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INTERNATIONAL HEALTH INSURANCE

POLICY WORDING PREFERRED

This document is a translation of the terms and conditions of the Summary of Benefits written in French. The Insurer or the Policyholder cannot be held responsible if any statement in this translation and any provision in the policy differs. In that case, the policy wording in French will prevail.

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SECTION 1
PURPOSE AND BASIS OF THE SUMMARY OF BENEFITS

1.Purpose of the Summary of Benefits

The policy corresponding to this Summary of Benefits is a group insurance policy taken out by the Policyholder (ASPMI) with the Insurer. The policy is subscribed by ASPMI with MFPREVOYANCE and VYV IB, collectively referred to as “the Insurer”.
It is covered by branch 2 Sickness defined in article R.321-1 of Code des assurances and is governed by both its stipulations and the provisions of the Code des assurances and applicable French legislation.
The purpose of the contract is to provide insurance cover to individual expatriate Insured Persons from 18 to 70 years, and their Dependants if any, for reimbursement of medical expenses recognised by the French Sécurité sociale, and in accordance with this Summary of Benefits.

2. Effective date, duration, renewal of the insurance certificate and request for termination

2.1 Enrolment

The applicant must fill out an application form approved by the Insurer, and which includes a medical questionnaire. This document must be completed, dated and signed by the applicant. A medical examination, at the expense of the Insurer, may be requested.
The application form includes the ID of the Insured Person, the required elements to determine the coverage and the calculation of the premium. The applicant declared to have acknowledged and accepted the Summary of Benefits.
The Insured Person, if applicable, must opt for the same cover for his/her Spouse or any Beneficiaries covered by this policy.
At the time the Insured Person or a Beneficiary takes out the policy, the Insured must pay an advance of the first installment. In case of cancellation as per the terms of the agreement, the premium shall be returned in full.
The application of the policy is recorded in a certificate of insurance, particularly stating:

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- Insurance certificate number
- Effective date
- Insured Person's full details
- Dependants' full details
- Area of cover; and
- Option opted for

Nevertheless, in view of the enrollment documents, the Insurer, or its Delegate where relevant, may apply a premium loading or a specific exclusion on the certificate of insurance. The insurance applicant may reject these new conditions by informing the Insurer in writing within 30 days of the date of receipt of the proposal.
The termination shall be effective from the first day of the calendar month following the applicant's rejection notice. If no response is received within thirty days, the Insurer shall consider that the Insured Person has accepted the new proposed conditions.

2.2 Start date and renewal

For the Insured Person, the insurance takes effect on the date indicated on the certificate of insurance, for a period ending 12 months following the effective date of the application.
It is then renewed tacitly on the anniversary date each year for a period of one year.
Application may also terminate under one of the following conditions:

- **In the event of non-payment of premiums of the Insured**
- **On the date on which the Insured ceases to be an applicant of the Policyholder,**
- **In the event of cancellation of this group insurance policy,**
- **In the event of dissolution of the Policyholder at any time after twelve (12) months from the first enrollment to the contract, as per conditions of article L113-12 of Code des Assurances. The termination of the application will be effective one (1) month after the Insurer received the notification of the Insured Person (the 1st or the 15th of the following month).**

In any case, the Insured Person can notify his/her request of termination as per article L113-4 of Code des assurances, as follows and at his/her convenience:

- **A simple letter or any other durable format or**
- **A declaration made at the head office or at a branch of the Insurer or**
- **By means of an extrajudicial document or**
- **If the contract was concluded by means of a distance communication mode, by the same mode of communication.**

When the contract is terminated as per mid-term cancellation, premium is due on behalf of the Insured Person for the portion corresponding to the period during which he/she was insured, this period being calculated until the effective date of the termination.

2.3 Cancellation

The Policyholder undertakes to send to the Insured Person information concerning the cancellation right.
In accordance with article L 112-2-1 of Code des assurances, a cancellation period of 14 calendar days applies in case of distance selling. This period begins on the date the policy is concluded or from the date the applicant receives the policy conditions and information mentioned in article L.222-6 of the French Code de la consummation (when application is posterior to the date the policy is concluded).
The date of conclusion of the policy corresponds to the application start date. **This cancellation right shall not apply if the policy is entirely executed by the two parties at the Insured Person's explicit request before the Insured exercises his/her cancellation right.**
To exercise his/her cancellation right, the Insured Person must send to the Insurer, through ExpaTPA, a written communication stating his/her desire to cancel his/her insurance. The following template may be used:
"*By this letter, I the undersigned …… (full name and address) hereby cancel my application of policy G0462 which I signed on ……in ……. (place of insurance) and ask for reimbursement of the payment I made, corresponding to the sum of € .... [amount in euros]. On ... (date and signature).*"

Effects of cancellation

The Insurer, via the Policyholder, reimburses the premiums paid within 30 calendar days from the date the registered mail is received. Application is considered never to have existed and cover does not apply, upon receipt by the Insurer, via the Policyholder, of the cancellation letter sent by registered mail. After the period of thirty (30) days, the sum to be refunded generates interest at the legal rate.

3. Various provisions

3.1 Limitation period

The provisions related to the limitation on actions resulting from the policy which is the object of this Summary of benefits are governed by articles L 114-1 to L 114-3 of the Code des assurances as stated below:
Article L.114-1 of Code des assurances:
All actions deriving from this Contract are limited to two years after the event giving rise to them. However, this two-year limit shall start:

- **In the event of reticence, omission, false or inaccurate statement as to the risk incurred from the Insured Person, as of the day on which the Insurer was informed of it**
- **In the event of an occurred risk, as of the day or the interested parties have been informed about it, if they can prove that they have ignored it until then.**

When the cause of the action by any Insured Person against the Insurer is third-party recourse, the time limit for the limitation only begins on the date this third-party initiates legal action against the Insured Person or has been compensated by the Insured Person.

Article L.114-2 of Code des assurances:

Pursuant to article L.114-2 of Code des assurances, time limit is interrupted by one of the ordinary causes of interruption of statute of limitations (namely in particular the legal claim and recognition of the Insured Person's rights by the Insurer) and by the appointment of experts following the occurrence of a risk. The interruption of the limitation period for the action may also result from the mailing out of a registered letter with acknowledgment of receipt by the Insurer to the Insured Person for the purpose of payment recovery, and by the Insured Person or his Dependants to the Insurer for a claim settlement.

Article L.114-3 of Code des assurances:

Limitation can be interrupted by the ordinary causes of interruption of limitation formulated in articles 2240 et seq of the French Code civil:

- **Acknowledgement from the debtor of the rights of the creditor (art. 2240 Code civil),**
- **Legal action (art. 2241 to 2243 of Code civil),**
- **A protective measure for enforcement or forced enforcement taken in application of the Code de procédure civile (article 2244 Code civil),**
- **The interpellation made to one of the joint debtors by a legal action or by an act of forced enforcement or the acknowledgement by the debtor of the rights of the creditor (art.2245 of the Code civil),**
- **The interpellation made to the principal debtor or its recognition for the cases of limitation applicable to deposits (art. 2246 Code civil).**

3.2 Subrogation

The Insurer will be subrogated to the rights of an Insured Person who is victim of an Accident in its action against the responsible third party, whether the third party's responsibility is whole or shared.

If the Insured has been directly compensated by the third party, the Insurer will request the recovery of the paid benefits if any.

Should an Insured Person make the recovery impossible, whether by negligence or voluntary abandonment, this Insured Person will be obliged to reimburse the received amounts.

3.3 Delegated administrative agreement

A separate administrative agreement between the Insurer and ExpaTPA, 142 rue de Rivoli, 75001 Paris, France is established. It specifies the operations related to the Contract that the Insurer delegates to ExpaTPA, and precisely the obligations of the Administrator towards the Insurer with respect to risk acceptance, collection and administration of premiums, administration of medical benefits and production of statistics. They may be reached 24/7 by phone: EU: +33 1 76 46 10 19 or USA: +1 205 236 5117 and by email to health.service@insurednomads.com or insurednomads@expatpa.com.

How to submit medical claims and treatment pre-authorisation:

Online Insured Portal: access insurednomads.expatpa.com, register by setting up an account (Your ID is your email address, click on 'get my password' to obtain your password) and provide the information requested.

Mobile App: search for "*My Insured Nomads – Health*" in the Apple Store or Google Play. Once the app is downloaded, register by setting up an account (ID and password are provided when joining the plan) and provide the requested information. Individual key contact information and digital insurance card will be available through the app and Insured portal. We recommend that users download the application (iOS or Android) when joining the plan.

