Your International Healthcare Partner

International Private Health Insurance

GENERAL CONDITIONS FOR INDIVIDUALS

Welcome,

and thank you for choosing MediSky Healthcare Plan, the International Healthcare Insurance Programme.

This plan is created for individuals.

MediSky International journey to cover your health insurance needs

Dear Insured Person,

Please check your certificate of insurance and make sure that all details are correct.

If any changes need to be made, please let Us know immediately.

Please take a few moments and familiarise yourself with your Policy and make sure that you are fully aware of the following issues:

- The coverage (both benefits and limitations),
- How the Policy is administered,
- How to use the policy, including receiving treatment and submitting claims.

Your policy has been written using plain language wherever possible and has been designed to set out all of the features and benefits of the International Healthcare Insurance Plan in a straightforward and easy to understand format. You will find a glossary of terms at the end of these General Conditions.

Membership Pack is formed of the following documents:

- Membership Guide (General Conditions) – current document including all policy details,
- Membership certificate (Specific Conditions) – confirming adhesion to the MediSky Healthcare Plan, showing the details of your coverage under MediSky Healthcare programme

Please note that there are specific conditions and exclusions which apply to specific sections of the General Terms and Conditions and there are general conditions and exclusions which apply to the General Terms and Conditions as a whole. Your Membership Certificate is your evidence that you have been accepted for cover on the conditions mentioned herein. Please read these documents fully and carefully to familiarise yourself with the details of your selected Programme, and what is and is not covered for each Insured Person. Any benefit not included in the selected programme cannot be paid.

***We will provide the services and benefits in accordance with the selected Programme during the Period of Insurance within the Area of Coverage**, subject to the Limits indicated in Table of Benefits and all other terms, conditions and exclusions provided by the present General Terms and Conditions, and following payment of the appropriate premium for the level of cover in the frame of selected Programme.*

The Policy concluded on the basis of MediSky Healthcare Plan is subject to Polish law.

General conditions are listed below providing all the information you will need, from receiving treatment to having any health care expenses settled. MGEN has appointed MediSky International to act as the provider of certain Third-party administration services in Europe. *If there is any aspect of the Healthcare Plan for individuals that you are unsure about, please let Us know.*

MediSky International sp. z o.o., ul. Trębacka 4, 00-074 Warsaw, Poland

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CHAPTER 1 – Contract objectives

Your MediSky International Plan is a Healthcare Plan underwritten by VYV International Benefits on behalf of MGEN, French mutual insurance companies acting under the freedom of services (see more details on MGEN in "Definitions"). The Policy is subject to Polish law.

This document is designed for individual Insured persons covering local nationals and expatriates and their eligible Dependants residing in Poland/ Romania/ Hungary/ Bulgaria. The subject matter of insurance is provisioning and covering costs of benefits defined in the present General Terms and Conditions rendered to the Insured Person in case of occurring an Insured Event.

General Terms and Conditions describe all benefits which are available in the frame of the 5 plans, but the cover which will be provided to the Insured Person or Policyholder will be in accordance with the selected programme as shown in the Membership Certificate issued to the Insured Person and the Table of Benefits. Any benefit which is not provided by a selected programme cannot be granted.

Your insurance plan can be at five chosen levels:

1. **YELLOW Plan =** € 500 000
2. **SUNRISE Plan** = € 1 200 000
3. **HONEY Plan** = € 1 500 000
4. **MARIGOLD Plan** = € 1 750 000
5. **SAFFRON Plan** = € 2 000 000

CHAPTER 2 – Benefits and services

1. Covered persons

The covered persons may be:

- Either:

1.1 The Insured Person

The Insured Person alone.

Newly insured applicants are eligible to be included for cover under this policy provided they are **under age 69 at their date of acceptance**, subject to completion of the appropriate individual application form.

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- Or:

1.2 The Insured Person (policy holder) and the Dependants appointed hereinafter:

- Legal Spouse or the Civil union partner of the opposite sex (PACS or equivalent civil union);
- Child, step-child or legally adopted child if he/she is under age 18,

Only one Spouse or one Civil union partner shall be considered as a beneficiary.

