpatient</td>
<td>100% up to 90 days following treatment as an Inpatient</td>
<td>100% up to 90 days following treatment as an Inpatient</td>
</tr>
<tr>
<td>Organ transplant operation costs for bone marrow, cornea, heart, liver, kidney and lung transplants</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Cancer treatment within the usual limits of your plan</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Up to US$ 200,000 Lifetime limit</td>
<td>Up to US$ 200,000 Lifetime limit</td>
<td>Up to US$ 500,000 Lifetime limit</td>
<td>Covered</td>
</tr>
<tr>
<td>Pre-existing and Chronic Conditions</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>New Born Child can be enrolled without waiting periods with full benefits per your own plan if registered within 30 days of delivery.</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
</tbody>
</table>

### OUTPATIENT SERVICES

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct Settlement for Outpatient services within the HENNER - GMC medical network</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioner fees</td>
<td>100% up to US$ 60 / visit No limit with Direct Billing</td>
<td>100% up to US$ 150 / visit No limit with Direct Billing</td>
<td>100% up to US$ 150 / visit No limit with Direct Billing</td>
<td>100% up to US$ 150 / visit No limit with Direct Billing</td>
</tr>
<tr>
<td>Specialist fees</td>
<td>100% up to US$ 100 / visit No limit with Direct Billing</td>
<td>100% up to US$ 230 / visit No limit with Direct Billing</td>
<td>100% up to US$ 230 / visit No limit with Direct Billing</td>
<td>100% up to US$ 230 / visit No limit with Direct Billing</td>
</tr>
<tr>
<td>Nursing care</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Prescribed medicines, vaccinations, radiology, diagnostic and laboratory tests</td>
<td>100% up to US$ 3,000</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Prescribed Health Supplements (e.g.: Vitamins)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Prescribed complementary therapies and medicines with registered chiropractors; osteopaths; homeopaths; podiatrists; traditional Chinese medicine practitioners (and any medications they may prescribe); acupuncturists; paramedical professionals and physiotherapists</td>
<td>-</td>
<td>100% up to US$ 150 / visit Max 10 sessions</td>
<td>100% up to US$ 180 / session Max 20 sessions</td>
<td>100% up to US$ 1,250 (No Direct Billing)</td>
</tr>
<tr>
<td>Psychologist fees with a registered psychologist</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Psychiatric treatment with a registered psychiatrist</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Hormone replacement therapy</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Medical Checkup</td>
<td>-</td>
<td>Included in your Hospitalization HIV/AIDS benefit limit</td>
<td>Included in your Hospitalization HIV/AIDS benefit limit</td>
<td>Included in your Hospitalization HIV/AIDS benefit limit</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Pre-existing and Chronic Conditions within the usual limits of your plan</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
</tbody>
</table>

---

(1) Included in your Hospitalization
(5) Limited to 1 every 2 years
(6) No Direct Billing
## PROSTHESIS

<table>
<thead>
<tr>
<th>Service</th>
<th>Primary</th>
<th>Vitality</th>
<th>Serenity</th>
<th>Prestige</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prosthesis following hospitalization</td>
<td>100% up to US$ 3,000</td>
<td>100% up to US$ 4,500</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopaedics, Assistive Hearing Devices</td>
<td>100% up to US$ 900 / device within your US$ 3,000 limit</td>
<td>100% up to US$ 1,200 / device on top of your US$ 4,500 limit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## EMERGENCY ASSISTANCE, EVACUATION & REPATRIATION

<table>
<thead>
<tr>
<th>Service</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency medical evacuation and repatriation</td>
<td>100%</td>
</tr>
<tr>
<td>Round-trip airfare for your spouse or next of kin in the event of hospitalization lasting more than 5 consecutive days</td>
<td>100% Limited to one ticket Up to 10 days, up to US$ 120 / day</td>
</tr>
<tr>
<td>Repatriation of mortal remains, Related expenses / Casket</td>
<td>100% Up to US$ 4,000</td>
</tr>
<tr>
<td>Compassionate visit in the event of death of a direct family member</td>
<td>100%</td>
</tr>
<tr>
<td>Second medical opinion</td>
<td>100%</td>
</tr>
<tr>
<td>Dispatch of medicines unavailable locally</td>
<td>Covered</td>
</tr>
</tbody>
</table>

## PERSONAL LIABILITY

<table>
<thead>
<tr>
<th>Service</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Liability</td>
<td>Subject to sublimits and up to a maximum of US$ 7,800,000</td>
</tr>
<tr>
<td>Tenants and Neighbors Liability</td>
<td>Subject to sublimits and up to a maximum of US$ 350,000</td>
</tr>
</tbody>
</table>