Email: health.claims@insurednomads.com

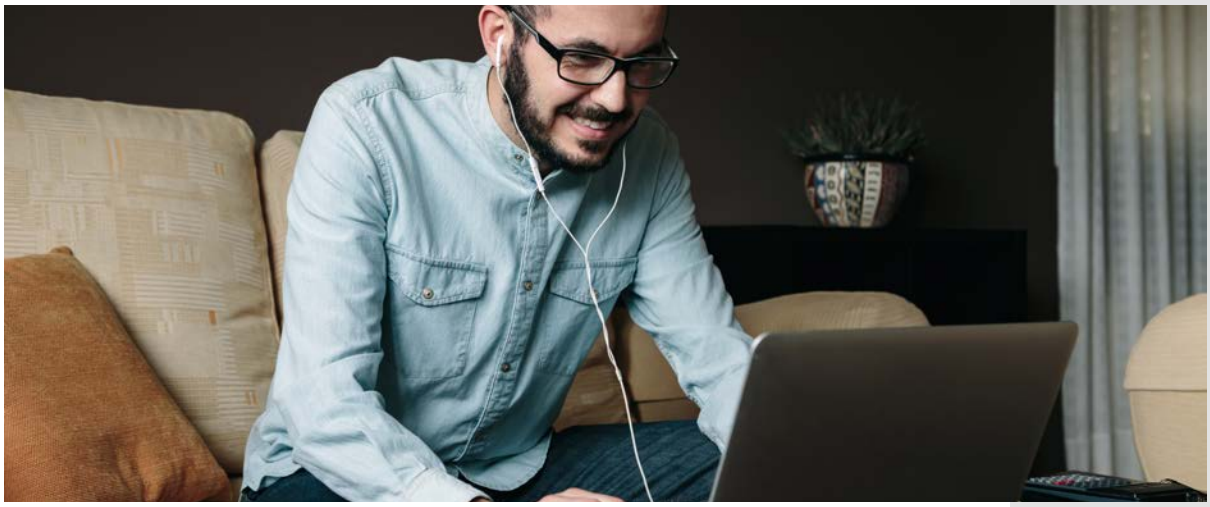
Telephone: EU: +33 1 76 46 10 19 or USA: +1 205 236 5117

Post mail: Send the legible, itemized bill on the provider's letterhead to

Insured Nomads c/o ExpaTPA
Attn: Claims
142 Rue de Rivoli
75001 Paris, France

When submitting a claim, indicate:

- Number of the assistance agreement: Policy number: G0462
- Name, subscribed contract and contract number;
- Name of the Administrator of the medical contract;
- The Insured Person's first and last name;
- The benefit claimed for;
- The telephone number and/or address where the Insured Person can be reached, as well as the contact details of the persons who are taking care of the Insured;
- To the assistants' doctors, all relevant medical information about the Insured Person's claim request.



The Insured Person must communicate to the Claims and Service Team all supporting documents to assess the validity of the claim in order to be refunded from any advanced expenses. Services which have not been submitted to prior approval nor have been organised by the Claims and Service Team will not be subject to reimbursement nor compensatory allowance.

How to access 24/7 emergency assistance and or repatriation claims:

Please call (EU) +45 7020 1478 or (USA) +1 321 307 9411 and include the following information:

- Number of the assistance agreement: Partner code: 75C026
- Name and contract number,
- Name of the Administrator of the medical contract: ExpaTPA
- The Insured Person's first and last name,
- The telephone number and/or address where the Insured Person can be reached, as well as the contact details of the persons who are taking care of the Insured

Please note that services which have not been submitted to prior approval nor have been organised by the Claims and Service Team will not be subject to reimbursement nor compensatory allowance.

What to do in an emergency:

Where possible, in an emergency situation please contact our Claims and Service team whose details are available on the mobile application or the Insured portal.

Our team of specially trained advisors will help co-ordinate arrangements with local hospitals or even arrange for an evacuation or repatriation, depending on your circumstances. However, there may be occasions where you have not been able to contact us in advance of treatment and you are admitted to hospital. Do not delay in receiving treatment. You or your representative should try to contact us at the earliest practical opportunity (usually within 48 hours of the emergency occurring). Alternatively make sure that the hospital is aware of your insurance cover with us so that they can contact us on your behalf. We, or our partners, will then communicate with the hospital to enable direct settlement, where eligible.

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There are different ways in which a claim can be settled:

Pre-authorisation

It is important that you verify that the service or treatment you are receiving requires pre-authorisation. For services or treatment requiring pre-authorisation, you must contact the Claims and Service team 5 days before the planned service or treatment direct billing.

Important information

- Pre-authorisation does not guarantee that all costs and expenses will be covered.
- We reserve the right to review each claim for medical expenses incurred and co-ordinate coverage according to the terms and conditions of this policy.
- All other costs and expenses that are not covered under this policy must be settled directly with the network provider and we shall have no liability in this regard (unless otherwise agreed with the Claims and Service team.
- For in-patient stays that extend beyond the pre-agreed duration approved by the Claims and Service team, you or your medical practitioner must send us a medical report before the pre-authorised duration ends, confirming any complications necessitating the extended hospital stay, treatment already given, proposed treatment and/or discharge date.
- Our reimbursement rates are based on reasonable and customary charges. Costs that are deemed not reasonable and customary will not be covered (unless we agree otherwise in writing with you) and we shall be entitled to charge you an additional fee for the costs incurred if not pre-authorised.
- You will be notified by the Claims and Service team as soon as the services have been authorised.

Reimbursement claims

If you have paid for your treatment upfront, you must submit the reimbursement to us within 6 months from the date of treatment. You can submit your reimbursement claim online via the mobile application or the Insured Portal at insurednomads.expatpa.com

We will settle or reject a claim, as the case may be, within 10 days of the receipt of the last necessary document.

Through the mobile application and Insured portal:

- You can track the progress of your claim
- You can choose to receive email notifications of your claim's status. You can also choose to unsubscribe.
- After a claim has been processed you have access to your explanation of benefit statement.
- This will show you what was paid including details of any ineligible items that we did not pay.
- We will send any eligible reimbursement to you by bank transfer to the account of your choice.

Digital insurance card and information

The plan has been designed to be with you when you need it most and for this reason, we provide a personalized digital insurance card for you and each insured person in your family via the mobile application or Insured portal.

Please note that access to the card and information does not necessarily guarantee cover. If you are no longer covered by the policy, your card and insurance certificate number will be ineffective. If any correction is required, simply contact us.

Please check both your insurance card and certificate of insurance to confirm all personal information is correct. Please contact us as soon as possible if any corrections are required.

You can access our services through our Claims and Service team. The contact details are available on the mobile application and the Insured portal.

Follow the access Instructions on the provider finder as you may be required to contact the Claims and Service team prior to presenting your insurance card to a healthcare provider.

Explanation of benefit statements which provide information about what is paid are available on the mobile application as well as on the Insured portal.

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3.4 Data protection

In accordance with the Regulations (EU) 2016/679 of 27 April 2016 on the protection of individuals concerning the processing of personal data and on the free movement of such data (known as General Data Protection Regulation) and for the purpose of the management of the insurance contract, the personal data of the Insured Person may be transferred to the Insurer and to its delegates, service providers, subcontractors or reinsurers. Insured Persons are informed that processes concerning them, and their Dependants if any, are implemented for the signing, management and execution of this insurance contract along its commercial management. Personal data may also be used for control operations, fight against fraud and money laundering and the financing of terrorism, search for beneficiaries of unpaid Life contracts, the implementation of legal and regulatory provisions, with respect of the enforcement of this contract.

Collected Data are indispensable for the implementation of these processing and are intended for the relevant departments of the Insurer and its outsourced Administrators as well as, where applicable, its subcontractors, providers or partners. The Insurer is liable to ensure that this data is accurate, complete and up to date when necessary. The data collected will be kept for the entire duration of the Contract which may be increased by legal prescriptions or in order to be compliant with the durations provided for by the CNIL Commission Nationale de l'Informatique et des Libertés (National Commission for Data Protection). These personal data may be transferred to service providers or subcontractors which are established in countries outside of the European Union. These transfers may only involve countries recognized by the European Commission for having a satisfying level of protection of personal data, and recipients of the data must justify appropriate guarantees.

Insured Persons and/or Dependants have a right of access, rectification or deletion, limitation of the processing of their data, portability, opposition to processing, along with the right to provide instructions on the outcome of the data after their death.

They can exercise their rights towards CNP Assurances for MFPrévoyance: Data Protection Officer, 4 Place Raoul Dautry, 75716 Paris Cedex 15, or urgence.dpofs@mfprévoyance.fr. When exercising their rights, an identity document may be requested. In the event of a persistent conflict, they have the right to appeal to the CNIL on www.cnil.fr or at 3, place de Fontenoy - TSA 80715 - 75334 Paris Cedex 7, France.

Data related to medical information on the Insured may be exploited for the conclusion, the management and the execution of the contract, as their processing is necessary in order to fulfil the obligations and to exercise the rights of the Insurer or the rights of the Insured Persons to social protection. These data are exclusively intended for the medical service of the outsourced Administrator. The exercise of rights is carried out by email, along with an identity document, to the medical advisor of medical@vyv-ib.com.

3.5 Information - Complaints - Mediation

When Insured Persons or any Dependant wish to obtain details, they should contact

ExpaTPA, 142 rue de Rivoli, 75001 Paris, France
Email: Contact@expaTPA.com for any request or complaint related to:

- Insurance enrollment conditions
- Premium payments
- Claims

The complaint will be acknowledged within 10 days of its receipt, unless the matter is answered within this period. In any case and in accordance with the applicable law, a response will be sent before the expiry of a period of 2 months from the date of receipt of the complaint.

If the complaint has not been settled after the response, the Insured Person or the Dependants may contact customer service - along with copies of the written responses made to them - at the following address:

VYV International Benefits - Customer Relations Department, 3/5/7 Square Max-Hymans 75748 Paris Cedex 15, France.
Email: clients@vyv-ib.com.

In the event of disagreement with a decision by the Insurer and having exhausted all means of appeal offered by the Insurer, within a maximum of one year from the date of the written complaint, the Insured Person or his/her beneficiaries may contact the Insurance ombudsman at the following address:

La Médiation de l'Assurance - TSA 50110 - 75441 Paris Cedex 09, France.

The Ombudsman's opinion is not binding, and the parties can still proceed in the competent courts. The Ombudsman is not empowered to adjudicate on the conditions for admission to insurance.

3.6 Misrepresentation (Article L113 of Code des assurances)

Regardless of the ordinary causes of nullity, any reluctance or intentional false statement from the policyholder shall have for consequence the nullity of the contract, if this reluctance or false declaration changes the nature of the risk or reduces the evaluation for the insurer, and even if the omitted or denatured risk by the Insured Person has no influence on its realization.

Any reluctance or intentional false statement from the policyholder leads to the enforcement sanctions: the insurer is still entitled to collect due premiums as a compensation; the Insured Person must reimburse any benefit paid in the event of claims under its contract.