At the date of enrolment, the Policy Holder and the Dependants acquire the status of Insured Persons as soon as they are enrolled in Insurance. The coverage shall be terminated for the Dependants as soon as they no longer fulfil the afore-defined conditions and, in any case, at the same date as termination of the policy for the Policy Holder.

Our liability for any Claim from an Insured Person will cease immediately on the date of their lapsing of the Policy or when the Policy concluded for him will be terminated.

2. Changing the level of Plan

Subject to the Insurer's acceptance, the Policy Holder can only apply to change the level of coverage at the annual renewal date of the policy and by informing the Insurer at least two months before the renewal date. All individual family members should be insured on the same insurance plan.

3. Schedule of benefits

The benefits consist of covering medical and hospital costs incurred by the Insured person (see Chapter 7 "Definitions"). The benefits are presented in the Table of Benefits (Annex 1) according to the chosen Plan.

Medical care to be covered must be recognized by the local medical authorities and provided by authorized practitioners (in compliance with the laws, regulations or others relating to the practice of this profession in the country concerned).

Every time, Our benefits will be limited to the costs that are reasonable and customary accepted. In case of all and any benefits in "Schedule of benefits", the insurance protection covers exclusively benefits Medically Necessary.

The medical costs must have been incurred in the Area of Coverage within the insurance period (see Chapter 7 – Definitions).

The medical and hospital services are covered as below:

3.1 Medical services and hospital services

3.1.1 Ambulance services

We will arrange and pay for the Insured Person's transport to the nearest suitable Hospital within the Limits stated for this service in Table of Benefits, using the most appropriate means available, comprising road / off-road ambulance, train, helicopter or fixed-wing aircraft, with a medical escort if Medically Necessary.

3.1.2 Hospitalisation costs

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We will arrange and pay for the Medically Necessary Insured Person's Inpatient or Day-care admission to the Hospital and for the following Medical Expenses and services if it is Medically Necessary and only in the extent justified by Medically Necessary reasons:

- Accommodation in a single-bedded room, meals, all Hospital medical facilities;
- Diagnostic procedures (including CT, MRI and PET scans), medical Treatment and services recommended by a Physician for Inpatient or Day-care admission including Physician's charges, surgical appliances and prostheses, Physiotherapy and Prescription Drugs;
- Oncology and Cancer Treatment costs;
- Surgical fees including Surgeon and Anaesthetist's charges;
- Intensive care unit accommodation;
- Medicines, drugs and dressings;
- If the Insured Person is a child aged under 16 who requires Hospitalisation, this benefit includes necessary overnight accommodation for one parent in the same Hospital, or when no such accommodation is available, for necessary bed and breakfast accommodation in a nearby hotel up to EUR 50 each night
- Day-case surgery of a type formerly carried out on an Inpatient basis;
- During the three months period immediately following the Insured Person's discharge from an Inpatient admission in a Hospital, post-Hospitalisation Treatment received on an Outpatient basis provided the Insured Person remains under the control and supervision of the treating Physician or specialist consultant or such Treatment has been recommended by the Physician and for which Treatments are directly resultant from the Accident or Illness for which the Insured Person was Hospitalised.

3.1.3 Organ and tissue transplant

We will pay for Organ Transplant and Tissue Transplant as per the Limits defined in the Table of Benefits

3.1.4 In-patient Cash-benefit

We will pay an In-Patient Hospital Cash benefit when treatment is free for up to the maximum number of days specified in the Table of Benefits in any one Period of Insurance.

3.1.5 Rehabilitation

On the condition that the selected Programme includes this benefit, We will pay up to the Limit stated for this benefit in the Table of Benefits for Treatment received during a Hospital stay or in a Rehabilitation center following your discharge from Hospital after an Insured Event.

3.1.6 Nursing at home

Following a Claim for Inpatient Treatment under this Section and on discharge, We will pay up to the Programme Limit stated for this benefit in Table of Benefits for medically necessary medical services of a licensed nurse in the Insured Person's Home when prescribed by a Physician and directly related to such Treatment.

