Policy Wording

Plan Argent 100

under

Master Contract Number:7193EHC/PBAT18

Plan Argent 150

under

Master Contract Number:7194EHC/PBAT18

This is to certify that in accordance with the authorisation granted by the Insurers and in consideration of the payment of premium specified herein or hereon, the Insurers agree to provide cover as set out in this Policy.The Policy gives full details of the cover provided, which is described in this Policy Wording issued to Exclusive Healthcare.

On receipt of the Policy, PLEASE READ IT AND KEEP IT IN A SAFE PLACE. If it is found that this Policy does not meet the Insured Person's needs, please return it within 14 days by registered mail and, provided there are no claims, the Insurers will refund the premium.

The policy is taken out with Identités Mutuelle (hereinafter the "Mutual"), a mutual society governed by Book II of the French Mutuality Code, Registered number (SIREN) 379 655 541, whose registered office is at 24, boulevard de Courcelles, 75017 PARIS,through the mediation of Exclusive Healthcare. The membership application form and the table of benefits are part of the policy.

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SIGNED

CHARLES M. WILSON
PRESIDENT DIRECTEUR GENERAL
On behalf of The Insurers

EXCLUSIVE HEALTHCARE SA
Bat A, La Tour Vadon
15 rue Henri Vadon,
83700 St Raphaêl

Registered with ORIAS under the number 07 029 474

Objectives of cover:

Cover is designed to provide the Member and designated dependent beneficiaries with benefits, as per the terms, conditions and limits set out in the policy, relating to medical and maternity expenses incurred by him/her.

General provisions and definitions:

Member: The person who has joined the Mutual by signing the membership form, which entails acceptance of the provisions of the society's Articles, Rules of Procedure and the rights and obligations of the Mutual Society Regulations. This is the person who receives payment of the benefits and has, prior to this, received a copy of the Regulations.

Membership year:

The period of one year between two cover inception anniversary dates.

Renewal date

1 January of each year provided membership is still current.

Acceptance conditions

This policy is open only to persons who are members of one of the obligatory French social security (SS) health insurance schemes ("*régime obligatoire*").

Geographical limits

Cover is valid in metropolitan France, the DOM-TOMS and member States of the European Union, only in conjunction with the CEAM (Carte Européenne d'Assurance Maladie).

Beneficiaries

The member, his/her spouse and their children - as set out in the membership application - and who are entitled to cash benefits from one of the obligatory French SS health insurance schemes, provided they are named in the membership application form.

Third parties

A natural or legal person, not insured by membership of this insurance policy and who is a separate party vis a vis the beneficiary.

Limitation period

All actions arising from this policy are time-barred 2 years from the date of the event that gives rise to those actions.
The limitation period may be interrupted by one of the ordinary causes of interruption, and in particular by the sending of a registered letter with return receipt by the insurer concerning payment of the premium or by the insured or beneficiary to the Mutual concerning payment of a benefit.

Definition of the terms used in describing cover

Accident

Any bodily harm that is not intentional on the part of the beneficiary, arising out of the sudden action of an external cause.

Basis for reimbursement

The tariff serving as the basis for calculation of the reimbursement due under obligatory health insurance. The following terms are used:
***Tarif de convention* (TC)** (**regulated tariff** or standard scale of charges) when treatment is delivered by a health practitioner operating within the obligatory health insurance Agreement (*Convention*). This is a scale of charges set out in an agreement between obligatory health insurance and representatives of the profession.

***Tarif de responsabilité* (TR)** (**responsible tariff**) for medicines, devices and other medical supplies.
Synonyms: *tarif de responsabilité* (TR), *tarif de convention (TC), tarif d'autorité (TA), tarif de référence (*reference tariff*), base de remboursement de la Sécurité sociale (BRSS) (*basis for reimbursement by social security/obligatory health insurance*).*

Social security co-payment amount (*ticket modérateur*)

That part of the Basis for reimbursement or the Authorised tariff (TA) that remains to be paid by the beneficiary after operation of obligatory health insurance (*régime obligatoire*).

Hospitalisation

A stay in a public or private healthcare establishment as a patient, prescribed by a doctor for a minimum of 24 hours duration, provided such stay is for observation, medical or surgical treatment
of an illness, injuries resulting from an accident or maternity.
Home hospitalisation or day hospitalisation are deemed to be routine medical care.

