Allianz Partners

GROUP INSURANCE CONTRACT
HEALTHCARE PLAN - 1st USD

CONTRACT NUMBER: 910.048/501
EFFECTIVE DATE: 1 JUNE 2021

Between

THE IRAQI MINISTRY OF FOREIGN AFFAIRS ("MoFA")
Baghdad, Al-Karkh – Salhiya
IRAQ

Hereinafter referred to as the "Policyholder"

And

AWP Health & Life SA,
Public Limited Company with a capital of EUR 65,190,446, registered with the Trade and Corporations Registrar of Bobigny under number 401 154 679. Governed by the French Insurance Code and whose registered office is located at Eurosquare 2, 7 rue Dora Maar, 93400 Saint Ouen, France

AWP Health &Life SA is regulated by the French Prudential Supervisory Authority (Autorité de Contrôle Prudentiel et de Résolution (ACPR)) located at 4 Place de Budapest, CS 92459 - 75436 PARIS CEDEX 09.

Hereinafter referred to as the "Insurer"

Hereinafter, collectively referred to as the "Parties"

The Present Contract is in English and has been translated in Arabic, both versions being equally valid. The Parties hereto acknowledge that in case of conflict between the English version and the Arabic version, any legal interpretation as to the content shall be based on the English version.

BY MUTUAL AGREEMENT BETWEEN THE PARTIES, IT HAS BEEN AGREED AS FOLLOWS:

THE PRESENT CONTRACT IS GOVERNED BY THE FRENCH INSURANCE CODE AND IS ESTABLISHED SUBJECT TO THE FOLLOWING TERMS AND CONDITIONS:

Insurance contract between the Insurer and the Policyholder

Insurance contract Schedule ("Schedule")

GENERAL TERMS	
Insurer:	AWP Health & Life SA Eurosquare 2 7 rue Dora Maar 93400 Saint Ouen France
Policyholder:	THE IRAQI MINISTRY OF FOREIGN AFFAIRS ("MoFA") Iraq, Baghdad, Al-Karkh – Salhiya
Commencement Date:	01.06.2021 at 00:00 GMT
End Date:	31.05.2022 at 24:00 GMT
Renewal Notice Period:	3 months
Cover:	As per the attached Table(s) of Benefits
Eligibility Notification Period:	4 weeks

PREMIUM	
Payment Frequency:	The annual premium will be paid in four instalments and an End of contractual year adjustment invoice. Each instalments will correspond to 25% of the contract value of USD 12 676 024,80 (twelve million six hundred seventy six thousand twenty four US dollars and eighty cents), which will be invoiced by the Insurer as per the following schedule: **Date of issue / Payment date** 1st instalment: 01/07/2021 / 31/07/2021 2nd instalment: 01/09/2021 / 01/10/2021 3rd instalment: 01/12/2021 / 31/12/2021 4th instalment: 01/03/2022 / 31/03/2022 End of contractual year adjustment: 01/06/2022 / 01/07/2022 The End of contractual year adjustment invoice will reflect all membership adjustment (additions/deletions) for the full duration of the contractual insurance year.
Credit Terms:	30 days
Currency:	USD
Premium rates and taxes	The premium for Eligible Persons joining or leaving the agreement will be calculated on a pro rata basis. The premium rates set out in this Agreement are exclusive of any applicable Insurance Premium Tax and all other taxes and levies, considering the Policyholder is exempt from all direct taxes.

Cover	Medical
Eligible Persons:	All employees who are employed by the Policyholder and their dependants, provided the employees and their dependant spouse or partner's age at entry has not exceeded the maximum Term Age at the time of application as set out below and the employees maintain full active employment with the Policyholder outside of Iraq.
Term Age:	75
Geographical Area of Coverage:	• Worldwide cover for employees based in the USA • Worldwide cover excluding USA for employees based outside of the USA All Insured Persons within one policy are required to have the same region of cover. If a dependant is in full time education in a country outside the region of cover, only this dependant can have a different region of cover. Any changes in region of cover to include the USA within the geographical region of cover are subject to acceptance by the Insurer. Supporting evidence of US residence or US citizenship for the members or dependants to be changed is required.
Premium:	The yearly premium is calculated as follows Worldwide cover for employees based in the USA: Per single: 8 113.60 USD Per married: 16 227.20 USD Per family: 24 340.80 USD Per single parent family: 12 170.40 USD Worldwide cover excluding USA for employees based outside of the USA: Per single: 3 688.00 USD Per married: 7 376.00 USD Per family: 11 064.00 USD Per single parent family : 5 532.00 USD
Underwriting Terms:	Full details set out below.
Waiting Periods Applicable:	Refer to Table of Benefits

Underwriting Terms

Medical History Disregard (MHD)

The Insurer accepts all Eligible Persons under this Agreement without medical underwriting. This is subject to the Policyholder insuring all Eligible Persons in this Agreement.

There are no waiting periods to qualify for covered benefits. Pre-existing and chronic conditions are covered within the terms of this Agreement.

The Policyholder agrees to notify the Insurer about any Eligible Persons that are deemed to be a material risk (i.e. health conditions that can lead to significantly high claim(s) resulting from that condition per Insurance Year) or where cover has previously been rejected by the Insurer or any previous Insurer. The Insurer reserves the right to accept those Eligible Persons under this Agreement or apply special conditions including the recalculation of the premium from the start of the Insurance Year to reflect the additional risk. If the Policyholder fails to notify the Insurer, the Insurer has the right to deny any claims for the Insured Person.

