

AMI ASSOCIATION

ACS In France 1st Euro Health Scheme Summary of Benefits

As a member of the AMI Association, you have selected the "Health" cover that the Association has taken out with:

MGEN International Benefits 3-7 Square Max Hymans, 75648 Paris Cedex 15 RCS Paris 813 36 1441 ORIAS 16002500 on behalf of MFPrévoyance, limited liability company with a board of directors and a supervisory board with a capital of 81 773 850 euros. Regulated by the French insurance code, RCS PARIS 507 648 053 headquarters: 62, rue Jeanne d'Arc - 75013 PARIS, under contract number G0295.

If the repatriation assistance option and liability insurance have been selected with Allianz IARD (limited liability company with a capital of 991.967.200 euros, Regulated by the French insurance code, headquarters: 1 cours Michelet, CS 30051 – 92076 Paris La défense Cedex, France, registration n°542 110 291 RCS Nanterre, under the number 78 295 612.

How the cover is applied and the details of the benefits to which you are entitled are set out in this leaflet. In case of discrepancy between the French version and the English version, the French version will prevail.

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1/ General

Qualification – affiliation

Those who qualify are members of the AMI Association who are under 65 years of age, of foreign nationality and reside in France. The membership does not exempt you from the affiliation to the French social security scheme, when the latter is mandatory.

The Insured member must, when joining, complete and sign the application form including a medical questionnaire validated by the Insurer. A complementary medical examination may be requested by the Insurer.

The Insurer reserves the right to make acceptance conditional upon the production of any additional information it considers necessary.

The Insured makes a commitment for himself/herself and potentially his/her spouse, and their children aged under 21 years under the condition that they do not carry out a paid work and that they are indeed financially dependent on the Insured.

At the date of acceptance by the Insurer, the member and his/her dependents where appropriate, become the "Insured" and their membership is effective until 31st December of the current year. The membership is then renewed on January 1st of each year by tacit agreement for a period of 12 months, unless terminated by either party by registered mail, no later than October 31st of the previous year.

Choice of formulas

The choice of formula is made by the Insured at the time of joining. It cannot be modified until membership is renewed. In case of increase of benefits, the Insured must fulfil a new application form including a medical questionnaire.

Effect of cover

The Insurer takes responsibility to pay the expenses for each of the beneficiaries accepted for cover **after it has examined and accepted the medical questionnaire for all expenses**, subject to the payment of the first insurance premium installment, except the following, after the qualifying time set out below and beginning on the date of acceptance by the Insurer that appears on the application form:

- **Dental Prostheses: 6 months.**
- **Optical: 6 months.**
- **Spa Treatment in France: 6 months.**

However, the qualifying times do not apply if the Insured can give proof of equivalent coverage at the time of joining or, if cover is interrupted, in the context of the present agreement, for less than one month between two memberships.

Duration of cover

Once accepted for Insurance and subject to the penalties specified by the Insurance code for false declarations, the Insured may not be barred provided that he fulfils the conditions for benefiting therefrom.

In all cases, cover ends:

For each Insured member:

- At the initiative of the Member in case of annual termination of his insurance contract. In such a case, he must inform the Insurer via ACS by registered letter at least two (2) months before renewal date.
- In case of false declaration (See. Article 4),
- In case of death of the Member,
- When the Insured no longer belongs to the insured category aimed by contract n° G0295,
- in case of non-payment of the insurance premium in compliance with the corresponding provisions of the *Code des Assurances (Insurance code)*,
- on the last day of his/her period of membership,
- in case of dissolution of the Association or judicial liquidation of the Insurer,
- on the day of his/her 70th birthday.

For all those Insured:

- in the event of cancellation of the contract n° G0295.

The cessation (or suspension) of cover simultaneously results, for the Insured, in the removal of entitlement to the benefits for all the treatment and care that occurs from the date of cessation even if they began or were prescribed before that date.

2/ Definitions

The terms and expressions used in this agreement in italics and starting by a capital letter have the following meanings:

Accident: any unintentional bodily injury caused to the Insured, arising from abrupt, sudden and unexpected action with an external cause, to the exclusion of an acute or chronic *Illness*.

Attack / Acts of terrorism: any act of violence, constituting a criminal or illegal attack, against persons and / or property, in the country in which you reside, aimed at seriously disturbing public order.
This "attack" should be recorded by the French Ministry of Foreign Affairs.

Civil war: armed opposition of several parties belonging to the same country, as well as any armed rebellion, revolution, sedition, insurrection, coup, under martial law or border closure commissioned by local authorities.

Childbirth expenses: medical expenses (including double room) incurred for vaginal childbirth. Any complication including cesarean section if medically necessary, and private room, will be paid for by the "*Hospitalization*" cover.

Consequential loss: any financial loss that results from the loss of enjoyment of a right, the interruption of a service rendered by a person or by an item of personal property or immovable property, or the loss of a benefit, and that is the direct consequence of covered *Physical Injury* or *Material Loss*.

Cost for parent accompanying a child under 16 years: price of a Hospital room for a parent during the admission of an insured child to Hospital for treatment. If a Hospital bed is not available, the Insurer takes into charge the equivalent cost of room up to the indicated amount. Miscellaneous expenses such as meals, telephone calls and newspapers are not covered.

Country of origin: is considered as country of origin, the one stated on the passport of the beneficiaries and / or the country declared as country of origin on the application form.

Disease or Illness: deterioration in health established by a medical authority, requiring medical treatment.

Deductible: refers to the amount of expenses to be covered by the Insured, which must be deducted from the sum that is to be reimbursed.

Dental prosthesis: prosthetic care, including crowns, inlays, onlays, reconstruction or repair, bridges and implants, as well as all necessary and related treatments if dental coverage provided.

Domicile: domicile means the Insured's main and usual place of residence in his/her country of origin.

Emergency: a term used in the event of an *Accident* or the beginning of a serious *Illness* requiring immediate measures and medical treatment for the Insured or one of the Insured's dependents. Only medical treatment given by a doctor, generalist or specialist or *Hospitalization* occurring within twenty-four (24) hours of the direct cause of the *Emergency* shall be considered conditions necessary for reimbursement.

Foreign war: armed opposition declared or not from a State to another State, as well as any invasion or state of siege.