3.1.7 Outpatient care

On the condition that the selected Programme includes this benefit, We will pay up to Limit stated for this benefit in Table of Benefits for eligible Medically Necessary costs for Outpatient services, including:

- Physicians fees, Surgical Treatment, Prescribed medicines
- Oncology & Cancer Treatment
- Physiotherapy
- Laboratory, X-Ray fees, diagnostic tests
- -

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Emergency Outpatient Treatment

3.1.8 Maternity Care

On the condition that the selected Programme includes this benefit, We will arrange and pay up to the Limits stated for this benefit in the Table of Benefits for Routine Maternity care and Complications of Maternity, when the Insured Person's expected delivery date is at least 12 months after the initial Date of Entry.

In respect of routine maternity care, We will pay up to the Policy Limits stated for this benefit in the Table of Benefits in total per each pregnancy, for the following:

- Pre-natal examinations by a Physician;
- All costs of normal childbirth.
- Post-natal examinations by a Physician
- Home Delivery
- The limit for each newborn child applies for the first 14 days after birth (subject still to the Insured Person's expected delivery date being at least 12 months after the initial Date of Entry) without any notification.

3.1.9 Routine Health Check and Vaccinations

On the condition that the selected Programme includes this benefit, We will pay up to the Limits stated for this benefit in Table of Benefits for one annual health check of the Insured Person consisting of costs of examination of the Insured Person (having regard to their age) to ascertain the potential presence of Illness or disease; these may include, (but are not limited to):

- GP and Specialists consultations
- Vital signs, including blood pressure, cholesterol, pulse, respiration, temperature;
- Cardiovascular and neurological system examinations;
- Breast/ Ovarian/ Colon/ Prostate cancers screening;
- Well Child examination;
- Vaccinations except travel vaccines.

3.2 Medical transfer benefits

3.2.1 Emergency medical transfer, evacuation and repatriation

If during the Period of Insurance an Insured Event occurs either inside or outside the Country of Residence and which, requires the Insured Person's Emergency Medical Transfer or Evacuation:

- We will arrange and pay all necessary costs for the Insured Person's medical transportation to the nearest suitable and appropriate Hospital, which may be in a country other than the one where the Insured Event occurs.
- If the Insured Person has been Hospitalised as the result of the Insured Event, We may arrange for the Insured Person's medical transfer to a Hospital which is more suitably equipped or more suitably specialized to treat his / her condition.
- If the Insured Person's best interests will be served by arranging for Emergency Medical Transfer or Evacuation to a country outside the Geographical Area then We will meet all subsequent medical costs of Medically Necessary Treatment.
- The most appropriate means of transport available locally will be used. If by air We will employ a regular scheduled or charter airline, or, if Medical, a specially chartered air ambulance. If the Insured Person had been traveling by plane, transport will be in the same class as the original airline ticket (unless medical needs prescribe otherwise), but if they were not, transport will be by the airline's economy / tourist class (unless medical needs prescribe otherwise).
- When it is Medically Necessary, We will arrange and pay for a medical escort to accompany the Insured Person.

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- We will arrange and pay the reasonable travel costs of one other person to accompany the Insured Person during transportation, being a relative or friend travelling with the Insured Person at the time of the Insured Event; in addition, We will pay for that person's overnight accommodation to stay near by the Insured Person while the Insured Person is Hospitalised, up to EUR 50 each night for a maximum of 10 nights.
- Once the Insured Person fits to travel after the transfer (and not later than three days after), We will arrange and pay all necessary costs for the Insured Person to return to their Place of Residence (or to a suitable Hospital nearby) by the same mode and class of travel as above.

We will also arrange and pay the reasonable travel costs of the travelling companion to return to their nearest Place of Residence.

Contact details are mentioned in Chapter 5.

SPECIFIC CONDITIONS APPLYING TO SECTION 3.2.1

- **Our decision is final and We are entitled to refuse any request which is incompatible with the insured person's medical condition and safety,**
- **We will set up the medical team and resources to be used as and when appropriate, to ensure the insured person's safety during the emergency medical transfer or evacuation,**
- **If the insured person rejects the assistance procedures, We propose then We shall be released from Our obligations under this section.**

3.3 Benefits following death

3.3.1 REPATRIATION OF REMAINS

On the condition that the selected Programme includes this benefit, We will pay for:
- Preparation and repatriation (by air) of the mortal remains of the Insured Person from the country where death occurs to the place of the funeral in the Home Country or in the Country of Residence. We will make all necessary arrangements as required under international regulations and will pay up to EUR 200 towards the cost of the coffin.
- The additional travel costs of one other person (who was accompanying the deceased at the time of death) to return by first class train or economy / tourist class air travel to attend the funeral.