The Insurer reserves the right to withdraw from offering cover without medical underwriting if the required minimum number of insured employees and/or dependants as per the Insurer's standard guidelines at the time is not met during the Insurance Year or at renewal. The Insurer will, in this case, continue to offer cover, subject to full medical underwriting with the appropriate terms applicable.

Insurance contract Terms and Conditions

General Conditions

1. Scope of the Insurance contract ("Agreement")

1.1 This Agreement is composed of

- the Schedule
- these General Conditions
- Appendix 1 – Special Conditions
- Appendix 2 – Table of Benefits (TOB)
- Appendix 3 – Benefit Guide(s)
- Appendix 4 – Financial Offer
- Appendix 5 – Service Level Agreement
- Appendix 6 – Special Agreements
- any endorsements, subsequent variations or replacements.

2. Purpose of the contract

2.1 The purpose is to provide insurance cover (as set out in the Schedule) by the Insurer for the benefit of all Eligible Persons.

2.2 Benefits are payable subject to the Table of Benefits (as set out in Appendix 2) and in accordance with the Benefit Guide(s) (as set out in Appendix 3).

3. Definitions

3.1. Unless a different meaning is given in this Agreement, words and phrases have the same meanings as set out in the Benefit Guide(s).

4. Eligibility

4.1 The Policyholder hereby guarantees that all eligible employees as at the Commencement Date of this Agreement will be included and that other eligible employees who become eligible for inclusion subsequently will be included from the first day on which they become eligible, subject to the provisions of Clause 4.3.

4.2 Where eligible for the insurance cover (as set out in the Schedule), dependants who are eligible will be included from the same date as the associated eligible employee or from the date on which the person concerned first satisfied the definition of a dependant, subject to the provisions of Clause 4.3.

4.3 The Insurer must be notified of Eligible Person additions, changes or cancellations, in writing, within 4 (four) weeks of the person becoming eligible, the change event or the person not being eligible anymore. Where notification is not made by the Policyholder within the agreed period, the Policyholder is obliged to highlight to the Insurer the late notification. In that case the Insurer reserves the right to only make the requested change from the day such notice is given or to decline any addition requested. If the Policyholder fails to advise the Insurer of changes and/or cancellations within the agreed 4 (four) week period, for any reason, the Policyholder will remain responsible for the payment of the relevant premium until such notice is given and accepted by the Insurer.

4.4 It will not be possible to backdate changes and cancellations if claims have been processed or if Treatment Guarantees have been issued. Furthermore, the start date for Insured Persons cannot be backdated to include any claims or events that would give rise to a claim that have already taken place.

4.5 The Policyholder will add only persons whom are Eligible Persons as defined in this Agreement. Any person added to the group scheme whom is found by the Insurer not to have been eligible, shall be deemed to be not covered and any claims, invoices, fees or charges paid or payable in respect of that ineligible person will be the responsibility of the Policyholder.

4.6 The Policyholder hereby agrees to inform the Insurer at least once a month of the additions, changes and cancellations of Insured Persons. Membership information must be provided by the Policyholder in a format specified/approved by the Insurer.

4.7 The Insurer will issue a complete membership list along with contact details of the Policyholder to the Policyholder for confirmation before the renewal of the group scheme. The Policyholder will review the membership list and confirm that it accurately reflects the up-to-date membership and highlight any additions, changes and cancellations. If the Policyholder fails to advise the Insurer in writing before the renewal date of required changes, the Insurer reserves the right to renew the group scheme with the latest membership information available and issue an invoice based on this membership. The Insurer reserves the right to decline any additions, changes and cancellations with an effective date before the renewal date that are requested after the renewal has been processed. The Policyholder will remain responsible for the payment of the premium for the policies where the Insurer has not been notified in time.

4.8 The Insurer shall be entitled to cancel this Agreement by giving 30 (thirty) days' notice if the Insurer becomes aware that the Policyholder offers insurance of the type covered by this Agreement from a provider outside this Agreement to eligible persons. Eligible Persons who have been members of an individual, privately purchased scheme before becoming eligible for this Agreement have no obligation to join this scheme.

5. Commencement, Renewal and Termination

5.1 This Agreement is contracted for the period specified in the Schedule starting on the Commencement Date at 00:00 GMT and ending on the End Date at 24:00 GMT. This period is deemed to be the Insurance Year

The cover for the policies of the Insured Persons shall commence at the agreed risk Commencement Date.

5.2 The Insurer may offer the Policyholder the renewal of this Agreement by providing the new renewal conditions including the Table of Benefits, Benefit Guide(s), Group Policy Change Document (where applicable) and premiums, by the agreed Renewal Notice Date as set out in the Schedule, before the expiry of this Agreement. Upon receipt of these documents, the Policyholder has 1 (one) month in which to inform the Insurer in writing of its decision to renew or not to renew.

5.3 Silence or payment of the premiums calculated in accordance with the revised renewal terms denotes the Policyholder's acceptance of renewal in accordance with the revised renewal terms, including any changes in the Insurer's terms and conditions as well as the revised premiums and will therefore replace the need for a signed contract. The Insurer will process the renewal and issue the invoice based on the latest details available.