For optional individual and collective covers, the omission or inexact declaration of the Insured Person from whom bad faith is not established do not void the benefits provided in the enrollment form or in the group contract.
If the deliberate omission or false declaration is detected before any claim, the insurer may decide to maintain the enrollment subject to a premium increase that must be accepted by the policyholder. In default of acceptance thereof, the application or the contract ends 10 days after notification addressed to the Insured Person by registered letter. The Insurer must refund the portion of premium paid for the period which is not covered anymore.
If the deliberate omission or false declaration is discovered after the realization of the risk, the benefits are reduced in proportion to the paid premiums and what should have been collected if the declaration of the Insured Person would have been accurate.

3.7 Limitation provision

Should there be any risk of sanction, prohibition or restriction under United Nations resolutions regarding economic or commercial sanctions, or under the laws and regulations of the European Union, the United States of America or any other jurisdiction, the Insurer will not be held liable for the coverage of an insurance benefit, nor for the settlement of a claim or the implementation of services.

3.8 Jurisdiction

The competent courts are the courts of France. French language shall prevail for the purpose of this Contract.

3.9 Supervisory authority

The Insurer's control body is Autorité de Contrôle Prudentiel et de Résolution 4, place de Budapest 75436 PARIS CEDEX 09 FRANCE.

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SECTION 2
INSURED PARTIES

4. Insured Persons

All Expatriates applicants of the Policyholder, aged from 18 to 65, living in a country different from their country of origin, and their Dependants up to 65, are eligible for the insurance.
All applicants must complete and sign the application form which includes a medical questionnaire validated by the Insurer. A complementary medical examination may be requested by the Insurer at its expenses.

5. Application conditions

The Insurer reserves the right to request any additional information it considers necessary for the acceptance of the applicant.
At the date of acceptance by the Insurer, the applicant (and his/her Dependants) become the "Insured Person(s)". This acceptance is formalized by sending a certificate of insurance.
The Insured Person undertakes to provide evidence of his/her declarations at any time by sending supporting documents corresponding to his/her situation.
Once admitted to the insurance the Insured Person cannot be excluded from the contract as long as eligible, with the exception to the sanctions detailed above in the event of a misrepresentation.

6. Effective date of coverage - Waiting period

Once the policy related to this Summary of Benefits is in force, cover is effective for each Insured Person, and their beneficiaries where relevant, who acquire the status of Insured once their application is approved.

6.1 Insured enrolled on the policy start date:

On the policy date for those affiliated from this date, or

6.2 Insured enrolled after the policy start date:

On the date they join the category of Insured Person to be insured, as mentioned on the certificate of insurance.

6.3 Cover in favour of Beneficiaries of the Insured Person

At the same time as those in favour of the principal Insured Party or, later, when the parties concerned fulfil the required conditions.

6.4 Waiting periods

The insurance cover starts for each of the applicants as from the date of acceptation.
For some benefits, coverage is effective after a Waiting period which begins on the application start date of the Insured Person (and his/her Dependant if any), as follows:
6 months: Wellness check-ups
10 months: Maternity
12 months: Mental health and substance abuse
24 months: Organ transplant

Waiting periods do not apply if the Insured Person can provide evidence of uninterrupted (or less than a month before enrollment) and valid equivalent insurance cover, by producing a certificate stating the level of benefits and the date of termination.
If, during the lifetime of the contract, the Insured choses a formula higher than the one initially opted for, the waiting periods will apply to increases of benefits.

6.5 Territorial application scope of the cover

Medical expenses are reimbursable in one of the following areas:

- **Area 1:** Worldwide excluding the USA
- **Area 2:** Worldwide excluding Canada, Switzerland, USA
- **Area 3:** Worldwide excluding Bahrain, Brazil, Canada, China, Hong Kong, Israel, Kuwait, Lebanon, Mexico, Oman, Qatar, Russia, Saudi Arabia, Singapore, Switzerland, UAE, United Kingdom, USA.
- **Area 4:** Worldwide excluding Andorra, Australia, Bahrain, Brazil, Canada, China, European Union, Hong Kong, Iceland, Israel, Japan, Kuwait, Lebanon, Liechtenstein, Mexico, Monaco, New Zealand, Norway, Oman, Qatar, Russia, Saudi Arabia, Singapore, South Africa, Switzerland, UAE, United Kingdom, USA.

Nevertheless, medical expenses are reimbursed outside of the area of cover during trips of 45 days or less and further to an Accident or an Emergency as defined in the Definitions.
In all other cases, express approval by the Insurer is required.

6.6 Available options

The choice of option is made by the Insured Person at the time of his/her enrollment.
The choice of a superior cover is subject to acceptance by the Insurer of a new medical questionnaire from the Insured and his/her Dependants, and subject to the application of waiting periods.
Any change of option, once accepted by the Insurer, shall give rise to the issue of a new certificate of insurance.
In case of family enrolments, the option must be the same for all of the Insured Persons.

7. Cessation or suspension of cover

Once admitted to the insurance the Insured Person cannot be excluded from the contract as long as eligible, with the exception to the sanctions detailed in article L.141-3 of Code des assurances.
In any event, cover will terminate:

7.1 For each Insured Person

At the initiative of the Insured. The Insured Person must inform the Insurer, through the Policyholder, by written communication within 2 months of the renewal date. It is agreed and understood that the Insured can terminate his/her cover after one year of continuous cover by letter sent by registered mail, termination will be effective after 30 days from the mailing date.
As soon as the Insured ceases to belong to the category of Insured Persons to which the policy applies,
In the event of false declaration in accordance with article 8,
In the event of non-payment of premiums, and as per the provisions of Code des assurances,
On the date on which the Insured ceases to be an applicant of the Policyholder,
In the event of the death of the Insured Person,
At the latest the day of his 70th birthday.
For Dependants, on the date they no longer meet one of the conditions stipulated in Article 8.

7.2 For all Insured Persons

On the effective termination date of the policy which is the basis of this Summary of Benefits.

7.3 Cover of Dependants will cease at the same time of the main Insured

The termination (or suspension) of the benefits will lead to the cancellation of the right to claim for any medical act and any treatment performed from the date of cessation for the Insured and any Dependant.

7.4 Continuation of benefits

In case of the return of the Insured to his/her Country of origin, his/her medical insurance may be continued, subject to payment of premiums, during a maximum three-month (3) period. The continuation may also apply for the Dependants.

SECTION 3
COVER AND BENEFITS

8. Beneficiaries of cover

The medical expenses described in the policy which is the basis of this Summary of Benefits applies to:

- Either the Insured only, or
- The Insured and his/her Dependants.

In this case, the following may be included on the policy:

- The Spouse: husband or wife of the employee who is neither divorced nor legally separated,
- The Partner who concluded a Pacte civil de solidarité with the insured person, aimed at organizing their common life according to article 515-1 of French Code civil, or any equivalent partnership agreement concluded under another legislation
- Or in the absence of a Spouse or Partner, a cohabitant can be designated as Dependant. A cohabitant is defined as the person living with the Insured Person and fulfilling together the following two cumulative conditions:
    - They are both free of any former marriage or partnership agreement bond,
    - Cohabitation must be declared by the Insured Person upon enrollment, along with a cohabitation certificate or proof of residency mentioning both names and a sworn statement that they live together. The certificate must be in force and legally recognized by a competent authority in the country of cohabitation. Termination of cohabitation must be declared in writing by the Insured Person. Only one person can be enrolled as a cohabitant.
- The unmarried children of the Covered Person and those of his/her spouse (or, in the absence of a Spouse, those of the Common Law Spouse or Civil Partner specified above), living under the Insured Person's roof:
    - Aged less than 20 or whatever their age, if they hold the disability card as specified in Article L. 241-3 of the French Social Action and Families Code,

Or if they fulfil the following conditions:

- Be under 26 years old,
- Not be employees or do not benefit from own resources because of their work (except, if they are students, in case of casual employment for less than three months).
- Dependant on the Insured Person for tax purposes if they are:
- Considered for at least a half-share in the calculation of the Insured Person's income tax payable in the year of the event invoking the coverage,
- Students who have not chosen to be attached to the tax household and who receive a living allowance from the Insured Person which is deductible when calculating the Covered person's taxes payable in the year of the event invoking the coverage.

The Child(ren) of the Insured Person or Child(ren) of the spouse/partner/cohabitant as defined above and under the following conditions:

- Under the age of 20, provided they are financially Dependant of the Insured,
- From 20 until their 26th birthday provided they pursue higher education in a country which belongs to the Insured Person's area of cover. The Dependant child may have a paid occupation provided it does not exceed 3 months per year.
- Physically or mentally disabled, regardless of their age (proof of disability must be regularly provided to the Insurer) and if they meet the following cumulative conditions: not being employed or not to benefit from their own resources due to their work and be financially Dependant of the Insured Person.

A certificate of education will be requested on behalf of Dependants in higher education and will be forwarded to the Administrator upon enrolment and for each consecutive academic year thereafter.

If the Insured does not fall within the French tax system, the quality of Dependant child as defined above will be assessed according to the French legislation.

Dependants must fulfil the same application process as the main Insured Person. Benefits cease for any Dependant from the moment they no longer fulfil the above conditions and in any event on the same date of the Insured Person. Any change of situation must be brought to the attention of the Insurer, via the Administrator if any. The benefits under the contract are provided only for the period during which the Dependant belongs to the category. However, in the event of the death of the Insured, the benefits are maintained free of charge for the Dependants and for a period of one month.

9. Benefits covered

9.1 Type of cover

9.1.1 The insurance coverage consists in reimbursing medical expenses incurred by the Insured Person, as from the first euro (EUR) and limited to the reasonable and customary costs.

Treatments must be recognised by local medical authorities and performed by practitioners exercising within a field in which they are qualified (in line with legislative, regulatory and other requirements in respect of professional standards in the given country).

If one of the Insured Persons is covered by a scheme of Sécurité sociale or an equivalent government healthcare program, the reimbursement amounts received from this agency shall be deducted from the benefits of the present Contract. If the spouse (or civil partner or cohabitant) is an employee, the benefits paid by the Insurer shall be complementing any medical insurance scheme from which this Dependant may benefit personally.