Illness

Any deterioration in health diagnosed by a competent medical authority.

Obligatory health insurance (*Régime obligatoire*)

The French obligatory health insurance scheme of which the Beneficiary is a member as stated in the Membership certificate (general, miners' or local Social security regime, student regime or regime for the self-employed).

Benefit limits

Reimbursements or flat benefits under the policy may be capped per person, per family or per calendar or membership year, depending on the level of cover chosen. These are set out in the Table of benefits and are subject to deduction of any benefits that may have been paid by any other organisation. The aggregate of the various reimbursements obtained by a beneficiary may not exceed the actual expense incurred.

Waiting period: the period running from the policy inception date until such time as cover begins. During this time, cover confers no right to any benefits. The waiting periods are set out in the membership application form.

CHAPTER I BENEFICIARIES

Article 1: Acceptance

Applications for membership must be made on the standard form, fully completed, dated and signed. An application for membership of the Mutual should be accompanied by:

- a copy of the applicant's social security certificate (*attestation vitale*) or healthcare green card for the miners' regime and for all the beneficiaries to be covered with the member. If the applicant's spouse is insured under a different social security regime then he/she should fill out a separate application.

- a direct debit authorisation for a bank or post office account together with a bank or postal account identification slip (RIB or RIP).

The policy comes into effect on the date chosen by the member but at the earliest in the evening (at midnight) of the day the policy is taken out, provided the first contribution (premium) has been collected. It terminates on 31 December of that year and then continues on a tacit renewal basis on 1 January of each calendar year thereafter except if membership is resigned or the policy cancelled.

Article 2: Termination - Cancellation

2-1 Right of cancellation - distance selling

Under the provisions of articles L221-18 and R221-1 of the Mutuality Code relating to distance selling, the cooling-off period for private individuals taking out insurance is 14 full calendar days. Under article L121-20-11 of the Consumer Code, this period runs from the day membership incepts or the day when the consumer receives the terms, conditions and details of membership if this is received after inception date.
The insured should send a registered letter with return receipt within the above-mentioned 14 days. Cancellation results in a refund of all premiums paid. The insured undertakes to return all "*tiers payant*" (payment by third party) cards issued to him/her. The refund is sent

by the Mutual within a maximum of 30 calendar days following receipt of the registered letter. On expiry of that period the amount attracts interest at the legal rate.
Here is an example of a cancellation letter:
Dear Sir or Madam,
Please consider this letter as a formal request to cancel my health insurance policy no. XXXXX, which I signed on (date)____________.
I am also requesting return, by application of article L221-18, of the premiums I paid on taking out the policy, within a maximum of 30 calendar days of your receiving my registered letter.
Made in ....
On ....
Signature

2-2 Resignation - termination

Notwithstanding the provisions of the CHATEL Act, resignation from the Mutual may only take effect on 31 December of each calendar year.

Notice of resignation must be sent by registered letter with return receipt at least 2 months before renewal date.

Failing this, membership will be renewed for a further period of one year and the relevant contributions (premiums) shall be due in their entirety, regardless of any instalment arrangements in place.

Resignation must be sent by registered letter with return receipt.

In compliance with the Chatel Act, the final date for the member to exercise the right to resign membership is set out in the annual renewal notice. The member then has 20 days from the date the notice is sent (as proven by the postmark) to cancel tacit renewal of the policy.

In that case, cancellation takes effect on the day after the date appearing on the postmark.

Cover ceases for dependent persons just as soon as they no longer fulfil the conditions of article 1 above.

A member who leaves the Mutual for any reason whatsoever should return any membership cards in his/her possession.

On an exceptional basis, a member who produces evidence of moving away abroad and is no longer a member of a French social security regime may cancel without waiting for renewal date and without giving 2 months notice.
Cancellation takes effect on the date the "*tiers payant*" card is returned to the Mutual.

Article 3: Information to members

The Mutual shall provide each member with a copy of the society's Articles, a copy of the Rules of Procedure and the Mutual Society Regulations and a "*tiers payant*" ("payment by third party") card. This is also the membership card.
This card sets out the names of the persons entitled to benefits from the Mutual and the option chosen by the member.