5.4 The Policyholder has the right to cancel this Agreement at any time, without fees or penalties at the expiration of a period of 1 (one) year, starting from the first subscription. The termination takes effect 1 (one) month after the Insurer has received notification by registered letter, single letter, e-mail or other durable medium.

The Insurer can cancel this Agreement with effect from the next Renewal Date by giving 2 (two) months prior written notice to the Policyholder.

5.5 In the event the Policyholder fails to pay all the premiums in full within 1 (one) month following their due date, the coverage is suspended 30 (thirty) days after the Insurer has sent a registered letter constituting formal notice of said suspension as provided for in Article L.113-3 of the French Insurance code.

If beyond that period, the Policyholder has not made the requested payment, the contract of the Policyholder may be terminated without any further formality within the following 10 (ten) days.

5.6 The Insurer reserves the right to cancel this Agreement by giving 30 (thirty) days written notice should the Policyholder mislead the Insurer in any way or should the Policyholder not discharge any of its obligations arising under this Agreement.

5.7 The Policyholder reserves the right to cancel this Agreement by giving 30 (thirty) days written notice should the Insurer mislead the Policyholder in any way or if the Insurer is in material breach of its obligations arising under this Agreement.

6. Claims Liability

6.1 For events that result in a claim when somebody else is at fault, the Insurer has full rights to subrogate any costs for any claim from the relevant third party. The Policyholder and the Insured Persons agree to fully cooperate with the Insurer and disclose all relevant information and take any reasonable steps the Insurer asks for. The Insurer reserves the right to deny all or part of the claims if the Policyholder and/or Insured Persons do not cooperate.

6.2 The Insurer shall not be held liable for the coverage of a guarantee of the insurance and shall not be liable to pay any claim or provide any benefit provided for herein to the extent that the provision of such coverage, payment of such claim, and/or provision of such benefit would expose that Insurer to any sanction, prohibition, and/or restriction under United Nations resolutions, trade or economic sanctions, laws or regulations of France, the European Union, United States of America, or any other applicable law or regulation.

7. Premiums

7.1 The Insurer calculates the payable premium at the beginning of the Insurance Year. The Insurer reserves the right to change the total payable amount of the premium during the Insurance Year (not the individual rate per member as per the Schedule) and issue an adjustment invoice to reflect any changes in the number of Insured Persons and/or Gross Annual Salary (for any relevant cover as outlined in Appendix 1).

7.2 The premium rates outlined in the Schedule are exclusive of any applicable Insurance Premium Tax or other taxes and levies, considering the Policyholder is exempt from all direct taxes.

7.3 The premium shall be paid according to the payment frequency selected as specified in the Schedule (with the appropriate premium surcharges applying depending on the payment frequency selected), by bank transfer or cheque. The initial premium falls due on the Commencement Date of this Agreement. Subsequent premium payments fall due on the first day of each payment frequency period as specified in the Schedule. Premiums must be paid within the Credit Terms. Credit Terms run from the date of the invoice issued by the Insurer.

7.4 The Insurer reserves the right to discontinue any agreement to accept premiums by instalment if an interval payment shall not be received by the Insurer within the Credit Terms. In such event all remaining premium instalments in respect of that year shall become immediately due and payable.

7.5 If the Policyholder Agreement is not renewed or is terminated by either party, the Insurer will immediately issue an adjustment invoice. If the invoice shows an outstanding amount to be paid by the Policyholder, payment is due within 30 (thirty) days of receipt of the invoice. If the outstanding and owing amount is not paid within the payment deadline, the Insurer reserves the right to suspend all claims payments until all outstanding premiums have been paid in full. If the adjustment invoice shows a refund is due by the Insurer to the Policyholder, reimbursement shall be made within 15 (fifteen) days of receipt by the Insurer of all necessary information (including bank details) required to process the payment.

8. Obligations

8.1 The Policyholder undertakes that it will advise all eligible employees immediately if for any reason this Agreement should not be renewed or this Agreement should be terminated in accordance with the

provisions of Clause 5 above, so that such eligible employees are made aware that all cover has ceased and that benefits will not be payable in respect of Insured Persons.

8.2 Should the Policyholder engage any third party to act as Group Secretary or intermediary, the Policyholder shall be liable for the acts and omissions of such third party.

8.3 The Policyholder hereby indemnifies the Insurer from and against any and all costs, losses and expenses incurred by the Insurer consequent upon any failure by the Policyholder to discharge its obligations under this Agreement.

8.4 The Policyholder shall remain responsible for ensuring its obligations under this Agreement are fully discharged notwithstanding that all or any part of those obligations are delegated to an intermediary or agent who shall be deemed to be the agent of the Policyholder.

8.5 The Policyholder shall advise the Insurer immediately if it goes into liquidation or becomes bankrupt, or if an administrator or receiver or an administrative receiver is appointed in respect of all or any part of the business or assets of the Policyholder. The Insurer reserves the right to issue an adjustment invoice and request immediate payment, suspend claims if premium payments are outstanding or cancel the agreement.

8.6 The Insurer shall advise the Policyholder immediately if it goes into liquidation or becomes bankrupt, or if an administrator or receiver or an administrative receiver is appointed in respect of all or any part of the business or assets of the Insurer.