Forfeiture: the loss of any warranty claims.

Formal Hospital Admission:

- (i) For stays of at least 24 hours, Formal Hospital Admission is the formal acceptance by a hospital or other inpatient health care facility of a patient who is to be provided with a room, board as well as continuous nursing service in the hospital in which the patient resides at least overnight.

- (ii) For stays of less than 24 hours in case of *Surgical Procedures*, Formal Hospital Admission is the formal document indicating that the patient is provided with nursing services and a bed, despite the fact that s/he does not stay overnight.
- (iii) For stays of less than 24 hours in case of non-*Surgical Procedures*, Formal Hospital Admission is the formal document indicating that the patient has entered the hospital for less than 24 hours for chemotherapy, radiotherapy or dialyses treatment for less than 24 hours. The patient enters for *Treatment* and leaves after treatment.

Hospital: refers to any establishment licensed as a medical or surgery hospital in the country where it is located. The establishment must offer its patients ongoing monitoring by a physician. Convalescent and nursing homes, thermal baths and cures at spas, are not deemed to be hospitals.

Hospitalization: refers to:

- (i) a stay for at least 24 hours for medical treatments or *Surgical Procedures* in a public or private *Hospital* due to an *Accident* or *Illness*, provided that the insured receives a *Formal Hospital Admission*. In such a case are covered:
- *Surgical Procedures* and corresponding accommodation costs,
 - medical and paramedical expenses provided in the context of hospitalization, and
 - the transportation of the patient between the patient's home or the site of the *Accident* and the closest hospital located in the same country.
- (ii) a stay of less than 24 hours, provided that the insured receives a *Formal Hospital Admission*, in case of:
- Surgical Procedures,
 - fibrescopy, colonoscopy, endoscopy, and
 - chemotherapy, radiotherapy or dialyses treatments.

Stays of less than 24 hours for emergency rooms visits which do not result in *Surgical Procedures* are deemed to be outpatient treatments and are not reimbursed as hospitalization expenses.

Material loss: any damage, destruction, deterioration, loss or disappearance of a thing or substance and any physical attack on an animal.

Medical auxiliaries: nurses, carers and other state-registered medical personnel.

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.

Natural disasters: Abnormal intensity of a natural agent not arising from human intervention.

Physical injury: any physical injury sustained by an individual and the distress resulting therefrom.

Pollution: environmental degradation by the introduction into the air, water or soil, of materials not naturally present in the natural environment.

Prescribed Medication: designate medication sale and use of which are legally subject to a doctor's prescription. Medication that can be purchased without a prescription is not included in this definition.

Prescribed spectacle lenses, frames and contact lenses: Reimbursement of an eye exam by an optometrist or an ophthalmologist per insurance year and of contact lenses or glasses to correct vision.

Spa treatment: medical treatment prescribed for a maximum of 21 days making use of mineral spring water and its derivatives. The establishment must provide its patients with regular medical supervision and monitoring.

Surgical procedures: acts carried out under general or local anaesthetic or the reaching of an organ to be treated after an incision are deemed to be surgical procedures.

Subrogation: legal situation by which a person's rights shall be transferred to another person's rights (substitution by the Insurer in order to prosecute the other Party).

Strike: collective action consisting in a concerted work cessation by employees of a company, an economic sector, an occupational category to support their demands.

Third party: any person other than the Insured responsible of the damage. Any member victim of a physical injury, material loss, or consequential loss caused by another Insured (The Insured persons are considered as Third party between them).

Waiting period/ qualifying time: period during which the Insured is not entitled to certain benefits.

3/ Health cover and benefits

Coverage zone

Medical expenses are repayable Worldwide, except USA, Canada, Switzerland, Israel, Japan, Hong Kong and Singapore.

However, during a stay of less than seven (7) weeks in the country of origin or in a country outside the expatriation zone, only expenses arising from an *Accident* or an *Illness* of an urgent nature as defined above under *Emergency* provided that the treatment has been given by a doctor, generalist or specialist, or that the *Hospitalization* was required as a direct cause of the *Emergency* and that it took place within 24 hours, shall be reimbursed.

In other cases, on express approval by the Insurer.

Illness – Surgery – Maternity cover

Subject to the exclusions below, within the limits of the chosen formula and as indicated in the table of sums insured on the last page of this information leaflet, **medical expenses recognized by the sickness - maternity insurance of French social security and reimbursed by the latter for the same circumstances but within the maxima of the table of sums insured, except for prescribed contact lenses, are covered.**

Furthermore, requests for reimbursement will be honoured only if the Insurer considers the amount of the bills and the receipts supplied to be reasonable and within normal limits.

Otherwise, the Insurer reserves the right to reduce the amount of benefit.

Amount of benefit

The amount of benefit is determined for each expense item according to the terms indicated on the table of sums insured.

Reimbursements are paid up to the maxima indicated on the table of sums insured and up to the limit of the actual costs.

By actual costs one must understand normal and reasonable costs, i.e. the lowest amount between the cost requested by the medical provider and the cost which is applicable in the same geographical area for a similar service by providers of identical professional level.

The "normal and reasonable cost" of a service varies according to the treatment, the quality of service and equipment, the location and the country where the treatment is received. The Insurer is entitled to decide to limit the level of reimbursement of medical costs and additional costs as well as the duration of the hospitalisation, to what is normally applied in the geographical area where the insured is treated.

The claims paid by the Insurer are in addition to those of any other Life and Accident insurance scheme from which the Insured may benefit personally.

By annual limit on must understand the limit per civil year.

Limitation to actual cost

In accordance with Article 9 of Act n° 89-1009 of December 31 1989 and Decree n° 90-769 of August 30 1990, reimbursements or payments covering expenses caused by an *Illness*, maternity or an *Accident* shall not exceed the amount of the expenses for which the Insured remains liable after the reimbursements of all kinds to which the Insured is entitled.

Similar cover taken out with several insurance organizations shall have an effect on the limit of each item of cover irrespective of when the cover was taken out.

In this limit, the beneficiary of the Agreement may obtain additional payment by sending details of the reimbursements made by the other organization(s).

For application of the aforementioned arrangements, the limitation of expenses for which the Insured is still liable is determined by the Insurer for each of the treatments or expense items.