Article 4: Data protection and individual liberties

The personal data that you have supplied to us (by post, telephone, email or other means) is absolutely necessary for electronic data processing in connection with issuing and managing your policy. Such data may be used for canvassing purposes, unless you refuse permission.
It may also be subject to special processing and declaration to the competent authorities under current laws and regulations in particular those relating to combating money laundering and the financing of terrorism, or fraud.
It may also be used by our outside contractors, reinsurers, partners and trade bodies.
You may at any time exercise your right to oppose, have access to, correct or delete your personal data by applying to Identités Mutuelle, who are responsible for data processing, at 24 boulevard de Courcelles, 75017 Paris. Proof of identity is required when making such requests.

CHAPTER II CONTRIBUTIONS

Article 5: Contributions (premiums)

The amount of contributions is decided by the society's General Meeting or else by the Board of Directors by virtue of the authority granted to it by article 25 of the Articles.

It may vary depending on the regime, family composition and age of each beneficiary and the region in which he/she lives.

If the amount of the contribution changes as a result of the age reached during the insurance year then the change of age shall apply on 1 January of that year. Age is determined by subtracting the year of birth from the insurance year. Contributions may be calculated year by year or for five year periods. This information is set out in the description of cover or in the quote supplied to the insured.

Contributions are payable by direct debit on a French bank account, by French cheque or by an authorised bank/credit card.

Article 6: Premium payment

Contributions are payable in advance on the basis chosen by the member (monthly or annually).

Members must be up-to-date with their premiums in order to receive benefits.

Article 7: Premium payment reminders

If any premium is not paid with 10 days of its due date then Exclusive Healthcare will address a final demand by registered letter with return receipt indicating to the Member that failure to pay within 40 days from the date of sending the final demand will result in termination of the policy. All cover will then cease.

The cost of collecting unpaid contributions will be claimed from the member.

Article 8: Premium adjustments

The amount of contributions may be altered by decision of the Board of Directors, by virtue of the authority granted to it by the General Meeting, as a result of trends in the population insured, changes in the regulations or criteria used by social security and the technical results of the schemes.

Article 9: Changing options

At the time of making the application, the member should choose one single cover option to apply to him or herself and to any dependent beneficiaries.

CHAPTER III HOW MEDICAL EXPENSES COVER OPERATES

Article 10: Objectives and amount

Cover is designed to provide the member and designated beneficiaries with benefits relating to medical and maternity expenses incurred by him/her. Cover may be extended to expenses incurred by the member's family.

For cover to operate for alternative healthcare, the practitioner concerned must be officially registered as a doctor or physiotherapist and hold the diplomas and certificates necessary for the exercise of those professions as laid down by current legislation and especially article 75 of the law of 4 March 2002.

This "medical expenses" cover complies with the provisions relating to responsible insurance policies set out in articles L871-1, R871-1 and R871-2 of the Social Security Code in terms of the obligatory extent of cover and allowable exclusions.

Article 11: Beneficiaries

Cover usually extends to the member for him/herself, the spouse and any dependent children within the definition contained in the Articles and the application form.

Article 12: Benefits

The benefits payable by the Mutual are calculated, item by item, on the basis of the expenses actually reimbursed by social security and which have been incurred for illnesses, accidents or maternity subsequent to the member joining the scheme and during the duration of his/her membership.

The rates and basis for reimbursement used for calculations are those applicable on the date the treatment is dispensed. For prostheses and optical expenses, the agreement to pay benefits is based on the date of the prescription.

The amount of any reimbursements due may not exceed the amount of the expenses actually incurred after deduction of benefits paid by social security, or any mutual society or social insurance provider of any kind or, where applicable, any liable third party.

For all benefit items, the Mutual must provide cover for the SS co-payment amount (*ticket modérateur*) relating to all items of treatment reimbursable by the obligatory health insurance scheme (except for thermal cures, medicines reimbursed at 15%, those reimbursed at 30% and homeopathic remedies), the co-payment amount relating to all reimbursable items of prevention as well as any flat co-payment amount (*ticket modérateur forfaitaire*).

No waiting period shall apply to providing cover for the co-payment (ticket modérateur) on items that are reimbursable by SS.
A waiting period may however apply to benefits relating to covering any authorised fee overrun (*dépassement*), such as for optical or dentistry items.

The daily hospital charge (*forfait journalier*) is covered for an unlimited duration.

The minimum and maximum coverage for fee overruns (*dépassement*), if covered, are set out in the table of benefits.