9. Dispute Resolution

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

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

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

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

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

10. Changes, Declarations

10.1 The Insurer may alter both the Benefit Guide(s) and/or the Table of Benefits from time to time but no alteration shall take effect until the next annual renewal of this Agreement. The Insurer shall notify such changes to the Policyholder in writing as part of the renewal process.

10.2 This Agreement can only be varied in writing. No variation will be admitted unless it is in writing and signed on behalf of the Insurer and the Policyholder by authorised employees or officers.

10.3 Any notice to be sent under this Agreement must be in writing and be sent either by post, by fax or by email.

11. Provision for invalidity

The effectiveness of the whole Agreement shall not be in question if parts of the Agreement are found to be invalid or unfeasible or should there be a gap in the provisions of the Agreement.

The invalid or unfeasible provision shall be replaced or the gap be filled with a regulation that both parties wanted or would have wanted if they had considered the point.

12. Applicable Law

This Agreement shall be governed by:
- the Iraqi regulations on public procurement with regard to the public procurement, its meaning, its interpretation; the relations established between the Parties within the framework of the Public Market will be subject to the law of Iraq;
- French law and in particular the French Insurance Code, mainly by the provisions of Title IV of Book I of the said Code relating to group insurance, with regard to the present Agreement, its application and interpretation.

13. Legal action

The provisions relating to the limitation of actions arising from the insurance policy are laid down by Articles L.114-1 to L.114-3 of the French Insurance Code reproduced below:

Article L.114-1 of the French Insurance Code:
All legal actions arising from an insurance policy shall be barred two years as from the event that gave rise thereto.
However, such a period shall run:
1° in the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only as from the date on which the Insurer is aware thereof;
2° in the event of a claim, only as from the date the persons concerned are aware thereof, if they prove that they were unaware of such facts until then.
When the Covered Person's action against the Insurer arises from a third party's recourse, the limitation period shall run only from the date on which such third party brings a legal action against the Covered Person or this one has paid it compensation.

Article L.114-2 of the French Insurance Code:
The limitation period shall be interrupted by one of the ordinary causes that interrupt the limitation period and by the designation of experts following a claim. The limitation period of the legal action may also be interrupted by the Insurer sending the Covered Person a registered letter with acknowledgement of receipt in respect of the action for payment of the premium and by the Covered Person to the Insurer in respect of the settlement of the claim.

Article L.114-3 of the French Insurance Code:
By way of derogation from Article 2254 of the French Civil Code, under no circumstance shall the limitation period be amended or further causes of suspension or interruption be added by the contracting parties, even if agreed by mutual agreement.

Further information:
The ordinary causes of interruption of the limitation period are set out in Articles 2240 et seq. of the French Civil Code; they include in particular: the debtor's acknowledgement of the right of the person against whom he/she applies the limitation period; a service of process, even provisionally; enforcement proceedings. For

more information about the completeness of the ordinary causes of interruption of the limitation period, see the aforementioned Articles of the French Civil Code.

14. Data protection

The Insurer and the Company hereby confirm that they will comply with all data privacy legislation (including, where applicable, any code, legislation, regulation, recommendation or opinion issued by a relevant data protection authority relating to the protection of personal data, the General Data Protection Regulation 2016/679 of 27 April 2016 and any European Union or EU Member State legislation, regulation, recommendation or opinion replacing, adding to or amending, extending, repealing or consolidating same) that applies to that party in its capacity as a separate independent data controller. The Insurer is acting as a separate independent data controller for insurance purposes.

Signed in Berlin, GERMANY, on June 1st 2021.

AWP Health & Life SA

Ministry of Foreign Affairs in Iraq

Appendix 1 - Special Conditions

Insurance contract:

Medical Cover

1. Purpose

The purpose of this section is to confirm the special conditions that apply to the provision of Medical Cover, as set out in the Table of Benefits.

2. Continuation of Cover

Members transferring to a standard individual plan with the Irish branch of the Insurer.

If cover under this Policyholder Agreement comes to an end, the employee and his/her dependants may apply for a transfer to a standard individual plan offered by the Irish branch of the Insurer. Applications for transfer of cover must be submitted within 1 (one) month of leaving the group scheme and there must be no break in cover. Transfer of cover can not be offered to dependants only.

Please note that cover in some countries is subject to legal restrictions, particularly for nationals of that country. It is the individual's responsibility to ensure that the cover is legally appropriate.

The employee can choose from the Irish branch of the Insurer's standard individual plans. Waiting periods will not apply if the chosen plan offers fewer or similar benefits to those of the group scheme.

The transfer of cover is subject to full medical underwriting. The Irish branch of the Insurer reserves the right to accept or reject the employees and/or dependants application. The acceptance may be subject to premium surcharges, the exclusion of certain benefits from the cover or other special conditions.

For certain countries special agreements are in place with regards to continuation of cover. Please contact us for further details.

3. Claims Liability

3.1 The liability of the Insurer to pay benefits for Medical Cover is limited to Treatment received during the period for which the Insurer has provided cover and received the premium.

3.2 The date of treatment is the relevant factor when deciding on the Insurer's liability to pay medical benefits. The liability ceases 6 (six) months after the end of the Insurance Year of the Policyholder Agreement or 6 (six) months after termination of the individual policy if the Insured Person leaves the Agreement during the Insurance Year, or if the Agreement terminated by the Insurer in accordance with Clause 5 of the General Conditions.