In case of undue payments: the beneficiary of the benefit commits to repay to the Insurer, as soon as possible, the undue claims. As a consequence, the Insurer can make compensation between these amounts and any other benefits due by the Insurer to the Insured.

Excluded benefits

It is understood and agreed that medical expenses not recognized by French social security are not covered in this agreement, except for prescribed contact lenses.

Furthermore, the risks and benefits listed below are also excluded even if they would have otherwise been reimbursed by the French "Sécurité Sociale".

It should be noted that this agreement does not cover:

- **treatments outside the geographic zone of expatriation as indicated in the application form, except for cases specified in the section on the zone of coverage,**
- **any form of experimental or unsupervised treatment that does not follow commonly accepted, customary or conventional medical practice, unless specific consent has been given by the Insurer,**
- **incidental expenses or comfort expenses in the case of *Hospitalization* (telephone, television, etc.),**
- **treatments for drug addiction or alcoholism,**
- **expenditure incurred on the acquisition of an organ (but not the organ itself),**
- **any operation or treatment relating to a sex change,**
- **aesthetic treatments, age-reducing treatments, slimming treatments,**
- **the checks, examinations, treatments and complications associated with sterility, sterilization, sexual dysfunction, contraception including the insertion or removal of contraceptive devices, the voluntary termination of pregnancy except in the case of a pregnancy termination that is medically necessary and complies with local legislation,**
- **any elective/voluntary surgery and/or plastic/cosmetic surgery,**
- ***Spa Treatments* outside French territory,**
- **transport and accommodation costs associated with *Spa Treatments*,**
- **outpatient consultations with regards to psychotherapy, psychoanalysis and psychiatry, as well as related medication,**
- **medical expenses associated with a stay at a thalassotherapy centre or fitness centre, rest home or recovery home even if this stay is medically prescribed, (except for reeducation centres immediately following a *Hospitalization*),**
- **consultations, treatments and complications associated with the loss of or implantation of hair unless the treatment is related to a hair loss caused by a serious illness,**
- **treatments to modify the refraction of an eye or the eyes (laser eye correction), including refractive keratotomy (KR) and photorefractive keratotomy (KPR),**
- **unprescribed medication, and commonly used non-medical products such as medical alcohol, absorbent cotton, suncreams, dental hygiene products, dressings, shampoos etc.**

4/ Formalities necessary when claiming medical expenses

Declaration

In the event of *Hospitalization*, the Insured may obtain a guarantee of payment, in order to prevent making advance payments, by calling us on 00 33 (0) 1 84 79 08 80 (or e-mailing us at: hospim@medical-administrators.com).

For other expenses, the documents must be sent to:

MAI - Claims Department for Medical Expenses - 37, rue Anatole France - 92300 Levallois-Perret - FRANCE – Telephone : 00 33 (0)1 84 79 08 80/ Email : acs@medical-administrators.com.

In the event of illness: the detailed bills with prescriptions and medical expense claim forms including the stickers for reimbursement of medication costs.

In the event of *Hospitalization* (if a refund is not delivered): the paperwork providing proof of *Hospitalization*, bills, fees.

In the event of home confinement: a birth certificate of the child.

The Insurer may request any other additional supporting documentation it requires.

No copy, photocopy or duplicate invoice is accepted. By way of exception, copies can be sent by email for any invoice under 500 euros per invoice, provided that the Insured keeps the originals. In this case, the Insured should keep the originals during 24 months as from the processing date. During this period, the Insurer is entitled to request the originals. In the absence of such originals, the corresponding reimbursement could be challenged.

Prior approval

Reimbursements of:

- *Hospitalization* expenses (in *Hospital* or at home)
- physical rehabilitation that immediately follows a *Hospitalization*
- MRI
- physiotherapy (if over 10 sessions)
- physical therapy
- chiropractic, osteopathy, homeopathy, acupuncture
- *Childbirth Expenses*

is subject to the Insurer's prior approval, except in the event of *Emergency* (as defined in this Plan). Each admission to a *Hospital* must be notified to the Insurer at least 10 days prior to the effective admission, and within 48 hours for *Hospitalizations* following an *Emergency* (as defined in this Plan).

The Insurer reserves the right not to reimburse expenses that have not been notified beforehand, as required by the Plan. If, thereafter, treatment becomes medically necessary, the Insurer will reimburse only 80% of the amount specified for the benefits in case of *Hospitalization* and 50% for other benefits.

In the event of *Hospitalization*, surgery, radiography or medical treatment, a medical certificate must be requested from us in advance. It should be returned to us after having been completed by the doctor of the Insured.

Any failure to fulfil this obligation could result in a refund being refused.

The Insurer reserves the right to require any Insured person or beneficiaries to provide all the information necessary for the processing of their personal data and data relating to claims for reimbursement. The Insurer may therefore have access to their medical files with all the legal obligations of confidentiality attached thereto.

Penalties in case of false declaration

Any information supplied by the Insured or one of their beneficiaries that is incorrect, falsified, exaggerated or any fraudulent acts on their part shall be the direct responsibility of the Insured and shall give rise to:

- the nullity of your contract in case of intentional misrepresentation (113-8 of French insurance code), premiums paid are kept by the Insurer, who is entitled, as a compensation, to the payment of all premiums due; in such a case, the Insured will have to reimburse all the claims paid by the Insurer under the contract;
- if the intentional misrepresentation, discovered before any claim, is not established, premium increase or termination of the contract (113-9 of the French insurance code)
- if the intentional misrepresentation, discovered after the claim, is not established, decrease of claim according to the ratio between the paid premium and the premium that should have been paid if the initial declaration had been consistent with the reality (113-9 of the French insurance code).

5/ Premium

Premiums are paid by the Insured, according to his age and that of his/her beneficiaries. Age is calculated by difference between birth year and year of admission.

Premiums are paid in advance in euros annually, bi-annually, quarterly, or monthly by the Insured to ACS according to the procedure defined in the membership form. The amount of premium excludes taxes. Any taxes and costs resulting from applicable legislation would be added to the amount of the premium and would be integrally paid by the Insured.