If the policy provides cover for fee overruns by doctors then the conditions for such cover and the level of benefits depends on whether the doctor has joined the CAS (*contrat d'accès aux soins*) 'contract for medical treatment' scheme.

If the policy provides cover for fee overruns on optical items then the minima and maxima (including *ticker modérateur* co-payment) will vary depending on the material in question. Cover for fee overruns on optical items is limited to a certain time frequency, details of which are set out in the table of benefits.

The table of benefits provides details of cover, if applicable, for items not reimbursable by obligatory health insurance and items not included in the official classification of medical treatments; thermal cures and medicines reimbursed at 15% or 30% (including homeopathic items).

Benefit amounts may be revised to take account of changes in the rules and criteria used by social security.

Article 13: Payment of benefits

The processing of claims for reimbursement or compensation submitted to Exclusive Healthcare is carried out by:
ASCORE Gestion, 30 rue Victor Hugo, 92532 Levallois-Perret, Cedex (France) Tel: **01 41 05 36 00** Fax: 01 47 30 11 52

All requests for payment of benefits must be made before expiry of the limitation period of 2 years from the date of treatment and should be accompanied by the following documentary evidence:

- The original statement of reimbursements issued by the obligatory health insurance scheme ("*régime obligatoire*") or, where applicable, a document showing why the obligatory scheme has refused to reimburse.
- An attestation as to the actual expenses incurred, signed by the practitioner or establishment concerned, giving exact details of the treatment if higher fees have been charged (fee overrun or *dépassement*) or in the event of hospitalisation,
- the statement of benefits paid by any other complementary health insurer and which are taken into account before calculating benefits payable by the Mutual.
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Further documentation may be requested, depending on the treatment.

Benefits are payable directly to the member on behalf of all beneficiaries. Payment is made by bank transfer to a French bank or postal current or savings account.

Payment may also be carried out by any other organisation, with whom the Mutual has entered into a claims processing agreement for some of its members.

The issue of statements of benefit payments for an amount lower than the amount fixed by the Board of Directors may be deferred until the total of all benefits payable under one or more claims reaches that amount.
In the event of a legal decision, benefits are paid to the person or organisation having the custody of a child or guardianship of an adult lacking legal capacity.

Article 14: More than one policy

If the member has taken out several insurances with one or more complementary insurance providers then the Mutual provides cover for those expenses remaining for the member's account after operation of obligatory health insurance and any other complementary health insurance providers up to the balance of expenses remaining for member's account.

Article 15: Complaints:

Any complaints should be addressed to Exclusive Healthcare SA,
Bat A, La Tour Vadon
15 rue Henri Vadon, 83700 St Raphaël, France.
After exhausting all internal complaint procedures, and without prejudice to the right to go to law, the member and any designated beneficiary, may, in order to find an amicable solution to the dispute with the Mutual, contact the mutual society's ombudsman by addressing a letter to the Médiateur de la Mutuelle, 24 boulevard Courcelles, 75017 Paris.

Article 16: Third party payment system known as NOEMIE

If a healthcare establishment or practitioner has joined the system, the Mutual will pay directly to them those expenses that would have been reimbursed to the member once incurred.
If an electronic data transfer agreement has been signed with a social security institution for reimbursement of expenses then the Mutual will automatically pay the member
but could ask to see an original of the social security statement of reimbursements later on for checking purposes.

Article 17: Subrogation

If the member is the victim of an accident, the Mutual is subrogated, as of right, to the remedies open to the member against the liable third party whether such liability is total or shared. Subrogation is exercised up to the amount of expenditure incurred by the Mutual in the same proportion as the compensation due by the third party for **the injuries to the victim .**

Subrogation does not apply to personal elements of such compensation, related to the physical or mental suffering endured by the victim or disfigurement or denial of enjoyment, unless the benefit paid by the Mutual includes such elements.

By the same token, in the event of accident followed by death, the share of compensation relating to pain and suffering is due to the beneficiaries under the same conditions.

In the event that the Mutual has obtained from a benefits agency - or any other organisation that manages the obligatory social security share of health coverage - approval to receive payments or authorisation to act as the mutual correspondent then the Mutual is subrogated to its members for the receipt of social security benefits.

Article 18: Supervisory authority

The Mutual comes under the supervision of the ACPR: ACPR (French Prudential Supervisory Authority), 61 rue Taitbout – 75436 PARIS Cedex 09