3.3 The Insurer will not be liable for claims where a member has been added to the group scheme or where the level of cover was upgraded after symptoms of a certain condition were already apparent at the start date of the policy, or at the date the Insurer was notified about the addition and where the only reason to add the person or to upgrade the level of cover was to provide cover for treatment of that condition.

3.4 Treatment in the USA is covered for Insured Persons with Worldwide cover, however treatment in the USA is not covered if the Insurer knows or suspects that cover was acquired for the purpose of travelling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the member prior to the purchase of cover. The Insurer reserves the right to claw back any claims amounts from the Insured Person that have been paid by the Insurer already.

4. Obligations

4.1 The Policyholder will inform its employees about any compulsory health insurance obligations which they may be subject to when they return to live in their home country.

5. Performance Security

5.1 The Insurer has to provide the Policyholder with an acceptable performance security amounts to 5% of the amount of the contract within a period of time that is no later than the date specified in the Award Notification (award letter), the security shall be in a form of a letter of bank guarantee in the amount and currency specified in the special conditions and should be issued by a bank that is acceptable by the Ministry of Foreign Affairs of the Republic of Iraq.

5.2 The letter of Guarantee should be valid and in force for a period of 6 (six) months after the date of the end of the contract.

5.3 The Insurer shall meet the Key Performance Indicators (KPIs) set forth in this Appendix 5 to this Agreement. The Policyholder will monitor the Insurer's performance against the KPIs on a monthly basis. Following the monitoring, the result is communicated every month to the Insurer with the detail of the evaluation by the Policyholder. No later than August 31st 2021, the parties will in good faith agree on the criteria to be used for scoring each KPIs. Upon prior written request of any Party, the Parties will conduct quarterly performance review meetings and as needed. The purpose of such meetings will be to assess and report whether the services are being delivered in accordance with the requirements of the present Agreement. Each KPI will be graded on a scale of 0 to 5, with 0 representing the lowest score and 5 representing the highest score. The Insurer shall be deemed to have failed to meets its obligation under this clause when (1) the Insurer scores an average of less than 4 on any KPI for a period of three months or more, or (2) the Contractor has a score of 0 on any KPI for a period of three months or more.

Failure to met the KPIs as set forth in Appendix 5 shall entitle the Policyholder to the remedies available under this section.

Appendix 2

Insurance contract:

Medical Cover

Table of Benefits

Core Plan	THE IRAQI MINISTRY OF FOREIGN AFFAIRS
Maximum plan benefit USD ($)	$2,100,000
In-patient benefits[1] - please refer to notes for more information on Treatment Guarantee	
Hospital accommodation[1]	Private room
Prescription drugs and materials[1] (in-patient and day-care treatment only)	Full refund
Surgical fees, including anaesthesia and theatre charges[1]	Full refund
Physician and therapist fees[1] (in-patient and day-care treatment only)	Full refund
Surgical appliances and prostheses[1]	Full refund
Diagnostic tests[1] (in-patient and day-care treatment only)	Full refund
Organ transplant[1]	Full refund
Psychiatry and psychotherapy[1] (in-patient and day-care treatment only)	Full refund, max. 15 days
Accommodation costs for one parent staying in hospital with an insured child under 18[1]	Full refund
Emergency in-patient dental treatment	Full refund
Other benefits - please refer to notes for more information on Treatment Guarantee	
Day-care treatment[2]	Full refund
Out-patient surgery[2]	Full refund
Nursing at home or in a convalescent home[2] (immediately after or instead of hospitalisation)	$5,000
Rehabilitation treatment[2] (immediately after acute medical treatment ceases)	$5,000
Local ambulance	Full refund
Emergency treatment outside area of cover (for trips of a maximum period of six weeks)	Full refund, max. 42 days
Medical evacuation[2]	Full refund
Expenses for one person accompanying an evacuated/repatriated person[2]	$4,250

CT and MRI scans (in-patient and out-patient treatment)	Full refund
PET[2] and CT-PET[2] scans (in-patient and out-patient treatment)	Full refund
Oncology[2] (in-patient and out-patient treatment)	Full refund
Routine maternity including home delivery[2] (in-patient and out-patient treatment)	$8,000
Complications of pregnancy and childbirth[2]	$15,000
Emergency out-patient dental treatment (where these benefit amounts are reached, any additional costs may be reimbursed within the terms of any separate Dental Plan)	$1,050
Palliative care and long term care[2]	Full refund, max. 30 days per lifetime
Out-patient Plan	**THE IRAQI MINISTRY OF FOREIGN AFFAIRS**
Maximum plan benefit	$8,000
Out-patient benefits	
Medical practitioner fees and prescribed drugs	80% refund
Specialist fees	80% refund
Diagnostic tests	80% refund
Chiropractic treatment, osteopathy, homeopathy, Chinese herbal medicine and acupuncture (Max. 6 sessions per condition for chiropractic treatment and max. 6 sessions per condition for osteopathic treatment, subject to the benefit limit)	80% refund
Speech therapy, oculomotor therapy and occupational therapy[2]	80% refund
Routine health checks including cancer screening	80% refund, max. $400
Infertility treatment	80% refund Max, $12,000
Prescribed medical aids	80% refund, max. $4,000
Prescribed glasses and contact lenses	80% refund, max $150