9.1.2 In the event of hospitalisation, the following medical expenses are covered:

- Medical hospitalisation in public or private facilities,
- Hospitalisation and Surgery. Procedures carried out under general anaesthesia or in relation to trauma Surgery and surgical procedures carried out under local anaesthesia are deemed to be surgical procedures,
- Related medical and paramedical costs provided in the context of Hospitalisation,
- Local Emergency transportation of the patient by ambulance.

In case of Hospitalisation, local Emergency transport of the patient by ambulance is covered within the same country between the patient's residence or the location of the Accident and the nearest Hospital facility. Local Emergency transportation is also covered if the patient's condition requires a further transfer from the original Hospital to another one nearby.
For any Hospitalisation, the prior approval of the Insurer is required, except in case of Emergency (see Definitions).
Conditions for which prior approval is required are indicated below.
9.1.3 In all other cases, coverages are defined in the table of benefits.

9.2 Amount of benefits

Reimbursements of Hospitalisation costs further to an illness, a maternity or an Accident may not exceed the amount of expenses remaining payable by the Insured Person after reimbursements of any kind for which he is entitled.
Benefits of the same kind taken out with several insurers may be claimed within the limit of each coverage, irrespective of the date they were taken out. In this limit, the Insured may obtain additional payment by sending details of the reimbursements made by the other insuring body(ies).
The Insurer reserves the right to request explanation of medical bills and may also request information of any reimbursement issued to the Insured Person from enforcing any other insurance contract the Insured would benefit from.
The Insured Person shall refund overpaid claims to the Insurer, as soon as possible. The Insurer may operate compensations between the refunded amounts and any claim which is due to the Insured in relation with this contract. Limitation of reimbursement to actual expenses is determined by the Insurer for each of the claimed benefits.

9.3 Declaration of claims

The declaration form is provided by the Insurer/Manager and must be sent to him along with supporting documents.
Copies, photocopies or duplicates of invoices are accepted. However, the Insurer may request, and without any reason the original copies for the enforcement of the benefit. The Insured Person must keep in this regards all originals for a period of twenty-four (24) months from the date of medical care. During this period, the Insurer may claim the originals, in the absence of which the reimbursements made could be subject to refunds.

The Insurer/Administrator reserves the right to assess the health conditions of the Insured Person, to control the performed medical acts and to request any Member to provide all the necessary information for the processing of personal data in relation with the reimbursement requests. The Insurer shall have access to the personal medical files with all the legal confidentiality obligations attached thereto.
Any information provided by an Insured Person which turns out to be incorrect, falsified, exaggerated or even any fraudulent act from their part will entail their liability and the recovery of sums unduly paid by the Insurer on the basis of this incorrect information.

9.4 Supporting documents

The claiming Insured Person must send to the Insurer/Administrator a claim form along with the following supporting documents:

- Hospitalisation: the supporting Hospitalisation documents (Hospital report, any paid invoices), indicating the names of the Hospital and the patient, dates of care and its cost,
- Illness: medical prescriptions and detailed invoices,
- Home birth: the child's birth certificate,
- Banking details of the Insured for reimbursement

The Insurer reserves the right to request any Insured Person to provide them with the necessary information to process their personal data and related to reimbursement requests. The Insurer will be entitled to have access to their medical files with all the legal obligations of confidentiality attached thereto.
Any information provided by an Insured Person which turns out to be incorrect, falsified, exaggerated or even any fraudulent act from their part will entail their liability and the recovery of sums unduly paid by the Insurer on the basis of this incorrect information.

10. Prior Agreement - Limitation to actual expenses

10.1 Prior agreement

Prior approval of the Insurer is required in the cases listed below – except in case of Emergency as per the definition:

- Any Hospitalisation
- Acts of Paramedics for series of acts above 10 sessions (unless specified otherwise in the table of benefits)
- Dental prostheses and dental implants
- Prosthetics
- Orthodontics
- Maternity

Except in case of an Emergency, each admission to a Hospital must be notified to the Insurer **at least 10 days prior to the effective admission.**
Acceptance by the Insurer is deemed obtained in case of no reply to the request within 5 working days. In the absence of prior approval, during Hospitalisation or during any other treatment for which this approval is necessary, the Insurer reserves the right to decline the reimbursement.
If the treatment subsequently proves to be medically justified, the Insurer will then reimburse 80% of the Hospital expenses and 50% of the amount due for any other act requiring prior approval.
Prior approval is not necessary in case of an Emergency as defined in the contract. However, the Insurer must be notified within 48 hours or as soon as possible in the event of force majeure.
The provisions related to reasonable and customary costs in the country where care is performed shall apply in all cases.

10.2 Limitation to actual costs

Reimbursements of Hospitalisation costs further to an illness, a maternity or an Accident may not exceed the amount of expenses remaining payable by the Insured Person after reimbursements of any kind for which he is entitled.
Benefits of the same kind taken out with several insurers may be claimed within the limit of each coverage, irrespective of the date they were taken out. In this limit, the Insured Person may obtain additional payment by sending details of the reimbursements made by the other insuring body(ies).
The Insurer reserves the right to request explanation of medical bills and may also request information of any reimbursement issued to the Insured Person from enforcing any other insurance contract the Insured would benefit from. The Insured shall refund overpaid claims to the Insurer, as soon as possible. The Insurer may operate compensations between the refunded amounts and any claim which is due to the Insured Person in relation with this contract.
Limitation of reimbursement to actual expenses is determined by the Insurer for each of the claimed benefits.

SECTION 4
EXCLUDED RISKS AND BENEFITS

EXCLUDED RISKS

THE COSTS INCURRED ARE NOT PAID BY THE INSURER IF THEY FOLLOW THE FOLLOWING EVENTS:

- A DISEASE OR ACCIDENT WHICH IS THE VOLUNTARY FACT OF THE INSURED, VOLUNTARY MUTILATION OR A SUICIDE ATTEMPT.
- ANY INTENTIONAL ACTION WHICH MAY ENTAIL THE BENEFIT OF THE POLICY AND ANY CONSEQUENCE OF A CRIMINAL PROCEEDING WHICH THE INSURED PERSON IS THE SUBJECT.
- A CLAIM ARISING DIRECTLY OR INDIRECTLY FROM THE DECAY OF AN ATOMIC NUCLEUS.
- TREATMENT AND SERVICES AS A RESULT OF WAR, INVASION, FOREIGN ACT OF ENEMY, HOSTILITIES (WHETHER WAR BE DECLARED OR NOT) CIVIL WAR, REBELLION, REVOLUTION, INSURRECTION, RIOT, CIVIL COMMOTION, MILITARY OR USURPED POWER, OR ACT OF TERRORISM EXCEPT WHERE AN INJURY/ILLNESS IS SUSTAINED AS AN INNOCENT BYSTANDER AND WHERE THERE WAS NO EXPOSURE TO NUCLEAR, CHEMICAL OR BIOLOGICAL WEAPONS OR CONTAMINATION.
- MEDICAL TREATMENTS RELATING TO A PRE-EXISTING MEDICAL CONDITION, OR A RELATED CONDITION, UNLESS THE MEDICAL CONDITION HAS BEEN DECLARED TO US ON THE APPLICATION FORM, ACCEPTED, AND AGREED FOR COVER BY US IN WRITING.
- MEDICAL TREATMENT FROM SUICIDE, ATTEMPTED SUICIDE, SELF-INFLICTED INJURY, SELF-HARM, RECKLESS OR NEGLIGENT BEHAVIOUR, FRAUDULENT, ILLEGAL OR CRIMINAL ACTIVITIES, OR SELF-EXPOSURE TO DANGER (EXCEPT IN AN ATTEMPT TO SAVE HUMAN LIFE).

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EXCLUDED BENEFITS

THE FOLLOWING BENEFITS ARE NOT COVERED UNDER THE CONTRACT, EXCEPT OTHERWISE MENTIONED IN THE TABLE OF BENEFITS:

- ANY MEDICAL EXPENSES FOR TREATMENTS OR PRESCRIBED ACTS PRIOR TO THE EFFECTIVE DATE OF THE CONTRACT OR DURING THE WAITING PERIODS IF ANY.
- ANY MEDICAL AND SURGICAL EXPENSES WHICH ARE NOT PRESCRIBED BY A QUALIFIED MEDICAL ENTITY.
- ACTS SUBJECT TO "PRIOR APPROVAL" FOR WHICH THE AGREEMENT HAS NOT BEEN REQUESTED NOR REFUSED.
- TREATMENTS OUTSIDE OF THE COVERED GEOGRAPHICAL AREA, EXCEPT IN CASE OF EMERGENCY AS PER DEFINITIONS SECTION.
- ANY FORM OF EXPERIMENTAL OR UNREGULATED TREATMENT WHICH ARE NOT COMMONLY ACCEPTED, CUSTOMARY OR TRADITIONAL MEDICAL PRACTISES, UNLESS FORMALLY ACCEPTED BY THE INSURER.
- PREVENTIVE TREATMENTS, MEDICAL CHECK-UPS, AND ROUTINE SCREENING TESTS.
- ADDITIONAL OR CONVENIENCE FEES IN CASE OF HOSPITALISATION (TELEPHONE, TELEVISION....) EXCEPT IF MENTIONED IN THE TABLE OF BENEFITS
- EXPENDITURES ON ORGAN ACQUISITION.
- ANY OPERATION OR TREATMENT RELATED TO GENDER REASSIGNMENT.
- COSMETIC TREATMENTS, REJUVENATION TREATMENTS, WEIGHT LOSS TREATMENTS.
- VERIFICATIONS, STUDIES, STERILISATION, SEXUAL DYSFUNCTIONS, CONTRACEPTION EXCEPT FOR ACTS OF INSERTION OR REMOVAL OF CONTRACEPTIVE DEVICES.
- CARE, ACTS AND MEDICAL TREATMENTS PROHIBITED BY LOCAL LEGISLATION.
- ANY ELECTIVE / VOLUNTARY SURGERY AND / OR PLASTIC / COSMETIC SURGERY.
- THERMAL CURES.
- MEDICAL EXPENSES RELATED TO A STAY IN A THALASSOTHERAPY CENTRE, A FITNESS CENTRE, A NURSING HOME AND A CONVALESCENT HOME, EVEN IF THE STAYS ARE MEDICALLY PRESCRIBED BUT WITH THE EXCEPTION OF STAYS FURTHER TO A SURGERY.
- OUTPATIENT FOR PSYCHOTHERAPY AND PSYCHOANALYSIS INCLUDING TREATMENTS UNLESS DOCUMENTED IN THE TABLE OF BENEFITS.
- CONSULTATIONS, TREATMENTS AND COMPLICATIONS RELATED TO HAIR LOSS OR IMPLANT UNLESS THIS MEDICAL CARE IS LINKED TO A SERIOUS ILLNESS.
- MEDICAL EXPENSES RELATED TO THE CURE OF CONGENITAL ANOMALIES OR MALFORMATIONS WITH ARE PRE-EXISTING TO THE ENROLLMENT DATE OF THE INSURED PERSONS – THIS EXCLUSION IS NOT APPLICABLE TO DEPENDANTS BORN AFTER THE EFFECTIVE DATE OF THE COVERAGE.
- NON-PRESCRIPTION DRUGS, NON-MEDICINAL PRODUCTS OF COMMON USE SUCH AS MEDICAL ALCOHOL, HYDROPHILIC COTTON, SUNSCREEN LOTIONS, DENTAL HYGIENE PRODUCTS, BANDAGES, SHAMPOOS, DIETARY SUPPLEMENTS AND SUBSTANCES, INCLUDING BUT NOT LIMITED TO VITAMINS, MINERALS, PROTEIN SUPPLEMENTS, BODYBUILDING SUPPLEMENTS, FIBRE, FATTY ACIDS, AMINO ACIDS, INFANT FOODS, ORGANIC SUBSTANCES, REGARDLESS OF WHETHER THEY ARE PRESCRIBED BY A MEDICAL PRACTITIONER/SPECIALIST AND/OR ARE ACKNOWLEDGED AS HAVING THERAPEUTIC EFFECTS.
- DRUGS, MEDICINES AND MEDICAL AIDS THAT CAN BE PURCHASED OVER THE COUNTER, WITH OR WITHOUT A PRESCRIPTION.
- INVESTIGATIONS AND MEDICAL TREATMENT FOR INFERTILITY, OR TO ASSIST REPRODUCTION.
- ALL AND ANY FORM OF TREATMENT AND SERVICES PROVIDED BY A PODIATRIST OR CHIROPODIST.
- TREATMENT OR CARE PROVIDED BY AN IMMEDIATE FAMILY MEMBER OR DEPENDANT OF THE INSURED PERSON.
- TREATMENTS AND CARE TO PROVIDE ARTIFICIAL LIFE MAINTENANCE, INCLUDING LIFE SUPPORT MACHINES, WHERE IT IS JUDGED BY THE TREATING SPECIALIST THAT THE
- TREATMENT WILL NOT RESULT IN A RECOVERY OR RESTORE YOU TO YOUR PREVIOUS STATE OF HEALTH.
- DENTAL TREATMENT REQUIRED AS A RESULT OF DAMAGE CAUSED BY EATING OR DRINKING, TOOTH BRUSHING OR OTHER ORAL HYGIENE PROCEDURE, EXTRA-ORAL IMPACT.
- DENTAL TREATMENT AS A CONSEQUENCE OF GUM DISEASE, GINGIVITIS, OR PERIODONTITIS, JAW SHRINKING, OR THE TREATMENT OF BONE DISEASE RELATED TO GUM DISEASE, TEMPOROMANDIBULAR JOINT, GNATHOLOGICAL TREATMENT AND SCANS.
- INVESTIGATIONS AND/OR MEDICAL TREATMENT FOR GENETIC TESTING WHEN SUCH TESTS ARE USED SOLELY FOR THE PURPOSE OF DETERMINING WHETHER YOU ARE LIKELY TO GENETICALLY DEVELOP A MEDICAL CONDITION.

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- TESTING OR MEDICAL TREATMENT FOR LEARNING DIFFICULTIES, AUTISM, HYPERACTIVITY, ATTENTION DEFICIT DISORDER, DYSLEXIA, SOCIAL OR BEHAVIOURAL PROBLEMS, AND PHYSICAL DEVELOPMENT PROBLEMS OR TREATMENTS THAT ENCOURAGE POSITIVE SOCIAL-EMOTIONAL RELATIONS.
- TREATMENT, SERVICES OR ANY CONSEQUENCES OF SELF-DISCHARGE OR EARLY DISCHARGE FROM A MEDICAL FACILITY OR A TREATMENT UNIT WHICH IS AGAINST THE MEDICAL ADVICE OF THE ATTENDING MEDICAL PRACTITIONER/ SPECIALIST.
- SECOND, OR SUBSEQUENT, MEDICAL OPINIONS FOR THE SAME MEDICAL CONDITION, UNLESS AGREED BY US PRIOR TO THE APPOINTMENT TAKING PLACE.
- MEDICAL TREATMENTS, SERVICES OR CARE ARISING AS A RESULT OF PARTICIPATION IN PROFESSIONAL SPORTING ACTIVITIES OR ANY HAZARDOUS OR EXTREME PURSUITS OR ACTIVITIES, INCLUDING BUT NOT LIMITED TO:

  KITE-SURFING, ROCK OR CLIFF CLIMBING, MOUNTAINEERING, MOTOR SPORTS OF ANY KIND, AERIAL ACTIVITIES AND SPORTS, BUNGEE JUMPING, SCUBA DIVING (TO A DEPTH GREATER THAN 30 METERS OR WHERE A PADI CERTIFICATE IS NOT HELD), TOMB-STONING, ANY SPORT INVOLVING ANIMALS, INCLUDING HORSE RIDING/RACING/POLO, SPEED COMPETITIONS OF ANY KIND, RACING OF ANY KIND OTHER THAN ON FOOT, SKIING OFF-PISTE.

- COSTS AND SERVICES RELATING TO SEARCH AND/OR RESCUE OPERATIONS TO LOCATE/RECOVER AN INSURED PERSON. AIR/SEA RESCUE AND EVACUATION FROM AN OFFSHORE STRUCTURE OR SEA VESSEL TO SHORE.
- TREATMENT FOR ANY CONDITION WHERE THE INSURED PERSON IS UNDER MILITARY AUTHORITY OR ENGAGED IN ACTIVITIES INVOLVING THE USE OF FIREARMS, OR PHYSICAL COMBAT OR IS IN AN AREA OF MILITARY CONFLICT.
- TREATMENT ARISING DIRECTLY OR INDIRECTLY FROM THE RELEASE OF OR THREAT THEREOF, OF ANY NUCLEAR WEAPON, DEVICE, OR CHEMICAL OR BIOLOGICAL AGENT.
- EVACUATION AND REPATRIATION COSTS WHERE THE INSURED PERSON HAS DIED IN THEIR HOME COUNTY, OR WHERE THE CAUSE OF DEATH IS NOT AN ELIGIBLE MEDICAL CONDITION UNDER THIS PLAN.
- ACCOMMODATION, TREATMENT AND CARE IN A HOSPITAL OR MEDICAL FACILITY WHERE THE SOLE AND PRIMARY PURPOSE OF ADMISSION HAS EFFECTIVELY BECOME THE PERMANENT RESIDENCE OF THE INSURED OR IS FOR DOMESTIC REASONS.
- HOME VISITS FROM A MEDICAL PRACTITIONER/SPECIALIST UNLESS YOU ARE MEDICALLY INCAPABLE OF GOING TO A MEDICAL FACILITY OR IF FAILURE TO SEEK A HOME VISIT WILL CAUSE SERIOUS THREAT TO LIFE OR LIMB.
- INVESTIGATIONS AND/OR TREATMENTS INCLUDING SURGERY FOR OBESITY, EATING DISORDERS, WEIGHT PROBLEMS, OR WEIGHT LOSS WHETHER OR NOT RESULTING FROM ANY MEDICAL OR PSYCHOLOGICAL CONDITION.

ON A GENERAL BASIS REFERENCE IS MADE TO WHAT IS COVERED BY FRENCH SÉCURITE SOCIALE EXCEPT FOR DENTAL PROSTHESES OR CONTACT LENSES.

SHOULD THERE BE ANY RISK OF SANCTION, PROHIBITION OR RESTRICTION UNDER UNITED NATIONS RESOLUTIONS REGARDING ECONOMIC OR COMMERCIAL SANCTIONS, OR UNDER THE LAWS AND REGULATIONS OF THE EUROPEAN UNION, THE UNITED STATES OF AMERICA OR ANY OTHER JURISDICTION, THE INSURER WILL NOT BE HELD LIABLE FOR THE COVERAGE OF AN INSURANCE BENEFIT, NOR FOR THE SETTLEMENT OF A CLAIM OR THE IMPLEMENTATION OF SERVICES.

SECTION 5
PREMIUMS

11. Calculation and payment of premiums

11.1 Premium calculation

The premium is determined by the age group and the premium mode. The age of the selected Insured is the one reached on his/her birthday preceding the application date then on his/her birthday for the following years. This amount will be revised at each anniversary depending on the age considered.
The newborn child is automatically covered from birth until the age of one (1) month. The continuation of this coverage is then subject to the application process (which includes a medical questionnaire) and payment of the insurance fee.