3.4 Dental treatment

On the condition that the selected Programme includes this benefit, Dental care (which includes Prevention, routine and major restorative, orthodontic) is covered.

Reasonable and customary charges for necessary basic dentistry are reimbursed according to the Table of Benefits and within € 1,000 maximum limit per year and per covered person.

Dental covered expenses include:
- Oral examination and required X-ray
- Prophylaxis, cleanings and preventative treatment
- Amalgam restorations
- Extractions
- Root canal therapy
- Gold fillings
- Solid inlays
- Crowns
- Bridges
- Dentures

- Dental surgery

Operations or procedures performed for cosmetic reasons are not reimbursed.

In the event of major dental care, the Insurer pays reasonable and customary charges with an annual maximum reimbursement per tooth in accordance with the Table of Benefits.

3.5 Vision benefits

On the condition that the selected Programme includes this benefit, vision benefits are covered.

Vision covered expenses include:
- One Eye examination/ eye test
- One pair of frames and one pair of eye glasses or contact lenses (corrective lenses) where prescribed by an ophthalmologist are reimbursed at up to a limit of maximum € 200 per year.
- Prescribed eyeglasses and contact lenses, frames including eye examination: a routine examination by an optometrist or ophthalmologist

Sun glasses are not covered.

3.6 Benefits in case of death

3.6.1 Lump sum in case of death from all causes

In case of death of an Insured Person due to accident or illness, a lump sum is paid to the designated beneficiary(ies) the amount of which is set out below:

1. **YELLOW Plan** = € 5 000
2. **SUNRISE Plan** = € 5 000
3. **HONEY Plan** = € 5 000
4. **MARIGOLD Plan** = € 10 000
5. **SAFFRON Plan** = € 15 000

To give entitlement to benefits, any accident likely to result in the early payment of the lump sum must be declared within 6 months from its occurrence date.

Unless particular designation of beneficiary, the covered amounts in the case of the Insured's death are attributed by order of preference:

- To the spouse, not legally separated of the married insured, or else, to the partner under a PACS or a cohabitant
- Otherwise, to the children of the insured born or unborn, equally between them, the share of the pre-deceased reverting to his own children or to his siblings if he has no children
- Otherwise, to the father and mother equally between them, the share of the pre-deceased reverting to the survivor
- Otherwise, to the heirs

The Insured can modify the above order at any time and designate any natural or legal person of his choice by sending a registered letter to Us with a request for acknowledgement of receipt.

When the beneficiary is specifically named, the Insured must indicate the contact details of the beneficiary so that We can use them in the event of death. Where the personal designation lapses, the above standard designation shall apply.

The designation of a beneficiary becomes irrevocable by the acceptance of the beneficiary. Acceptance by authentic deed or private deed signed by the Insured and the beneficiary must be notified to the Insurer to take effect.

In the case of death of an Insured and one or more designated beneficiaries, during the same event without it being possible to determine the order of death or when the beneficiary, who died before the Insured, did not have time to accept the benefit of the payment, the Insured is assumed to have survived when determining the beneficiaries of the payment.

3.6.2 Revaluation of the lump sum in case of death

In the event of the death of the Insured, the amount of the death benefits is adjusted from the date of the Insured's death until the receipt of the supporting documents necessary for the settlement of the capital and at the latest until the transfer to the Insured.

From the date of death, the lump sum in the event of death automatically generates interest, net of fees, for each calendar year, at least at a rate equal to the lower of two rates provided by French law and calculated on 1 November of the previous year.

The lump sum paid to natural persons is revalued in accordance with the French mutual insurance companies code. Sums due under a life insurance policy, which are not the subject of a request for payment, are deposited to the 'Caisse des Dépôts et Consignations' after a period of 10 years from the date on which the Insurer becomes aware of the Insured's death. 9 months prior to the transfer of the sums due to 'Caisse des Dépôts et Consignations', the Insurer shall inform the beneficiary(s), by any means, of the transfer. For 20 years from the transfer of the sums due to the 'Caisse des Dépôts et Consignations', the beneficiaries can approach the latter to claim their sums. After this period, the sums are acquired by the French State.