Premiums are automatically indexed on each 1st January, according to the evolution of annual consumption of medical care and medical goods by households and insurance companies (amount in Euro of medical care and goods included in the national health accounts under the headings "Household expenditure", "Mutual insurances and private insurances").

Premiums may be revised each 1st January according to the technical results of the contract, demographic changes, regulation, social security parameters, and the examination of health questionnaire results.

In case of new premiums, the Association shall inform the Insured three months before the entry date. In case of disagreement, the Insured may request the termination of the policy by registered letter within two (2) month from the date of notification by the Association. Termination shall take effect on the first day of the month following the receipt of the registered letter by the Insurer.

Should the Insured fail to pay all premiums within the month following their due date, the Insurer sends him a registered letter stating that the medical cover will be terminated forty (40) days after issuance of the letter without any further formality if the Insured has not made the requested payment within this period of time.

6/ Assistance cover (if the option has been selected)

Repatriation assistance

If the Insured is in one of the situations listed below, we provide the services described, requiring no more than a telephone request (reverse charges accepted from abroad) or a telex, fax or telegram request.

In all cases, the decision to provide assistance and the choice of the appropriate means shall lie exclusively with the Allianz IARD doctor, after making contact with the treating doctor at the location and, where necessary, the family of the beneficiary.

Only the medical interests of the beneficiary and compliance with the applicable health regulations shall be considered for deciding on the transport, the choice of the means used for transport and any place of *Hospitalization*.

In no cases will Allianz IARD become a substitute for local emergency services.

Repatriation or medical transport

If the Insured is ill or injured following a covered event and the Insured's state of health requires a transfer, we organize and pay for repatriation to:

- either the competent hospital closest to the Insured's place of expatriation
- either the competent hospital closest to the Insured's home in his country of origin
- either the Insured's home in his country of origin;

if the local medical infrastructure does not have the capacity to provide appropriate care.

Depending on the seriousness of the case, repatriation or transport is carried out under medical supervision, if necessary, by the most appropriate of the following means:

- special medical aircraft
- regular scheduled airline, train, sleeper train, ship, ambulance.

Accompaniment in case of repatriation or medical transport

Following the repatriation or the medical transport of the Insured, we organize and pay for the additional costs of transporting members of the Insured's family who are covered or a person insured under this agreement accompanying the Insured if the tickets provided for their return to their country of origin cannot be used because of the repatriation.

Transport of the body in the event of death

We organize and pay for transport of the Insured's body from the place where the body has been placed in a coffin to the international airport closest to the home of the Insured.

We also pay the ancillary expenses necessary for transportation, including the cost of the coffin, making transport possible, up to the amount indicated in the table of sums insured.

Costs of the ceremony, accessories, burial or cremation remain the responsibility of the families.

We organize and pay for the additional costs of transporting members of the Insured's family who are covered or a person insured under this agreement accompanying the Insured if the tickets provided for their return to their country of origin cannot be used because of the repatriation.

Return of the Insured after "consolidation" (when healing is complete)

Following the repatriation of the Insured to his/her country of origin organized by Allianz IARD, if a medical authority determines that the state of health of the Insured has consolidated and that it allows the Insured to return to his/her country of expatriation, we pay for the Insured's transport to the international airport closest to his/her place of expatriation. We also pay for the transport of members of the Insured's family who are covered or of a person who is insured under this agreement and accompanying the Insured.

Early return

If the Insured has to interrupt his/her stay abroad because of one of the below mentioned events, we will pay for the Insured's additional transport costs and those of the Insured's covered family members* or those of a person insured under the present contract accompanying the Insured, if their travel tickets provided for their return to their *Domicile* cannot be used because of this event.

The guarantee applies in case of one of the following events: A serious *Illness* or a serious *Accident* resulting in a hospitalization of more than 10 days, or the death of a family member* of the Insured.

We also take into charge the transport costs for the return of the Insured to his country of expatriation.

***Family members:** Family members are defined as spouse, children, brothers or sisters, father, mother, grandparents and grandchildren.

Special exclusions to personal assistance

In no circumstances can we be a substitute for local emergency services.

As well as the exclusions appearing in the section 7 entitled "General exclusions for all Health, Assistance and Public liability cover", we do not cover: convalescence and disorders (*Illness, Accident*) being treated that are not yet consolidated on the date the journey begins, pre-existing conditions that are diagnosed and/or treated that have been the subject of *Hospitalization* in the six months prior to the request for assistance, journeys undertaken for the purpose of diagnosis and/or treatment, pregnancies except for unforeseen complications, and, in all cases, after the 32nd week of pregnancy, conditions resulting from the ingestion of alcohol, the use of drugs, narcotics and similar products that have not been medically prescribed, and the consequences of suicide attempts.

Obligations of the Insured in the event of a claim

For any request for assistance, the Insured must contact us at any time of the day or night:

- by telephone from France: 01.55.98.57.77 or 01.45.16.77.18
 from abroad: 00.33.1.55.98.57.77 or 00.33.1.45.16.77.18
- by fax from France: 01.45.16.63.92 or 01.45.16.63.94
 from abroad: 00.33.1.45.16.63.92 or 00.33.1.45.16.63.94
- by e-mail: medical@mutuaide.fr

and obtain our consent prior to taking any initiative or committing to any expenditure including medical costs.

When we have organized the Insured's transport or repatriation, the Insured must send us his/her initial tickets, since they become the property of Allianz IARD.

Applicable limits in the case of force majeure

We cannot be held liable for failures in the execution of the Assistance services resulting from cases of force majeure or the following events:

Civil or Foreign Wars, acknowledged political instability, popular movements, riots, Acts of Terrorism, reprisals, restrictions to the free circulation of people and goods, Strikes, explosions, Natural Disasters, meltdown of atomic cores, nor delays in the execution of services resulting from the same causes.

7/ Public liability (if the option has been selected)

This Public liability cover takes effect only if there is a lack of, or as an addition to, any public liability insurance already existing and taken out by the Insured with any other company.

We cover the financial consequences of the public liability that the Insured may incur with respect to, on the one hand, personal injury and/or *Material Loss* and, on the other hand, the *Consequential Loss*, caused accidentally to any person other than a person insured or a member of the Insured's family, that is the Insured's fault or the fault of persons, things or animals under the Insured's care, this being provided up to the amount, and with the deduction of an *Deductible*, indicated in the table of sums insured.