11.2 Payment of the premiums by the Insured Person

Premiums are paid in euros monthly, bi-annually, quarterly, annually in advance by the Insured to the Policyholder according to the procedure defined in the application form. All taxes and costs resulting from applicable legislation are added to the amount of the premium and are integrally paid by the Insured.
The amount of the premium for the first year shall be calculated in full months pro rata temporis for the period between the effective date of enrollment and the following renewal at the anniversary date.

11.3 Annual revision and indexation of premiums

Premium rates may be amended at each annual renewal date based on changes in demographics, regulations, parameters used by Sécurité sociale, examination of health questionnaires and the policy's results.
If a new pricing is established by the Insurer, it shall be sent to the Policyholder four (4) months before the policy renewal date. **The Policyholder must inform the Insured three (3) months before this pricing comes into force.**
In the event of a disagreement, **the Insured Person may ask for its insurance to be terminated via registered mail within two (2) months of the notification by the Policyholder.** Termination shall be effective from the first day of the month following receipt of the letter sent by registered mail by the Insurer.

11.4 Non-payment of the premiums

In the event of non-payment of the premium or a fraction of the premium, a registered letter shall be sent to the Insured Person of the policy at least ten (10) days after the renewal date, informing him/her that at the end of a period of forty (40) days after the date of the later, non-payment of the premium shall result in cancellation of the policy, which is the object of this Insurance leaflet, without further notice.

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SECTION 6
MEDICAL ASSISTANCE

The Insurer has mandated **Falck Global Assistance AB "the Assistance Provider"**, who will act under the name of "MGEN Filia" for the organization of assistance - repatriation services under the conditions below.

Article 1. DEFINITIONS
As per above “definitions” in Section and definition under “Assistance and special benefits”.

Article 2. MEDICAL INFORMATION
The Assistance Provider provides the Insured Persons with a 24-hour helpline for medical information. On a simple phone call, doctors answer medical questions and can provide the contact details of physicians or Hospitals likely to arrange appointments.

Article 3. ACCIDENT, ILLNESS AND UNFORESEEN EVENT ASSISTANCE
3.1 Repatriation assistance
If the medical condition of the Insured Person requires repatriation, the Assistance Provider shall arrange the following:

- Organisation and support of the repatriation or transportation to a Hospital for the Insured Person: The Assistance Provider arranges and pays for the repatriation to the Country of Origin or the Residence of the Insured Person or the transportation to the nearest or the most suitable Hospital according to the observed medical conditions. In the latter case and if requested by the Insured Person, the Assistance Provider can later organize, as soon as the medical conditions allow it, a repatriation to the home country or to the Country of Origin.
- Organization and support of the travel of an accompanying person: The Assistance Provider, in agreement with its medical advisor, can also organize and support travel for a companion of the Insured Person during the repatriation.

Decisions being made are only taken according to the medical interest of the Insured Person, and they are the sole resort of the medical advisors of the Assistance Provider in agreement with the local doctors. The medical advisors of the Assistance Provider are in contact with the local medical structures and (if necessary) with the family doctor of the Insured Person in order to gather medical information and to allow them to make the best decisions with regards to the medical condition of the Insured Person.
The repatriation of the Insured Person is decided and arranged by medical personnel holding a legally recognized degree in the country where they usually exercise their professional activity.
If the Insured Person refuses to follow the decisions made by the medical advisors of the Assistance Provider, this latter is waived from any liability for any consequence of such refusal. All rights to claim under this benefit shall then be lost under this situation.
In addition, the Assistance Provider cannot in any case replace local Emergency entities, nor cover their incurred costs.
Special conditions for pregnant women: airlines companies apply different restrictions regarding pregnant women who have reached an advanced stage in their pregnancy because of the risks which could threaten their health. Restrictions are likely to be modified without notice: medical examination within 48 hours before departure, presentation of a medical certificate, medical authorization from the airline. With respect to the above conditions, the Assistance Provider will organise transportation of pregnant Insured Persons under the express condition that doctors and / or airlines do not object.
Instructions on how to file a claim for 24/7 emergency assistance and or repatriation are listed under item 3.3 of Section 3 of this document.

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3.2 Local Hospitalisation

If the Insured Person is locally hospitalised for more than 8 days, the Assistance Provider will cover the following expenses to allow a family member to visit the Insured Person:

- Return transportation to the Hospital for a family member
- Accommodation expenses for the family member

These expenses are reimbursed upon presentation of supporting documents and within the limits of the amounts shown in the table of benefits.

3.3 Early return assistance

The Assistance Provider will organize and pay for return trips when initial travel arrangements for the return of the Insured Person to the Country of Origin cannot be used.
Early return assistance is covered for the Insured Person in the following cases and for the following relatives:

- In the event of illness or Accident of the spouse/partner/cohabitant or one of the minor or disabled descendants, all living in the Country of Origin and resulting in an Emergency Hospitalisation, which started during the expatriation of the Insured Person and for which life-threatening condition is confirmed by the medical advisor of the Assistance Provider;
- In order to attend the funeral service, further to the death of the spouse/partner/cohabitant, one of their ascendants or descendants in direct line, siblings, the legal guardian, or any person placed under the Insured Person's tutorship.

3.4 Assistance in the event of the death of an Insured Person

In the event of the death of an Insured Person, the Assistance Provider will arrange and pay for:

- The transportation of the mortal remains from the placement in coffin to the place of burial in the Country of Origin or in the country of expatriation of the Insured Person,
- The funeral expenses, within the limit the table of benefits.

Article 4. RISKS AND BENEFITS EXCLUDED

COMMON EXCLUSIONS COMMON TO ALL ASSISTANCE BENEFITS

IN ADDITION TO THE EXCLUSIONS SHOWN FOR SOME BENEFITS IN THE TABLE OF BENEFITS, THE INSURER WILL NOT COVER THE CONSEQUENCES OF THE FOLLOWING CIRCUMSTANCES AND EVENTS:

- THE VOLUNTARY PARTICIPATION OF THE INSURED PERSON IN BETS, CRIMES OR FIGHTS, EXCEPT IN CASE OF SELF DEFENCE
- ANY CONSEQUENCE OF NUCLEAR ORIGIN OR CAUSED BY ANY SOURCE OF IONISING RADIATION;
- INTENTIONAL ACTS OR MISCONDUCT OF THE INSURED PERSON, INCLUDING SUICIDE AND ATTEMPTED SUICIDE;
- CONSUMPTION BY THE INSURED PERSON OF ALCOHOL, DRUGS AND ANY STUPEFYING SUBSTANCE MENTIONED IN THE FRENCH CODE DE LA SANTE PUBLIQUE (PUBLIC HEALTH CODE) AND WHICH ARE NOT MEDICALLY PRESCRIBED;
- THE DAMAGE CAUSED BY CIVIL OR FOREIGN WAR DECLARED OR NOT, RIOTS AND GRASS-ROOTS MOVEMENTS, ACTS OF TERRORISM, ATTACKS OR SABOTAGE.

IN ADDITION TO THE EXCLUSIONS COMMON TO ALL BENEFITS, THE CONSEQUENCES OF THE FOLLOWING CIRCUMSTANCES AND EVENTS ARE NEVER INSURED:

UNDER THE "ACCIDENT, SICKNESS AND UNFORESEEN EVENT ASSISTANCE" AND "DEATH ASSISTANCE" BENEFITS:

- COSTS INCURRED WITHOUT PRIOR APPROVAL OF THE ASSISTANCE PROVIDER;
- THE POTENTIAL RESULTS (CHECK-UP, ADDITIONAL TREATMENTS...) OF A CONDITION FOR WHICH A REPATRIATION WAS PREVIOUSLY ARRANGED;
- THE CONSEQUENCES OF CONDITIONS OR BENIGN INJURIES WHICH CAN BE TREATED LOCALLY;
- VOLUNTARY TERMINATION OF PREGNANCY EXCEPT IN THE EVENT OF A MEDICALLY NECESSARY TERMINATION OF PREGNANCY INTERVENING IN COMPLIANCE WITH LOCAL LEGISLATION, DELIVERIES, IN VITRO FERTILIZATIONS AND THEIR CONSEQUENCES AS WELL AS PREGNANCIES WHICH HAVE GIVEN RISE TO AN HOSPITALISATION WITHIN 6 MONTHS PRIOR TO THE REQUEST FOR ASSISTANCE;
- PSYCHIATRY;
- THE PARTICIPATION OF THE INSURED PERSON TO ANY SPORT EXERCISED ON A PROFESSIONAL LEVEL OR UNDER A CONTRACT WITH REMUNERATION, INCLUDING PREPARATORY TRAINING
- NON-COMPLIANCE WITH FORMAL PROHIBITIONS, AS WELL AS THE INSURED PERSON'S NON-COMPLIANCE WITH OFFICIAL SAFETY RULES RELATED TO SPORTS PRACTISES;
- THE CONSEQUENCES OF AN ACCIDENT WHICH OCCURRED FURTHER TO AN AIR SPORT (INCLUDING HANG-GLIDER, PARAGLIDER, GLIDER) OR ONE OF THE FOLLOWING SPORTS: SKELETON, BOBSLEIGH, SKI JUMPING, MOUNTAINEERING IN ROPE TEAM, ROCK CLIMBING, SCUBA DIVING, SPELEOLOGY, BUNGEE JUMPING, PARACHUTISM;
- ANY EXPENSE WHICH IS NOT EXPRESSLY MENTIONED AS COVERED, AS WELL AS CATERING EXPENSES AND ANY EXPENDITURE FOR WHICH THE INSURED PERSON CANNOT PRODUCE A RECEIPT.

Article 5. BENEFITS IMPLEMENTATION

The Insured Person must contact the Assistance Provider or have a third party to contact them, as soon as the situation may result in an early return or potential claims within the scope of this contract.