CHAPTER 3 - General conditions

1. Effective date, duration and renewal date of the contract

The Insured's membership is stated in the Insurance certificate, and mentions in particular:

- the Policy number,
- the effective dates (start and ending of the cover),
- the Dependants,
- the chosen *Plan* and chosen deductible,
- premiums to be paid for your cover.

After 69, at the renewal time, we will be in position to offer you a Continuation Senior healthcare plan.

The contract may also be terminated on the Insurer's initiative in the event of non-payment of the premium in accordance with the terms defined in Chapter 6 Article 1.

Cancellation rights for direct selling or distance selling

The Insurer, through MediSky, undertakes to send the main Insured Person information concerning their cancellation rights for direct selling or distance selling of the Policy.

Direct selling: The Insured Person has a right of cancellation in the case of direct sales at home or in workplace, where the latter signs in this context a proposal for insurance or a contract for purposes which do not fall within the scope of his commercial or professional activity. The Insured Person shall have fourteen (14) calendar days from the date of commencement of the contract to exercise his right to cancellation.

Distance selling: Distance selling provisions apply if the Policy is concluded via one or more distance selling techniques, particularly sold via correspondence or through the internet. A cancellation period of fourteen (14) calendar days applies in the case of distance selling from the date the Policy commences or from the date the Insured Person receives the Policy conditions and information mentioned in article L.222-6 of the French consumer code (if this is after the date the commences).

The date of commencement of the Policy corresponds to the membership 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 Person exercises his/her cancellation right.

To exercise his/her cancellation right (direct or distance selling), the Insured Person must send the Insurer, via MediSky, ul. Trębacka 4, 00-074 Warsaw, Poland, a letter by registered mail stating his/her desire to cancel his/her membership. The following template may be used:

"By this letter, I the undersigned …… (full name and address) hereby cancel my Policy which I signed on ……in ……. (place of membership) and ask for reimbursement of the payment I made, corresponding to the sum of € …. [in euros]. (Date and signature)."

On condition that you have not already made a claim and accept that you cannot make one later, the Insurer reimburses the premiums paid within thirty (30) calendar days from the date the registered mail is received. Membership is considered never to have existed and cover does not apply, from receipt by the Insurer of the cancellation letter sent via registered mail. After the period of thirty (30) days, the sum due accrues interest at the legal rate.

2. Obligations of the Insured person

The Insured person commits:

2.1 To provide the Insurer, through MediSky, with the following documents:

2.1.1 **When applying for membership**, an individual application form signed by the Insured person and stating the *Healthcare plan* selected.

Specific provision for the death benefit: the individual application form is completed with a medical questionnaire. The Insurer reserves the right to make their acceptance conditional upon production of any additional information it deems necessary.

The Insured person agrees to justify the statements given to the Insurer at any time.

IN THE EVENT OF OMISSION OR MISSTATEMENT BY THE INSURED PERSON, THE INSURER IS ENTITLED EITHER TO DECLARE THE CONTRACT NULL AND VOID, OR TO CONTINUE APPLYING IT UNDER NEW CONDITIONS THE INSURER SHALL SET.

The insurance cover shall enter into force once the agreed premium is paid and received by the Insurer.

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2.2 **The Insurer, through MediSky, commits to give to each Insured person at the time of enrolment these General Conditions and inform the Insured Persons** in writing of the modifications to be made, when appropriate, to their rights and obligations, in particular before any reduction in coverage, any change in the amount of premium or termination of the contract, in accordance with the French insurance mutual companies' code.

The Insured person shall be liable in case of non-compliance with these obligations.

3. Alterations

The conditions of this contract take into account the legislative and regulatory provisions in force on the contract's effective date. However, if these ones are amended during the contract period, the Insurer reserves the possibility to revise the contract, at the earliest from the effective date of the new provisions.

Nevertheless, the Insured person retains the possibility to request the termination of the contract without any notice period within 30 days following the proposal of the Insurer.

This termination shall take effect from the first day of the following month after the termination request. The coverage and premium conditions are maintained on the existing basis until the policy termination date.