Dental Plan	THE IRAQI MINISTRY OF FOREIGN AFFAIRS
Maximum plan benefit	$1,000
Dental benefits	
Dental treatment	80% refund
Dental surgery	80% refund
Periodontics	80% refund
Orthodontic treatment and dental prostheses	50% refund

Repatriation Plan	THE IRAQI MINISTRY OF FOREIGN AFFAIRS
Medical repatriation[2]	Full refund

NOTES

Treatment Guarantee/Pre-authorisation

Treatment Guarantee/Pre-authorisation is a process whereby we guarantee cover for certain treatment and costs, as indicated in the Table of Benefits with a **1** or a **2**. If Treatment Guarantee is not obtained for the benefits listed with a **1**, we reserve the right to decline your claim. If the treatment is subsequently proven to be medically necessary, we will only pay **80%** of the eligible benefit, and for those listed with a **2**, we will only pay **50%** of the eligible benefit. For further details please refer to the "How to Claim" Section of our Benefit Guide, or simply contact **our Helpline.**

Limitation on Actual Costs

Pursuant to Article 9 of the Act no. 89-1009 of 30th August 1990 and the Decree no. 90-769 of 30th August 1990, the reimbursements or payment of the expenses incurred from illness, maternity or an accident shall not exceed the amount of the expenses remaining payable by the Insured Person after the payment of the benefits of any type they are entitled to.
Coverage of the same nature subscribed to with several insuring bodies shall be enforceable up to the limit on each benefit, no matter the date the coverage was subscribed to. Within this limit, the policy beneficiary of the contract may obtain supplemental compensation by submitting the detail of the reimbursement(s) paid by the other insuring body (ies).
For the purpose of the aforementioned provisions, the limitation on the amount of the expenses remaining payable by the Insured Person is determined by the Insurer for each medical act, treatment or item.

Chronic Conditions

Chronic conditions are covered within the terms of your policy. Please refer to the definitions section of our Benefit Guide for further information or contact our Helpline.

Pre-existing Conditions

Pre-existing conditions are covered within the terms of your policy. For further details please refer to the "Definitions" section of our Benefit Guide or simply contact our Helpline.

Benefit limits

There are two kinds of benefit limits shown in the Table of Benefits. The **maximum plan benefit**, which applies to certain plans, is the maximum we will pay for all benefits in total, per member, per Insurance Year, under that particular plan. Some benefits also have a **specific benefit limit**, for example "Nursing at home or in a convalescent home". Specific benefit limits may be provided on a "per Insurance Year" basis, a "per lifetime" basis or on a "per event" basis, such as per trip, per visit or per pregnancy. In some instances we will pay a percentage of the costs for the specific benefit e.g. "80% refund, up to $4,000". Where a specific benefit limit applies or where the term "Full refund" appears next to certain benefits, the refund is subject to the maximum plan benefit, if one applies to your plan(s). All limits are per member, per Insurance Year, unless otherwise stated in your Table of Benefits.

Policy Terms and Conditions

The Table of Benefits provides an outline of the cover we offer under your policy. Please note that cover is subject to our standard policy definitions, limitations and exclusions. These are detailed in our Benefit Guide, which is issued to you upon policy inception. Our current Benefit Guide can also be downloaded from our website **www.allianzworldwidecare.com**

Policy Endorsement(s)

If there are any policy terms and conditions unique to your policy they will be listed below. Please read carefully in conjunction with our Benefit Guide.

<u>The following additional definition applies for "prescribed drugs":</u>

Prescribed drugs refers to products, including non - prescription drugs, insulin, hypodermic needles or syringes which have been prescribed for the treatment of a confirmed diagnosis or medical condition or to compensate vital bodily substances. The prescription drugs must be clinically proven to be effective and recognised by the pharmaceutical regulator in a given country.

Hospital & Clinic Exclusions

A number of hospitals and clinics have been excluded from use as part of your plan except for emergency treatment. Only treatment commencing within 24 hours of the emergency event will be covered. This means that any inpatient, day-case, outpatient treatment or dental treatment within these hospitals and clinics will not be covered. If you decide to go ahead with treatment at one of these hospitals or clinics then you will be liable for the full cost.

The list of hospitals and clinics excluded from use, as part of your plan, are listed in the Table of Benefits that will be provided to the Insured Persons.

Appendix 3

Insurance contract:

Medical Cover

Employee Benefit Guide

The Ministry of Foreign Affairs of Iraq Employee Benefit Guide (Version valid from June 1st 2021). It is also available on the Allianz Worldwide Care Website www.allianzcare-mofa.com

Appendix 4 – Financial Offer

Conditional Subject to: *This quotation is an indicative quotation only and is non-binding. It is subject to receipt of the following information which may impact the quotation positively, negatively or lead to a declinature to quote. Upon receipt of the outstanding information a confirmed quotation will be issued, valid for 30 days.*