How to access 24/7 emergency assistance and or repatriation claims:

Please call (EU) +45 7020 1478 or (USA) +1 321 307 9411 and include the following information:

- Number of the assistance agreement: Partner code: 75C026
- Name and contract number,
- Name of the Administrator of the medical contract: ExpaTPA
- The Insured Person's first and last name,
- The telephone number and/or address where the Insured Person can be reached, as well as the contact details of the persons who are taking care of the Insured

Please note that services which have not been submitted to prior approval nor have been organised by the Assistance Provider will not be subject to reimbursement nor compensatory allowance.

What to do in an emergency:

Where possible, in an emergency situation please contact our Claims and Service team whose details are available on the mobile application or the Insured portal.
Our team of specially trained advisors will help co-ordinate arrangements with local hospitals or even arrange for an evacuation or repatriation, depending on your circumstances. However, there may be occasions where you have not been able to contact us in advance of treatment and you are admitted to hospital. Do not delay in receiving treatment. You or your representative should try to contact us at the earliest practical opportunity (usually within 48 hours of the emergency occurring). Alternatively make sure that the hospital is aware of your insurance cover with us so that they can contact us on your behalf. We, or our partners, will then communicate with the hospital to enable direct settlement, where eligible.

For transportation

When the Assistance Provider arranges and covers transportation under these benefits, it must be by 1st class train and / or economy class plane or even by taxi, according to the decision of the Assistance Provider. The Assistance Provider then becomes the owner of the initial return tickets for the unused portion and the Insured Person must forward to the Assistance Provider any refund for the initial return trip.
When the Insured Person does not initially hold a return ticket, the Assistance Provider requests to the Insured Person to reimburse the costs of a return ticket, on the basis of 1st class train ticket and / or economy plane ticket, at the time of the Insured Person's early return and with the transportation company that sent him there.

Article 6. FRAMEWORK FOR ASSISTANCE INTERVENTIONS

The Assistance Provider operates in compliance with national and international laws and regulations and the services are subject to obtaining the necessary authorizations by local competent authorities.
Moreover, the Assistance Provider cannot be held responsible for delays or obstructions in the implementation of the agreed services further to force majeure or events such as strikes, riots, grass-roots movements, restrictions on free movement, sabotage, terrorism, civil or foreign war, consequences of the effects of a source of radioactivity or any other fortuitous occurrence.

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SECTION 7 DEFINITIONS

A

Accident: A sudden, unexpected event which causes a bodily injury, and which is unintentional from the Insured Person. An acute disease or a chronic illness shall not be qualified as an Accident under this policy.
Act of terrorism: an act, including but not limited to the threat or use of force or violence of any person or group of persons whether acting alone or on behalf of any organisations or governments, committed for political, religious, ideological or similar purpose or reasons include the intention to influence governments, and or put the public, or any section of the public, in fear.
Acute Medical Condition: The sudden onset of a medical condition which is likely to respond quickly to medical Treatment and is aimed to return You to the state of health You were in immediately before suffering the medical condition or which leads to Your full recovery.
Annual excess: The excess which corresponds to the amount to be borne by the Insured Person during one insurance year.

C

Certificate of Insurance: The document issued to You stating details of the Policyholder, the Insured Persons, the period of Cover, the Date of Entry of each Insured Person, the Area of Cover, the Plan level, the name of the Insurer, the medical underwriting terms including any special exclusions or restrictions to the Plan.
Childbirth costs: Medical expenses (including double or private room) incurred for vaginal delivery.
Chronic Medical Conditions: A disease, Illness or Bodily Injury that has 2 (two) or more of the following characteristics:

- It has no known recognised cure
- It continues indefinitely
- It is recurrent in nature
- It is permanent
- It needs Palliative Treatment
- It requires prolonged monitoring and/or supervision through consultations, examinations, check-ups, tests or medication
- It is Degenerative

Cohabitant: A cohabitant is defined as the person living with the Insured and fulfilling together the following two cumulative conditions:
They are both free of any former marriage or partnership agreement bond,
cohabitation must be declared by the Insured Person upon enrollment, along with a cohabitation certificate or proof of residency mentioning both names and a sworn statement that they live together. The certificate must be in force and legally recognized by a competent authority in the country of cohabitation. Termination of cohabitation must be declared in writing by the Insured. Only one person can be enrolled as a cohabitant.
Complication of Maternity: Medical conditions or events that arise during the antenatal stages of the pregnancy or at childbirth. Including but not limited to caesarean section delivery, ectopic pregnancy, stillbirth, retained placenta, placenta previa, placenta abruption, pre-eclampsia, eclampsia, toxaemia, post-partum haemorrhage, failure to progress in labour, miscarriage requiring surgical intervention, and Medically Necessary terminations.
Complementary Treatment: Therapeutic and diagnostic Treatments which exist outside of institutions where conventional medicine is taught and specifically within this Plan refers to acupuncture, homeopathy, osteopathy, chiropractic Treatment, traditional Chinese medicines, ayurvedic Treatments, provided by a practitioner who is qualified and licensed to practice in the country where Treatment is given.
Country of origin: The country of which the Insured Person holds a passport.
Country of residence: Country of expatriation of the Insured Person.

D

Dental prosthesis: Prosthetic treatments, including crowns, inlays, onlays, reconstruction or repairs using adhesive, bridges and implants, and all the necessary and ancillary treatments.
Doctor fees: Consultation of a general practitioner, family doctor, specialised practitioner legally registered in the professional registers, following an illness or an injury which does not require hospitalisation.

E

Emergency: Term used in the event of an Accident or at the onset of a serious illness requiring immediate medical assistance and treatment for the Insured Person. To qualify for Emergency under the terms of the contract the medical treatment must be performed within 24 hours by a general practitioner or a specialist whether in-patient or out-patient.
Excess: The annual amount that each person must pay each period of Cover before the Plan will pay for Benefits. The Excess amount is shown on the Certificate of Insurance.

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H

Health check-up: Medical examination carried out without any visible clinical symptom. These health check-ups aim at anticipating the detection of illnesses. They include the following tests: blood, sugar, cholesterol, kidney function, thyroid, lipids, bone densitometry.
Home care: Medical care provided by a registered nurse at the Insured Person's home and in accordance with the prescription of a doctor, immediately following or in the place of a hospitalisation or outpatient care.
Hospital: Any health facility holding the title of medical or surgical hospital in the country in which it is located. The health facility must provide its patients with continuous medical supervision by a doctor. Rest and nursing homes, thermal cure centres and cure and fitness centres are not considered hospitals under this policy.

I

Insurance year: The Insured Person's period of insurance beginning on the date indicated on the Certificate of Insurance and ending exactly one year later.
Insured Person: The party in respect of which the risk is insured. For the purpose of this policy, this refers to the main Insured individual and, where relevant, his/her Dependants.
Insurer: The insurance organisation covering the insured risk. This is MFPrévoyance, registered by Code des assurances, RCS 507 648 053 PARIS, Head office: 4, place Raoul DAUTRY, 75015 Paris, France.

L

Limitation period: The period beyond which a party's rights may no longer be invoked.

M

Medical prosthesis: Hearing aid, phonation aid (electronic larynx), wheelchair and personal mobility aid, artificial limb, ostomy product, hernia support, abdominal bandage, elastic support stockings or orthopaedic sole and any other medically prescribed apparatus.
Medical auxiliaries: Nurses, carers and other state-registered medical personnel.
Medically necessary: Corresponds to services and goods that are defined from a medical point of view as appropriate and necessary. They must:

- Be necessary to define or treat the condition, the illness or the injury of a patient,
- Be appropriated to the symptoms, diagnosis or treatment of the patient,
- Comply with the medical practices generally accepted and with the professional medical standards applied by the medical community at the time the patient receives the relevant care,
- Be required for other reasons than comfort or pleasure of the patient or his/her doctor,Have medical proven and demonstrated effects,
- Be considered as from the most appropriate type and level,
- Be provided with an equipment, in quantity and quality appropriate to the level of care required by the patient condition,
- Be only provided during the period appropriate to the patient condition.

Medically Necessary Treatment, which in the opinion of a qualified Medical Practitioner/Specialist is appropriate and consistent with the diagnosis, is proven and has demonstrated to give medical value, and which is in accordance with the generally accepted medical standards and could not have been omitted without adversely affecting the Insured Person's condition or the quality of care rendered. Treatments must be required for purposes other than comfort or convenience of the patient and provided only for an appropriate duration of time.

N

Newborn: A baby who is within the first 16 (sixteen) weeks of its life following birth.

O

Oncology: A malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue.The term malignant includes but is not limited to leukaemia, sarcoma and lymphoma.
Out of Pocket Expenses: The maximum amount that is your share of covered healthcare costs, including the money you pay for deductibles/excesses, co-pays, and coinsurance.

P

PACS: The person linked to the Insured Person by a civil union, in force (article 515-5 of the French Civil Code).
Palliative treatment: Aimed at alleviating the physical or psychological suffering of a progressive, incurable, chronic medical condition.
Physiotherapy: Physiotherapy prescribed by a certified doctor only for medical purpose. The "Mensendieck" physiotherapy is also included.

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Policyholder: The legal entity which signs the policy, which is the object of the Insurance leaflet, for the benefit of its Insured Persons.
Pre-existing Medical Condition: A Medical Condition, or a mental health disorder or any Related Condition for which You have suffered symptom (whether investigated or not), received Treatment or sought advice, prior to Your Date of Entry to the Plan.

R

Reasonable, customary and usual charges: The standard fee that would typically be charged in respect of Your Treatment costs in the country where the Treatment took place.

S

Spouse: Husband or wife of the employee who is neither divorced nor legally separated. For the purpose of this policy, a Civil Partner or a cohabitant as defined above is considered Spouse.

T

Third Party Administrator (or Administrator): Legal entity entrusted by the Insurer to carry out legal actions, services or specific activities on its behalf.
Treatment: Medical procedure necessary to cure or to alleviate illnesses or injuries.

U

Urgent Care Services: A medical facility that can provide medical treatment for a disease/injury which is urgent but not life-threatening.

V

Vaccinations: Injections required by the Health Authorities of the country of expatriation or the country of origin. Consulting fees and purchasing fees of vaccinations are covered.