Special exclusions to public liability cover

Besides the exclusions specified under section 7 entitled "General exclusions for all Health, Assistance and Public liability cover", our cover does not apply to:

- damage that the Insured has caused or provoked intentionally,
- damage resulting from the use of land motor vehicles, sailing boats and motor boats, and flying apparatus,
- damage resulting from any job-related activity,
- the consequences of any material and/or personal injury claims affecting the Insured's personally and the members of his/her family and any other person qualifying as an Insured person under this agreement,
- consequential damage except when it is the direct consequence of accidental or *Material Loss* and/or personal injury that is covered,
- damage the Insured caused due to a fire, explosion or flooding,
- damage resulting from the practice of air sports or hunting.

Limits of our cover

Transaction – Acknowledgement of liability

The Insured must not accept any acknowledgement of liability, or any transaction without our prior written consent.

However, simply the acknowledgement of the reality of certain facts is not considered an acknowledgement of liability, no more than the simple fact of having provided *Emergency* help to a victim when it is an act of assistance that anyone has a moral duty to perform.

The Insured must advise us within five working days, except for Acts of God or of force majeure, of any event likely to render him/her publicly liable; if this deadline is not met and, as a result, we suffer loss, the Insured risks the *Forfeiture* of his/her cover.

Procedure

In the event of any legal action being made against the Insured, we provide his/ her defence and handle the trial for the deeds and loss falling within the cover provided by this agreement.

However, the Insured may associate himself/herself with our action provided that the Insured can provide proof of a specific interest that is not covered under this agreement.

The simple fact of paying for the Insured's own defence for protective reasons may in no circumstances be interpreted as an acknowledgement of cover and in no way implies that we accept the detrimental consequences of events that are not expressly covered by this agreement.

Even if the Insured fails in his/her obligations after a claim, we are bound to indemnify the people to whom the Insured is liable. We nevertheless retain, in this case, the right to take action against the Insured for repayment of any monies that we may have paid or placed in downpayment on the Insured's behalf.

Legal proceedings

With respect to means of obtaining redress:

- before the civil, commercial or administrative courts, we are free to obtain redress under the present agreement,
- before the criminal courts, the means of redress may not be used without the Insured's consent,
- if the pending lawsuit before a criminal court relates only to civil interests, refusal to give his/her consent to use the planned means of redress gives us the right to claim an indemnity from the Insured equal to the loss that we suffer as a result.

Court costs

We pay the court costs, the discharge costs and any other payment expenses. However, if the Insured is sentenced to pay an amount greater than the cover limit, we each bear these costs proportional to our respective share in the sentence.

8/ General exclusions for all Health, Assistance and Public liability cover

The expenses incurred are not paid by the Insurer if they result from the following:

- an *Illness* or *Accident* due to the intentional act of the insured person, intentional mutilation or attempted suicide,
- any intentional act that might lead to the application of the contract cover and any consequences of criminal proceedings that might be taken against the Insured
- the consequences of a *Civil* or other *War*, insurrection, terrorist attack or popular movement,
- riot or *Strike*, except if the Insured does not take an active part in the event,
- a claim resulting directly or indirectly from the meltdown of an atomic core, or any irradiation originating from ionizing radiation.

The Insurer reserves the option to modify the cover in one or more specific territories subject to notifying the Subscriber 15 days in advance.

General exclusions specific to Assistance and Public Liability cover

We cannot take action when the requests for cover and benefits are the consequence of losses resulting from:

- epidemics, *Natural Disasters* and *Pollution*,
- alcoholism, drunkenness, the use of medications, drugs, narcotics that are not medically prescribed,
- any intentional act that may involve the cover of the agreement,
- duels, bets, crimes, brawls (except legitimate defence),
- the practice of the following sports: bobsleigh, skeleton, mountain climbing, competitive luge, air sports except for parascending and those resulting from participation in or training for official matches or competitions organized by a sporting federation,
- the absence of random,
- activities when an insurer is banned from providing a contract or an insurance service due to a sanction, restriction or prohibition provided by conventions, laws or regulations, including those decided by the United Nations Security Council, the European Union Council or any other applicable national law,
- activities when they are subject to any sanction, restriction total or partial embargo or prohibition provided by conventions, laws or regulations, including those decided by the United Nations Security Council, the European Union Council or any other applicable national law. It is understood that this provision only applies in the case where the insurance contract or insured goods and/or activities fall within the scope of the decision concerning the restrictive sanctions, total or partial embargo or prohibition.

9/ Limitation

TIME LIMIT OF ACTIONS STEMMING FROM THE INSURANCE CONTRACT

The provisions relating to the time limit within which action stemming from the insurance contract may be taken are set out by Articles L 114-1 to L 114-3 of the French Insurance Code (Code des assurances), as reproduced below:

Article L 114-1 of the French Insurance Code:

Any actions stemming from an insurance contract are time barred two years after the event from which the actions stem.

However, this time limit only starts running:

- 1 In the event of reticence/concealment, omission, misrepresentation or inaccurate declaration of the risk incurred, from the date when the Insurer learned of the said risk;
- 2 In the event of an insurance loss, from the date when the interested parties learned of it, if they prove they were unaware of it prior to that date.

When the action by the Insured Person against the Insurer is caused by recourse by a third party, the time limit for action only starts running from the date when the third party takes legal action against the Insured Person or has received compensation from the Insured Person. The time limit for action is increased to 10 years in life insurance contracts when the beneficiary is a person distinct from the Contrat holder and, in insurance contracts for personal accidents, when the beneficiaries are the assigns of the deceased Insured Person.

For life assurance contracts, and notwithstanding the provisions of point 2 above, the right to action by the beneficiary lapses at the latest 30 years after the death of the Insured Person.

Article L 114-2 of the French Insurance Code:

The time limit for action may be interrupted by any of the ordinary causes for interruption thereof, and by appointment of appraisers after a loss. Interruption in the time limit for action may also result from a registered letter with acknowledgement of receipt being sent by the Insurer to the Insured Person to obtain payment of the premium, and by the Insured Person to the Insurer to obtain payment of compensation.