- Pricing exclude and Taxes/Levies

Company name: MOFA - Ministry of Foreign Affairs, Republic of Iraq

Start date: 1 May 2021

Underwriting terms: MHD

Payment frequency: Quarterly

Payment currency: USD

EMPLOYEES & DEPENDENTS

Selected plans	OPTION 5v2 - TOB 250521								
Region of cover	Worldwide excluding USA								
Payment frequency		Annual		Half-yearly		Quarterly		Monthly	
	Number of members	Rate per member	Premium	Rate per member	Premium	Rate per member	Premium	Rate per member	Premium
Single	207	3 688,00	763 416	1 844,00	381 708	922,00	190 854	307,33	63 617
Married	84	7 376,00	619 584	3 688,00	309 792	1 844,00	154 896	614,67	51 632
Family	847	11 064,00	9 371 208	5 532,00	4 685 604	2 766,00	2 342 802	922,00	780 934
Single parent	35	5 532,00	193 620	2 766,00	96 810	1 383,00	48 405	461,00	16 135
Subtotal	1 173		10 947 828		5 473 914		2 736 957		912 319

Selected plans	OPTION 5v2 - TOB 250521								
Region of cover	Worldwide / Global								
Payment frequency		Annual		Half-yearly		Quarterly		Monthly	
	Number of members	Rate per member	Premium	Rate per member	Premium	Rate per member	Premium	Rate per member	Premium
Single	9	8 113,60	73 022	4 056,80	36 511	2 028,40	18 256	676,13	6 085
Married	3	16 227,20	48 682	8 113,60	24 341	4 056,80	12 170	1 352,27	4 057
Family	65	24 340,80	1 582 152	12 170,40	791 076	6 085,20	395 538	2 028,40	131 846
Single parent	2	12 170,40	24 341	6 085,20	12 170	3 042,60	6 085	1 014,20	2 028
Subtotal	79		1 728 197		864 098		432 049		144 016
TOTAL	1 252		12 676 025		6 338 012		3 169 006		1 056 335

Conditions of Quotation

This is a quotation only and does not guarantee acceptance of cover by Allianz Partners. We are free to accept or reject any request for insurance cover on the basis of this quotation (or any other quotation that we provide). If we accept any such application, we will only be bound to provide cover upon receipt of the agreed premium amount in full (this amount will vary depending on the payment frequency chosen).

This quotation is valid for 30 days from the date of issue.

This quotation and/or total amount payable is subject to change at our discretion as follows:

· To reflect any changes in the number of persons to be insured, or to the membership profile (e.g. age, principal country of residence or region of cover of any persons to be insured);

· To reflect any substantial claims that become apparent at any time prior to the start date or renewal date of the policy (including any claims and/or possible claims that arise between the date of quotation and date of us being bound to provide cover);

· To reflect any changes to, or to include any locally imposed premium taxes or government levies (these will be applied at the invoicing stage);

· If there are any changes to the benefits, plans, deductible amounts or the rate of commission payable (where applicable

· At renewal.

It is the company's (i.e. the group policyholder's) legal duty to ensure that all information which may influence us when judging the risk and offering terms is disclosed accurately and completely; even if the information is not favourable to the risk. The company is also obliged to notify us of any membership changes or substantial claims that arise at any time prior to us being bound to provide cover. Failure to disclose any relevant information may result in the claim amount payable being reduced, our refusal to reimburse claims or any contract between the company and us being voided from inception.

In addition, it is the company's responsibility to check whether insured persons are subject to any local compulsory health insurance restrictions and ensure that health insurance cover is legally appropriate. This quotation has been provided on the assumption that any US

nationals are not permanently resident in the US. This quotation has also been provided on the condition that all persons to be insured are resident outside of Switzerland. Please note that the cover provided by Allianz Partners is not suitable for residents of Switzerland.

Allianz Partners may not provide any cover or benefit to the extent that either the cover or benefit would violate any applicable sanction, law or regulations of the United Nations, the European Union or any other applicable economic or trade sanction, law or regulations.

A 0% commission rate has been included in this quotation.

The quotation is based on the cover as stated in the Table of Benefits provided. Please also refer to the accompanying Employee Benefit Guide for the standard policy terms and conditions that apply. No advice has been provided by us with regards to product selection i.e. this quotation has been provided on an "execution only" basis. Once cover has been confirmed and the policy becomes effective the benefits selected may be reviewed annually at renewal only.

Taxes and Levies

This premium quotation may be subject to locally imposed premium taxes and government levies, depending on the location of the company and the principal country of residence of each insured member(s).

The underwriter of your insurance is Allianz Partners.

Appendix 5 – Service Level Agreement

Service Level Agreement (SLA)

Dear Client.

The purpose of this document is to clearly define the services that Allianz Care will provide to the Iraqi Ministry of foreign affairs. It will allow for both parties to fully understand our obligations and commitments to each other and will also provide a platform on which our services can be defined, evaluated and enhanced.

The Iraqi Ministry of foreign affairs will compare the performance of Allianz Care against the Service Levels as detailed in this document. Following the start of the insurance year, our performance will be reviewed and discussed at predefined periodic intervals. For our Helpline, Administration and Medical Claims teams, we will provide monthly statistical information to be reviewed on quarterly basis to you which compares the actual performance levels achieved against the service levels detailed herein.

Where working days are referred to in this document, this means Allianz Care and their subcontractors' working days and excludes weekends and public holidays.

1. Account Management

Allianz Care will assign a dedicated Account Manager to your scheme who will be your main point of contact and will be responsible for resolving any service issues you may have.

1.1 Allianz Care will inform you at least 1 month in advance of any long term change to this arrangement.

1.2 The Account Manager will agree with you the frequency, type and location of meetings to be held with The Iraqi Ministry of foreign affairs.