4. Limitation period for insurance claims

The provisions relating to the limitation period on actions resulting from the Policy are governed by article L.221-11 and L.221-12 of the French mutual insurance companies' code reproduced below:

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:

4.1. In the event of concealment, omission, misrepresentation or inaccurate declaration of the risk incurred, from the date when the Insurer learned of the said risk;

4.2. 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.

The limitation shall be interrupted by usual causes of interruption to the limitation on action and the selection of appraisers following a claim. The interruption to the limitation on action may also result from the sending of a letter by registered mail with proof of receipt sent by the Insurer to the Insured Person in relation to action regarding payment of the premium and by the Insured Person to the Insurer provider in relation to settlement of compensation.

The ordinary causes for interrupting the limitation period are defined in articles 2240 to 2246 of the French civil code:

- **Recognition by the debtor of the right of the person against whom the time limitation was imposed,**
- **Legal proceedings,**
- **Measures taken to preserve rights pursuant to the French code of civil procedure or an order for enforced execution,**
- **A service of process made upon one, a joint, and several debtors or an order for enforced execution or recognition by the debtor of the right of the person against whom the time limitation was imposed,**

- **A service of process made upon the principal debtor or an acknowledgement for cases of time limitations applicable to guarantors.**

5. Subrogation

The Insurer may be subrogated to the right of the person entitled to benefits in order to exercise any recourse proceedings against any liable third party. The Insurer waives its right of recourse proceedings against the Insured Person.

6. Information - Complaint – Mediation

For any information or complaints relating to the policy which is the object of this prospectus, without prejudice to the Insured Person's right to bring legal proceedings to enforce execution of the policy in the event of a dispute, he/she may contact the usual representative at MediSky under the following circumstances:

- ✓ Information and complaints regarding the insurance admission conditions
- ✓ Information and complaints regarding payment of premiums
- ✓ Information and complaints in the event of a claim

After receiving a complaint, MediSky will send the Insured Person or his/her dependants, confirmation of receipt of the complaint within a maximum of ten (10) business days. The response will be sent to the Insured Person or his/her dependants within the following two (2) months, unless exceptional circumstances arise.

If Insured Persons are not satisfied with MediSky's response, they can send a standard letter or email to: VYV International Benefits, 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 dependants may contact the MGEN ombudsman at the following address: **MGEN - Le Médiateur - 3, square Max Hymans - 75748 Paris Cedex 15, France - email : mediation@mgen.fr**.

The Ombudsman's opinion is not binding on the parties in dispute and they retain the right to bring proceedings before the competent court. The Ombudsman is not authorised to give an opinion on insurance admissibility conditions. The terms and conditions of the Ombudsman's intervention can be consulted on the site mgen.fr (mediation section: http://www.mediation-mgen.fr) or obtained on request from the postal address above.

The claimant may, without prejudice to the actions of justice that they have the possibility of exercising and the claims that they can formulate to the Insurer, to address the ACPR, 4, Place de Budapest - 75436 Paris Cedex 09, France.

7. Data protection

The creation, modification, deletion or use of all automated processing of personal information related directly or indirectly to execution of the policy, must be carried out in accordance with legal and regulatory provisions, particularly those stipulated in the amended French Data Protection Law 78-17 of 6 January 1978.

According to the European General Data Protection Regulation 2016/679 of 27 April 2016 (the "GDPR") which entered into force on 25 May 2018, personal data collection is necessary for the management of the insurance contract by the Insurer, its TPA, its service providers, its subcontractors or its reinsurers. The data processing is intended to: issue, manage and execute insurance contracts; the development of statistics and actuarial studies; the recourses, management of claims and litigation; the

implementation of the legal and regulatory provisions in force: the fight against money laundering, financing of terrorism and against fraud; operations related to customer management and business development. The recipients of these data are the duly authorized staff of the Insurer, its TPA, its service providers, its subcontractors or its respective reinsurers, social organizations or insurance intermediaries.

The Insurer and MediSky undertake to take every relevant precaution to preserve the security of information and particularly to prevent it being deformed, damaged or communicated to unauthorized persons.