Article L 114-3 of the French Insurance Code:

Notwithstanding Article 2254 of the Code Civil (French Civil Code), the parties to the insurance contract may not, even by mutual agreement, either change the length of the time limit for action, or add causes for suspension or interruption thereof.

Additional information:

The ordinary causes for interruption of the time limit for action indicated in Article L 114-2 of the French Insurance Code are set out in Articles 2240 to 2246 of the French Civil Code, as reproduced hereafter.

To learn of any potential updates of the aforementioned provisions, you may consult the official website: "www.legifrance.gouv.fr".

Article 2240 of the French Civil Code:

Recognition by the obligee of the right of the person against whom the obligee could claim inaction within the time limit interrupts the time limit for action.

Article 2241 of the French Civil Code:

Instigating legal proceedings, even summary proceedings, interrupts the time limit for action and the time limit beyond which rights lapse.

The same applies when the matter is brought before an incompetent jurisdiction, or when the deed of referral to the jurisdiction is cancelled through procedural irregularity.

Article 2242 of the French Civil Code:

Interruption resulting from instigating legal proceedings is effective until the proceedings end.

Article 2243 of the French Civil Code:

The interruption is null and void if the petitioner withdraws the petition or lets the proceedings lapse, or if the petition is dismissed definitively.

Article 2244 of the French Civil Code:

The time limit for action or the time limit after which rights lapse is also interrupted by protective measures being taken pursuant to the French Code of Civil Enforcement Procedures (Code des procédures civiles d'exécution) or by an enforcement being ordered.

Article 2245 of the French Civil Code:

One of the jointly and severally liable obligees being summoned or notified through legal proceedings or through an enforcement order, or recognition by the obligee of the right of the person against whom the obligee could claim inaction within the time limit interrupts the time limit for action against all of the others, even against their heirs.

Conversely, one of the heirs of a jointly and severally liable obligee being summoned or notified, or that heir recognising such a right does not interrupt the time limit for action with regard to the other co-heirs, even for mortgaged debt, if the obligation is divisible. Such summons/notification or such recognition interrupts the time limit for action with regard to the other co-obligees only for the share for which that heir is liable. In order to interrupt the time limit for action for the entire obligation with regard to the other co-obligees, the summons or notification needs to be made to all of the heirs of the deceased obligee, or all of the heirs need to recognise the right;

Article 2246 of the French Civil Code:

Summons or notification made to the main obligee, or the main obligee recognising the right in question interrupts the time limit for taking action against the guarantor.

10/ Basis of the insurance agreement

This agreement is governed by the Insurance code. The definition of the cover, the insurance rates and their rules of application take account of French Social Security legislative arrangements and regulations that are in effect on the date that the insurance agreement takes effect.

Subrogation

The Insurer is subrogated to the rights and actions that the Insured may have against the *Third Party* responsible for the loss, in the limit of the amount of compensation that the Insurer has paid. In case *Subrogation* could not operate in favour of the Insurer because of the Insured, the latter will be relieved of the obligations regarding the Insured in respect of the *Subrogation* that would have been possible.

Overlapping Insurance

When several insurance contracts are taken out without fraud for the same risk, each of them is valid up to the limits of the cover provided for under the contract, and in accordance with the provisions of Article L 121-1 of the French Insurance Code. In this case, the Insured Person must inform all of the insurers.

Within these limits, the Insured Person may turn to the insurer of his choice. When they are contracted fraudulently, the sanctions provided for by the French Insurance Code (invalidity of the contract plus damages) are applicable.

Anti-money laundering

The controls that we are legally required to carry out as part of anti-money laundering and to combat the financing of terrorism, especially cross-border flows, may lead us at any time to ask you for explanations or supporting documents, including concerning the acquisition of insured goods. Pursuant to the French Data Protection law (loi Informatique et Libertés) of 6 January 1978 amended by the law of 6 August 2004 and the French Monetary and Financial Code, you are entitled to access the data that concerns you by sending a letter to the French Data Protection Agency (Commission Nationale de l'Informatique et des Libertés (CNIL)).

Jurisdiction of the courts

Any litigation between the Insured Person and the Insurer concerning the conditions of applying this contract shall be subject to French law and French courts shall have exclusive jurisdiction. Nevertheless, if the Insured Person is domiciled in the Principality of Monaco, Monaco courts shall have sole jurisdiction in case of litigation between the parties.

11/ Option of Cancellation

If you took out your contract remotely:

Sale of your insurance contract by telephone, by mail, or over the Internet is governed by Articles L. 112-2-1 and R. 112-4 of the French Insurance Code (*Code des Assurances*).

The following constitute remote insurance operations as defined by Article L.112-2-1 of the French Insurance Code: providing insurance operations to a subscriber who is a natural person, and who is acting outside any commercial or business activity, in the context of a remote system of sale or of provision of services that is organised by the insurer or the insurance intermediary who, for the contract in question, exclusively uses remote communications techniques up to and including the signing of the contract.

It is specified that the applicable rules for remote sales apply:

- only to the first contract, for fixed-term contracts followed by successive distinct operations or by a series of distinct operations that are of the same type and that are staggered over time;
- only with a view to and during signing of the initial contract for contracts that are renewable by tacit renewal.

Pursuant to the applicable provisions for remote sales of financial services, you are informed as follows:

- that a fund exists for covering victims of terrorism and of other offences (fonds de garantie des victimes des actes de terrorisme et d'autres infractions) as indicated in Article L. 422-1 of the French Insurance Code;
- that a fund exists for covering damage, injury, or loss consequent upon prevention, diagnosis, or treatment provided by healthcare professionals practicing in private practices (fonds de garantie des dommages consécutifs à des actes de prévention, de diagnostic ou de soins dispensés par les professionnels de santé exerçant à titre libéral) as indicated in Article L 426-1 of the French Insurance Code;
- that a national compensation bureau exists in France known as the Office national d'indemnisation des accidents médicaux, des affections iatrogènes et des infections nosocomiales (ONIAM) for paying compensation for medical accidents, iatrogenic diseases or disorders, and nosocomial (hospital-acquired) infections as indicated in Article L 1142-22 of the French Public Health Code (Code de la Santé Publique);
- that you have a right to cancel throughout a cooling-off period of 14 full calendar days starting either as from the date of remotely signing/entering into the contract, or as from the date of reception of the "Specific Provisions" ("Dispositions Particulières") and of the "General Provisions" ("Dispositions Générales") if that date is later than the date of signing, without having to give any reason or having to bear any penalties;
- that the contracts to which the right of cancellation applies may not start being performed by the parties before the end of the cooling-off period without the consent of the policyholder. You have manifested your will for your contract to take effect on the date appearing in the "Specific Provisions". A subscriber who has asked for the contract to start being performed before the expiry of the cooling-off period and who makes use of their right of cancellation, should pay for the fraction of premium or of subscription that corresponds to the period for which the risk has been covered; in addition, the Terror Attack (Attentats) contribution to the fund for covering terrorism victims (Fonds de garanties des victimes des actes de terrorisme) remains payable.