1.3 The agenda for these meetings will be agreed with you in advance, and the minutes, with agreed actions and timelines, will be issued after each meeting.

1.4 The Account Manager will respond to all service issues within 5 working days with either a solution or with a timeline within which the issue will be resolved. For exceptional service issues, a timeline will be agreed between The Iraqi Ministry of foreign affairs and Allianz Care on a case-by-case basis.

1.5 At least once a year, Allianz Care will organise a meeting at the Company's Headquarters between its representatives and the Policyholders' representatives for training on the Allianz services (Gsec). Allianz Care will be responsible for the organisation and logistic of this meeting and will cover the travel expenses (economy class plane tickets), accommodation, for policy holders representatives in the limit of USD 5000

1.6 Claims reports will be produced and sent to The Iraqi Ministry of foreign affairs on a quarterly basis. It will be issued on the last day of the following month of each quarter

2. Helpline Support

Our Helpline, which is operational 24 hours a day, 365 days a year, provides assistance and support to our members in our official company languages: Arabic and English. In addition, we also provide toll-free numbers from certain European, Asian, North and Latin American countries.

2.1 The average call abandonment rate of our Helpline will be 6% or below.

2.2 90% of all correspondence (email, fax and post) will be responded to within 10 working days.

3. Administration Support

Allianz Care's administration support is available from Monday to Friday, 9am to 6pm CET.

3.1 Upon request, The Iraqi Ministry of foreign affairs will send us a membership list to enable us to reconcile the original membership as per the agreed schedule.

3.2 You should notify us of any required group scheme membership additions, deletions or amendments on our standard membership template as per agreed schedule.

3.3 Upon receipt of a completed standard membership template, we will issue at least 95% of the member documentation within 10 working days. This will also apply if the membership is updated via our Online Services.*

3.4 Both parties will agree the turnaround time for the set-up and renewal of the scheme. This time will depend on a number of factors including the size of the group, the number of sub-groups, invoicing requirements etc. Once we have a full understanding of your particular requirements, we will agree specific Service Levels.

*Membership cards which are issued by a Third Party Administrator may take up to 6 weeks to issue

4. Medical Claims Support

Allianz Care's Medical Claims team is available from Sunday to Thursday, 9am to 5pm EGY.

Processing:

4.1 4.1 90% of fully completed Claim Submission that we receive in one of our core business languages (i.e. Arabic and English) will be processed within 5 working days and 98% within 10 working days, i.e. the insured member will be notified and payment instructions sent to their bank. The processing time for a non-core-language claim will be extended up to 5 working days.

4.2 Where further information is required to complete the claim, we will, in 90% of the cases, request the information from the insured member and/or his/her medical practitioner by email or mail within 5 working days and 98% within 10 working days of receipt of the incomplete Claim Form, aside from exceptional cases.

The settlement currency will be in the currency of choice of the insured member between the following currencies: GBP, USD and Euro (where the member's bank can support this currency). In certain circumstances, there may be payment delays due to currency restrictions or bank processing times and, if this occurs, we will do everything in our power to expedite these payments, but we cannot be held responsible for any resulting delays.

When a claim is processed, we will issue a claims settlement letter by email or mail and a detailed statement of accounts, which will include an exact breakdown of costs (reimbursable and non-reimbursable) as well as outlining any deductibles, co-payments etc.

Quality Audit:

4.3 98% of all the claims we process will meet our internal Quality Audit Targets for financial accuracy.

Fraud:

4.4 Please note that Allianz Care has a zero tolerance principle on fraud. If our Fraud Unit reports any suspicious activities, respective claims will not be paid.

5. Medical Services

Allianz Care's Medical Services Team in Dublin is available 24/7.

Our Regional Medical Services Teams are available from Monday to Friday with standard business hours.

One of this team's primary functions is to process requests for the pre-authorisation of certain treatments and expenses, i.e. Treatment Guarantee, and, in doing so, arranging for direct settlement of expenses between Allianz Care and the medical provider.

"Working days" takes into consideration Allianz Care and their subcontractors' national public holidays and weekends.

5.1 90% of fully completed Treatment Guarantee forms will be processed within 5 working days, 100% within 10 working days. A guarantee of payment will be issued to the medical provider.

In the event of an emergency, our Helpline will take the Treatment Guarantee details over the phone and this will be issued within 24 hours where necessary.

In addition, the Medical Services Team coordinate any necessary evacuations and repatriations for our insured members. These cases are dealt with the utmost priority and timelines and updates to the main point of contact will be agreed on a case-by-case basis.

6. Penalty Clause

Failure to processing claims reimbursements within the abovementioned period of 10 working days without providing a justification will render Allianz Care liable to pay a penalty of 10% of the value of the amount of claim (in question) for each day of delays.

The maximum penalty per insurance year is USD 100,000.00

Appendix 6

Insurance contract:

Special Agreements

Variations to the Ministry of Foreign Affairs of Iraq Employee Benefit Guide

a) References to the 'Company' in the Employee Benefit Guide shall mean THE IRAQI MINISTRY OF FOREIGN AFFAIRS ("MoFA") or 'Policyholder', referred to in this Insurance contract.

b) All references to 'Company Agreement' in the Employee Benefit Guide shall mean this agreement.