W

Waiting period: Period during which an Insured Person is not entitled to some benefits.

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APENDIX 1
SUMMARY OF BENEFITS - PREFERRED

Currencies: Benefits, deductible and premiums (EUR €)	PREFERRED
Area of coverage	International (excluding USA)
Maximum plan benefit EUR	€ 1,000,000
Excess / Deductible	€ 0, 500, 1000, 3000, 5000
Coinsurance: Preventive care is 100% covered and not subject to the excess/deductible; nor is there a calendar year maximum	none
Out-of-pocket: Individual	none
Out-of-pocket: family	none
Inpatient Benefits	
Hospital room and board (semi-private, or private when medically necessary), including high dependency units and coronary care units	100%
Surgeries, Anaesthetists' fees, Operating Theatre, Recovery Room Specialist, Physician and Nursing Fees, Intensive Care Nursing	100%
Inpatient rehabilitation, provided by a recognised Rehabilitation unit, including Room and Board, physiotherapy, occupational therapy, speech therapy and dieticians. Up to a maximum of 30 days	€ 15,000
Diagnostic Tests including pathology, radiology, Electrocardiogram, to diagnose, assess or monitor a Medical Condition during Hospital admittance & Procedures (including MRI, CAT, PET (or a combination thereof) and advanced imaging)	100%
Oncology/ Treatment received as an In-Patient or Day patient including surgery, oncologist fees, radiotherapy, and chemotherapy, (alone or in combination) scans, diagnostic tests, and Prescription Drugs to treat the condition or alleviate pain	100%
Organ Transplant Services for life-sustaining human organs, tissue and cell transplants including kidney, liver, lung, heart, cornea and bone marrow	€ 500,000 lifetime maximum
Outpatient Benefits (with a maximum of € 5000)	
Family doctor, GP, specialist and physician consultations fees; incl. minor outpatient surgeries	100%
Emergency care in an emergency room/department of a hospital which does not require an in-patient admission	100%
Urgent care services in a medical facility to receive immediate treatment of a medical condition which is not life-threatening or that requires admission to a hospital	100%
Diagnostic tests including pathology, radiology, electrocardiogram, to diagnose, assess or monitor a medical condition and procedures (including MRI, CAT, PET or a combination thereof) and advanced imaging)	100%
Physiotherapy	€ 2,500
Restorative speech therapy required as part of a rehabilitation programme, such as after a stroke	€ 2,500
Alternative & complementary treatments including chiropractic, homeopathy, osteopathy, acupuncture, ayurvedic, herbal and Chinese medicines, with registered practitioners and associated prescription drugs/medication	€ 2,000
Rental of durable medical equipment, including orthopedic supports and braces, crutches, wheelchairs, walking frames and any surgical supplies up to a maximum period of 45 days	100%
Terminal & palliative acute care phases, flare-ups of ongoing or long-term routine management of a Chronic Medical Condition to provide active treatment to stabilize and maintain the condition, including consultations, prescription drugs/medication and check-ups associated with the Chronic Medical Condition	€ 5000 annual limit € 30,000 (lifetime max benefit
HIV, AIDS & ARCS	€ 50,000 (lifetime max benefit
Mental Health & Substance Abuse	
Inpatient mental health, psychiatric treatment and psychotherapy of a recognized mental health disorder in a specific psychiatric unit of a Hospital, and under the immediate supervision and direction of a consultant psychiatrist, up to a maximum of 30 days	€ 5,000 (annual max benefit)
Outpatient mental health, psychiatric treatment and psychotherapy of a recognized mental health disorder, by a qualified psychiatrist or psychotherapist up to a maximum of 30 days	Not included
Inpatient substance abuse, hospital admission and treatment up to a maximum of 30 days	Not included
Outpatient substance abuse, maximum of 30 days	Not included

Continues on page 26.

APENDIX 1
SUMMARY OF BENEFITS - PREFERRED
(CONTINUED)

Assistance & Special Benefits	PREFERRED
Local road ambulance or local air ambulance, to transport you from the place of incident to the nearest appropriate medical facility in country	100%
Emergency Medical Transport by the most appropriate means of transport, to the nearest suitable hospital when local medical care is not readily available and returning them to their Country of Residence after treatment, including the costs of a medical escort if necessary	100%
Compassionate Travel Visit, maximum of 6 trips per lifetime	Not included
Parent accommodation room and board to stay at the hospital overnight with a dependent child under 18 years of age who is receiving hospital admittance	€ 100/night (15 nights max)
Hospital cash benefit where room and board in a hospital is free of charge. the benefit cannot exceed the value that would have been paid for an appropriate room charge. Maximum payment for 30 nights	€ 100/night
Medically necessary emergency treatment whilst you are temporarily travelling outside of your chosen territorial application scope of cover for a sudden, unexpected accident, illness or an acute episode of existing covered medical conditions	€ 100,000 / maximum 45 days per trip
Annual Wellness Check-up to cover lifestyle health assessment screenings for blood, sugar, cholesterol, kidney function, thyroid, lipids, bone densitometry	Not included
Adult vaccinations for overseas travel; includes the vaccination and consultation	Not included
Mammograms & PAP smear cancer screening for early diagnosis of a medical condition	Not included
PSA & colorectal cancer screenings for those over 50 years of age for early diagnosis of a medical condition	Not included
Bowel cancer screening, for those over 55 years of age for early diagnosis of a medical condition	Not included
Bone densitometry scan for early diagnosis of a medical condition	Not included
Well child visits/exams	Not included
Child immunizations for prevention of illness, up to the age of 10 years	Not included
Accidental emergency dental treatment required immediately following damage to sound, natural teeth following an Accident. Treatment must be sought within 7 days of the Accident	€ 500 within 7 days of incident
Repatriation of mortal remains when the death occurs outside of the home country/country of nationality	€ 5,000
Local burial when the death occurs outside of the home country/country of nationality	€ 3,000
Prescription Drug Benefits	
Generic (30- and 60-day supply)	100%
Brand drugs; preferred (30- and 60-day supply)	100%
Brand drugs; non-preferred (30- and 60-day supply)	100%
Maternity Benefits	
Complications of maternity that arise during the antenatal stages of the pregnancy or at childbirth	100%
Natural childbirth including pre- and post-natal including scans and natural delivery costs either at a hospital or at home	€ 7,500
Elective Caesarean operation	€ 5,000
Non-elective Caesarean operation	100%
Home delivery	€ 1,000
Newborn care, up to 45 days from the birth date	€ 20,000
Newborn care, premature up to 60 days from delivery	€ 100,000
Congenital conditions which can be cured by surgical intervention within the first year of life	€ 10,000
Vision Care Benefits	
Eye examination by optometrist/ophthalmologist (one per year)	€ 75
Lens/contact/frames spectacle frames, lenses and non-disposable contact lenses	€ 150
Waiting Period: None, with the following exceptions:	
Wellness check-ups	6 months
Maternity	10 months
Mental health & substance abuse	12 months
Organ transplant	24 mo. of continuous coverage

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PRE-CONTRACTUAL INFORMATION SPECIFIC TO DISTANCE SELLING

1. Policy no. G0462 is taken out with the Insurer by ASPMI, whose registration number is set out in Section VI of this Summary of Benefits.
2. The responsible entity for regulating the Insurer is the Autorité de Contrôle Prudentiel et de Résolution (ACPR) - 4 Place de Budapest - CS 92459 - 75436 Paris Cedex 09, France.
3. The premium structure is set out in Section 5 ("Premiums") of this Summary of Benefits.
4. Insurance lasts 12 months from the start of the certificate of insurance. It is then renewed each year by tacit renewal on the insurance date. The start dates and length of insurance are defined in article 2.1 ("Start, duration and renewal of insurance certificate and cancellation") of this Summary of Benefits.
5. The object of the policy, as mentioned in article 1 ("Purpose") is to provide medical insurance cover for the Insured Persons under the conditions defined in Section III ("Benefits") of this Summary of Benefits.
6. Exclusions are set out in Section IV ("Excluded risks and benefits") of this Summary of Benefits.
7. In case of distance selling, the policy provisions described in the Summary of Benefits for policy no. G0462 are valid until the date indicated in the cover letter, enclosed with this Summary of Benefits.
8. In case of distance selling, the policy no. G0462 may be taken out according to the method set out in article 4 ("Insurance Conditions") of this Summary of Benefits.
9. The premium payment terms are set out in article 10 ("Calculation and premium payment") of this Summary of Benefits.
10. This plan contains a cancellation provision: the time limit, the procedure for exercising it and the address to which the cancellation notice should be sent are set out in article 2.3 ("Cancellation in the case of direct selling or distance selling") of this Summary of Benefits.
11. Pre-contractual and contractual relations between the Insurer, the Policyholder and the Insured Person are governed by French law. Documents in French shall prevail over translations and French courts shall have jurisdiction.
12. The procedures for assessing complaints are explained in article 3.3 ("Information - Complaints - Mediation") of this Summary of Benefit.

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MEDICAL CONTRACT

POLICY NUMBER: G0462
PARTNER CODE: 75C026

Capacity Partner: VYV Groupe/VYV International Benefits

Policy Administration by: expaTPA

Emergency Assistance Services by: Falck Global Assistance AB

This policy is designed and provided by Insured Nomads Underwriting GmbH, IDK: D-614H-AG1IB-19 (Hamburg, Germany), Insured Nomads - UK Branch (London, England, UK), and Insured Nomads Corporation, NPN#19616300 (USA) a globally distributed, remote company serving the global citizens of the world with insurance and technology excellence.
The Insurer is **MFPrévoyance**, registered by Code des assurances, RCS 507 648 053 PARIS, Head office: 4, place Raoul DAUTRY, 75015 Paris, France, of **CNP ASSURANCES**
Ratings: Fitch: A+ | Standard & Poor's: A | Moody's: A1

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