A subscriber who wishes to exercise their right of cancellation under the above-mentioned conditions, may use the letter template given below, as duly filled in by the subscriber.

The letter should be sent by registered letter with return-receipt requested (*lettre recommandée avec avis de réception*) to ACS, 153, rue de l'Université, 75007, Paris, FRANCE.

Letter of Cancellation Template:

"I the undersigned, M.....residing athereby cancel my Contract No. taken out with, pursuant to Article L 112-2-1 of the French Insurance Code (Code des Assurances). I hereby certify that, at the date of sending of this letter, I have no knowledge of any loss that might involve the cover of the contract being applied."

By way of derogation, this right of cancellation does not apply:

- to travel or baggage insurance policies or to similar policies that are short-term or that have terms less than one month;
- to civil liability insurance contracts for Land Motor Vehicles;
- to contracts performed fully by the two parties at the express request of the policyholder before the policyholder exercises their right of cancellation.

In case of canvass selling:

The Insured Person has a right of withdrawal, according to Article L 112-9 of the French Insurance Code, which states: "Any individual who was canvassed at his/her home, residence or workplace, even on his/her request, and who signed, in this context, an application form or a contract for purposes which are outside his/her trade, business or profession, has the possibility to cancel this one by registered letter with request of acknowledgement of receipt within 14 calendar days from the date of conclusion of the contract, without having to give reasons for doing so or to pay fees.(...) In case s/he is aware of the existence of a claim in relation to this contract, the Insured Person is not entitled to this right anymore".

The Insured, who wishes to exercise his right of withdrawal under the aforementioned conditions, must send a letter by registered mail with acknowledgement of receipt to ACS, 153 rue de l'Université, 75007, Paris, France according to the

same procedure than the right of withdrawal in case of distance contract and according to Article L.112-9 of the French Insurance Code indicated above.

Effective date of right of withdrawal (in case of distance contract and doorstep selling):

In such case, the Insurer, through ACS, shall repay him/her in full the sum he/she has paid within 30 days from the date of receipt of his/her registered letter.

Membership is deemed never to have existed and the benefits do not apply, upon receipt by the Insurer through ACS of the registered letter with acknowledgment of receipt. Beyond the period of thirty (30) days, the amount due is producing interest at the legal rate.

12/ Mediation

The Insured's usual contacts are able to study in depth all his/her requests and complaints. If, after this review, the answers do not meet the Insured's expectations, he/she can submit his/her claim to:

**ACS, Complaints Department,
153, rue de l'Université, 75007 Paris, France
Email : contact@acs-ami.com**

For admission to insurance, settlement of premiums, claims.

Receipt of the complaint will be acknowledged within 10 days of its date of reception, unless the answer itself is given to you within this time-frame. In any case, in accordance with applicable legislation, an answer will be given to you within 2 months following the receipt of the complaint.

If the disagreement remains, the Insured can submit his/her claim to:

For health benefits:

**MGEN International Benefits – Service Relations Clientèle,
3/5/7 Square Max-Hymans 75748 Paris cedex 15, France
Email : client@mgen-ib.com.**

For repatriation / liability insurance :

**Allianz – Relations Clients
Case Courrier BS
20, place de Seine
92086 Paris La Défense Cedex, France
Email : clients@allianz.fr**

Allianz and MFPrévoyance adhere to the Mediation Charter of the Fédération Française de l'Assurance (French Federation of Insurance).

In the event of persistent and final disagreement, you have the option, after exhausting the internal processing channels indicated above, of referring the matter to the Independent Mediator, whose postal contact details are as follows: La Médiation de l'Assurance, TSA 50110 – 75441 PARIS CEDEX 09, without prejudice to the other channels for legal action.

The Ombudsman's opinion is not binding on the parties, who retain the right to apply to the competent court. The Ombudsman is not entitled to decide on the conditions for admission to insurance.

The parties declare that they submit to French law.

AUTHORITY IN CHARGE OF OVERSEEING INSURANCE COMPANIES

L’Autorité de Contrôle Prudentiel et de Résolution (ACPR) (the Prudential Oversight and Resolution Authority) 61, rue Taitbout -75436 Paris Cedex 09, France.

13/ Provisions of the Commission Nationale de l’Informatique et des Libertés – CNIL (French Data Protection Commission)

We inform you that the information collected is processed for the purposes of handling the present application and for commercial relations. Some of this processing may be performed by service providers inside or outside Europe. Unless you object, your data may also be used by us, for prospecting purposes for the insurance products that we distribute. Pursuant to the French data protection law (“loi informatique et libertés”) of 6 January 1978, as amended by the law of 6 August 2004, you are entitled to access, amend, rectify, delete and object to the data concerning you by sending a written request to your broker.

For health benefits: the subscriber may send a letter to MFPrévoyance – Correspondant CNIL, 62, rue Jeanne d’Arc - 75013 PARIS.

For assistance - repatriation and liability insurance: the subscriber has a right to access, to correct and to object information by sending an email to relationsconsommateurs@allianz.fr or by sending a letter to Allianz IARD - Service des relations avec les consommateurs – Immeuble Elysées La Défense - 7 place du Dôme – TSA 21017 – 92099 La Défense Cedex, FRANCE - e-mail : relationsconsommateurs@allianz.fr.

Under our contract for controlling risks and combating fraud, we reserve the right to make any verifications of the information, and, if necessary, to refer the matter to the competent Authorities pursuant to the applicable regulations.