## CHOOSE YOUR OPTIONS

### MATERNITY

<table>
<thead>
<tr>
<th>Service</th>
<th>Primary</th>
<th>Vitality</th>
<th>Serenity</th>
<th>Prestige</th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural Delivery and Elective Caesarean including pre &amp; post natal care</td>
<td>100% up to US$ 7,000</td>
<td>100% up to US$ 12,000</td>
<td>100% up to US$ 15,000</td>
<td></td>
</tr>
<tr>
<td>Non Elective Caesarean Delivery including pre &amp; post natal care, any other major complication covered by your Hospitalization plan</td>
<td>100% up to US$ 14,000</td>
<td>100% up to US$ 21,000</td>
<td>100% up to US$ 25,000</td>
<td></td>
</tr>
<tr>
<td>Major medical complications</td>
<td>Covered as Inpatient</td>
<td>Covered as Inpatient</td>
<td>Covered as Inpatient</td>
<td></td>
</tr>
<tr>
<td>Infertility treatment (^{(1)(5)}) for patients under 40 years of age and trying for their first child, AI and FIV</td>
<td>100% Up to US$ 3,000 / procedure Lifetime limit of 3 procedures</td>
<td>100% Up to US$ 3,000 / procedure Lifetime limit of 3 procedures</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DENTAL

<table>
<thead>
<tr>
<th>Service</th>
<th>Primary</th>
<th>Vitality</th>
<th>Serenity</th>
<th>Prestige</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAXIMUM ANNUAL LIMIT (per insured)</td>
<td>Up to US$ 1,000</td>
<td>Up to US$ 1,500</td>
<td>Up to US$ 2,000</td>
<td></td>
</tr>
<tr>
<td>Routine Dental treatment</td>
<td>100% up to US$ 500</td>
<td>100% up to US$ 900</td>
<td>100% up to US$ 1,500</td>
<td></td>
</tr>
<tr>
<td>Major Restorative Dental treatments (^{(1)}) including orthodontic work for children up to age 16</td>
<td>100% up to US$ 800</td>
<td>100% up to US$ 1,200</td>
<td>100% up to US$ 1,500</td>
<td></td>
</tr>
<tr>
<td>Teeth whitening (^{(6)})</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Adult Orthodontic work (^{(1)(6)}) after age 16</td>
<td>100% up to US$ 2,000 every 3 years</td>
<td>100% up to US$ 2,000 every 3 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### VISION

<table>
<thead>
<tr>
<th>Service</th>
<th>Primary</th>
<th>Vitality</th>
<th>Serenity</th>
<th>Prestige</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAXIMUM ANNUAL LIMIT (per insured)</td>
<td>Up to US$ 500</td>
<td>Up to US$ 800</td>
<td>Up to US$ 800</td>
<td></td>
</tr>
<tr>
<td>Spectacle lenses (excluding sunglasses)</td>
<td>100% up to US$ 300</td>
<td>100% up to US$ 500</td>
<td>100% up to US$ 500</td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>100% up to US$ 150</td>
<td>100% up to US$ 200</td>
<td>100% up to US$ 200</td>
<td></td>
</tr>
<tr>
<td>Contact lenses (excluding sunglasses)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lasik Surgery &amp; Lens Implants (^{(2)})</td>
<td>-</td>
<td>Included in the Vision Care benefit of US$ 800</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following Life Benefits can be taken with any Main Cover Plan or purchased on their own:

### LIFE INSURANCE

<table>
<thead>
<tr>
<th>Benefit Type</th>
<th>Primary</th>
<th>Vitality</th>
<th>Serenity</th>
<th>Prestige</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death (all causes) or Permanent Total Disability, choose your lump sum benefit (^{(8)})</td>
<td>US$ 25,000</td>
<td>US$ 50,000</td>
<td>US$ 100,000</td>
<td>US$ 250,000</td>
</tr>
<tr>
<td>Optional double benefit when Death is caused by Accident, your Death (all causes) or Total Permanent Disability lump sum multiplied by 2</td>
<td>US$ 50,000</td>
<td>US$ 100,000</td>
<td>US$ 200,000</td>
<td>US$ 500,000</td>
</tr>
</tbody>
</table>

All dollar benefits are per person, per policy year, unless stated otherwise. 100% means 100% of usual benefits payable.

- (1) These benefits are subject to prior agreement
- (2) To be eligible for benefits, consultations with a physiotherapist require a doctor’s referral
- (3) A 6 month-waiting period apply
- (4) A 12 month-waiting period apply
- (5) A 24 month-waiting period apply
- (6) 10% or 20% coinsurance are available for people who prefer lower reimbursement levels (80% or 90% of usual benefits payable) in return for lower premiums. The coinsurance applies to eligible Outpatient benefits and Maternity, Dental, Vision options if selected.
- (7) A deductible of US$ 150 is compulsory for any claim
- (8) Lump sum is limited to 3 times the gross annual income of the past 12 months
APPENDIX 2 - RIGHT OF WITHDRAWAL

The Insured right of retract defined in the article 5 of this policy must be notified to HENNER - GMC by registered letter with acknowledgement of receipt.

This notice should be sent to:

HENNER - GMC
HENNER PRO Team
137 Telok Ayer Street #07-01/02/03
SINGAPORE 068602
or
hennerpro.asia@henner.com

It can be written according to the following template:

**Right of withdrawal notice:**

“Madam, Sir,

I, the undersigned (full name of the insured), residing at (main address), inform you hereby that I withdraw my HENNER insurance cover (membership number), I signed on (date).

Please refund the premiums I have paid, net after deduction of 1 month of premium from the date the policy was in effect.”

In: ......................................
Date: ......................................
Signature: ..............................