CONSUMERS' RIGHT TO OBJECT TO TELEPHONE MARKETING

If you do not wish to be contacted for the purposes of telephone marketing, you can have yourself added to a telephone marketing opt-out list, free of charge. These provisions apply to any consumer, i.e. any natural person acting for purposes unrelated to their commercial, industrial, craft or self-employed activities.

QUESTION ON THE AGREEMENT

For any questions on this agreement, contact:

ACS
153, rue de l’Université – 75007 Paris - France
Tél. 00 33 (0) 1 40 47 91 00
Fax. 00 33 (0) 1 40 47 61 90
e-mail : contact@acs-ami.com

For claims/refunds, for repayment requests, contact:

M.A.I.
37, rue Anatole France – 92300 Levallois-Perret – France
Tél. 00 33 (0) 1 84 79 08 80
Fax. 00 33 (0) 1 77 68 01 68
e-mail : acs@medical-administrators.com
hospil@medical-administrators.com

In case of difference between the French and English versions of this summary of benefits, the French version shall prevail.

14/ Tables of sums insured

"Assistance and public liability" cover, if options have been selected

What is covered	Amount covered
Repatriation assistance	
<ul style="list-style-type: none"> • Repatriation or medical transport • Transport of the body in the event of death <ul style="list-style-type: none"> - Repatriation of the body - Funeral expenses required for transportation - Repatriation of other family members • Return of the Insured to the country of expatriation after "consolidation" • Early return 	<p>Actual expenses</p> <p>Actual expenses €1500</p> <p>Ticket (one way only)</p> <p>Ticket (one way only)</p> <p>Ticket (round trip)</p>
Public liability	
<ul style="list-style-type: none"> • <i>Physical Injury, Material or Consequential Loss</i> • <i>Material and Consequential Loss only</i> 	<p>€4 500 000</p> <p>€150 000</p>
<i>Deductible per claim</i>	€150

"Health" cover

Level of cover	Essential	Comfort	Excellence
Hospitalization (with prior consent)			
Maximum limit per beneficiary per year	€250 000	€250 000	€500 000
Medical <i>Hospitalization</i>	100% of actual expenses	100% of actual expenses	100% of actual expenses
Surgical <i>Hospitalization</i>	100% of actual expenses	100% of actual expenses	100% of actual expenses
<i>Hospitalization</i> ancillary expenses	100% of actual expenses	100% of actual expenses	100% of actual expenses
Private room	100% of actual expenses limited to €50/day	100% of actual expenses limited to €50/day	100% of actual expenses limited to €100/day
Organ transplant	100% of actual expenses	100% of actual expenses	100% of actual expenses
Psychiatry	100% of actual expenses limited to €1500/year	100% of actual expenses limited to €1500/year	100% of actual expenses limited to €3000/year
Accompanying bed for <i>Hospitalization</i> of a child under 16 years	100% of actual expenses limited to €25/day	100% of actual expenses limited to €25/day	100% of actual expenses limited to €50/day
Day surgery	100% of actual expenses	100% of actual expenses	100% of actual expenses
Mandatory preoperative consultations (surgeon and anesthetist)	100% of actual expenses	100% of actual expenses	100% of actual expenses
Outpatient care following <i>Hospitalization</i> (90 days following <i>Hospitalization</i>)	100% of actual expenses limited to €1000/year	100% of actual expenses limited to €1000/year	100% of actual expenses limited to €1000/year
Home nursing	100% of actual expenses limited to €1000/year	100% of actual expenses limited to €1000/year	100% of actual expenses limited to €2000/year
Cancer Treatment	100% of actual expenses	100% of actual expenses	100% of actual expenses
Physical therapy immediately following <i>Hospitalization</i>	100% of actual expenses limited to €1000/year	100% of actual expenses limited to €1000/year	100% of actual expenses limited to €2000/year
Local <i>Emergency</i> transport by ambulance	100% of actual expenses	100% of actual expenses	100% of actual expenses
<i>Emergency</i> dental plastic surgery following an <i>Accident</i>	100% of actual expenses	100% of actual expenses	100% of actual expenses
Out of zone coverage (trip of up to 7 weeks) : <i>Hospitalization</i> resulting from an <i>Emergency</i>	100% of actual expenses	100% of actual expenses	100% of actual expenses
Routine medical expenses			
Generalist and specialist fees	Not covered	80% of actual expenses limited to €50 per visit	90% of actual expenses limited to €100 per visit
Analyses, radiology, scans		80% of actual expenses	90% of actual expenses
MRI (with prior consent)		80% of actual expenses	90% of actual expenses
Prescribed medication and vaccines		80% of actual expenses	90% of actual expenses
Prescribed <i>Medical Auxiliaries</i>		80% of actual expenses	90% of actual expenses
Physiotherapy, chiropractor, osteopath, homeopath and acupuncturist (with prior consent)		80% of actual expenses limited to €50 per session and €500/year	90% of actual expenses limited to €50 per session and €1000/year
Prescribed speech therapy and orthoptics (with prior consent)		80% of actual expenses limited to €50 per session and €500/year	90% of actual expenses limited to €50 per session and €1000/year
Prescribed <i>Medical Protheses</i> (with prior consent)		80% of actual expenses limited to €1000/year	90% of actual expenses limited to €2000/year
<i>Spa Treatments</i> (with prior consent)		Not covered	Not covered
Optical			
Prescribed spectacle lenses, frames and contact lenses	Not covered	80% of actual expenses limited to €150/year	90% of actual expenses limited to €300/year
Dental			
Maximum limit per beneficiary for 12 months of membership	Not covered	€ 1 000	€ 2 000
Dental care		80% of actual expenses	90% of actual expenses
Orthodontics (child under 16 and with prior consent)		Not covered	90% of actual expenses limited to €500/year
<i>Dental Protheses</i> , including inlays, onlays, implants (with prior consent)		80% of actual expenses limited to €150/tooth	90% of actual expenses limited to €300/tooth
Maternity (with prior consent)			
<i>Childbirth Expenses</i>	Not covered	100% of actual expenses limited to €2000/year	100% of actual expenses limited to €4000/year
Health check			
Complete health check cover	Not covered	Not covered	100% of actual expenses limited to €300 one every three years