These personal data may be transferred to service providers or subcontractors established in countries outside the European Union. These transfers may only concern countries recognized by the European Commission as having an adequate level of protection for personal data, or recipients with appropriate safeguards. These data will be kept throughout the duration of the contract, until the expiry of both the limitation periods and the deadlines provided by the storage obligations.

The Insured has a right of access, rectification and erasure of his or her personal data. When consent is necessary for processing, he or she has the right to withdraw it. Under regulatory conditions, the Insured Person has the right to request the limitation of data processing or to oppose it.

The Insured Person also has the right to provide guidelines regarding the processing of personal data after his/ her death. Any request for the exercise of his/ her rights may be addressed to the VYV Group Data Protection Officer: Tour Montparnasse - 33, avenue du Maine - PO Box 245 - 75755 Paris Cedex 15 or dpo@groupe-vyv.com.

The Insured Person has the right to lodge a complaint with the Commission Nationale Informatique et Libertés [CNIL] located at 3, Place de Fontenoy - TSA 80715 - 75334 Paris Cedex 07 - France; Tel: +33 (0) 1.53. 73.22.22.

8. Regulatory information and governing law

Your International Healthcare Plan is underwritten by VYV International Benefits on behalf of MGEN. A Master Policy for Individuals has been signed between VYV International Benefits and MediHelp/ MediSky.

This Master Policy is covered by the French mutual insurance companies' code and is governed by both its stipulations and the provisions of the French mutual insurance companies' code and applicable French legislation. The statements from the Insured Persons form its basis.

Any dispute arising out of, or in connection with the insurance contract shall be settled by the courts of Paris, in France.

The Authority of Prudential Supervision and Resolution (ACPR) 4 Place de Budapest - 75436 Paris Cedex 09, France, ensures compliance of the commitments made by the Insurer.

9. Sanction limitation and exclusion clause

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

10. Other insurance

If there is any other private insurance covering any of the benefits that are provided under the Policy for which a claim is made, then the Insured Person must disclose this to the Insurer at the time of submitting the claim. In these circumstances, the Insurer will not be liable to pay or contribute more than its proper rateable proportion.

If it transpires that the Insured Person has been paid for all or some of the claim costs by another source or insurance, the Insurer has the right to a refund of any settlement paid. The Insurer reserves the right to deduct such a refund from the Insured Person from any impending or future claim settlements or to cancel his/ her Policy from the inception date without a refund of premium.

Furthermore, if there is a reimbursement from a mandatory social security scheme, the Insurer will reimburse in addition to a mandatory social security scheme based on invoices and according to the benefits of the chosen plan.

11. Eligibility conditions

All individual aged below 69 are eligible for this Insurance plan if he/ she resides in Poland, Romania, Hungary or Bulgaria.

These persons must, at the time of application for enrolment, fill out and sign an individual application form for enrolment and a separate nomination of beneficiaries in case of death.

The Insurer reserves the possibility to subject their acceptances to the provision of any additional information it deems necessary.

The Insured Persons, as well as their dependants when relevant, acquire the status of Insured Persons as soon as they are enrolled in insurance.

If a Dependant is not enrolled at the same time as the Principal member, he/ she will have a 3-months waiting period applied for patient treatments.

Adding dependants: the Insured may apply to include an eligible dependant at any time during the period of insurance subject to the payment of the required premium.

- Addition of a spouse/ legal partner is possible, provided that the application for these family members is made within one month following the date of marriage/ legal partnership.

- A new-born child may be added to this contract from the date of birth provided that the Insurer receives a request of adding the new born child within 30 days of their date of birth. After this period, the Insured will add the new-born child from the date we receive written notification and not their date of birth.

12. Effective date of coverage

Once the contract has come into effect, the coverage becomes effective for each individual who acquires the status of Insured Person on the following dates:

- Individual person enrolled on the effective date of the individual policy, from this date.

- Individual person enrolled after the effective date of the individual policy on the date the premium is paid date shown on the certificate of insurance.

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The coverage for dependants, as defined in Chapter 2, shall take effect at the same time as the coverage for the Insured Person or as soon as the persons concerned to meet the required conditions. The individual policy is renewed annually, every January 1st.

13. Termination or suspension of coverage

Except in the event of a reticence, omission or false declaration, the Insured person may not be excluded from the Insurance against his/ her will if he/ she is part of the category of Insureds person under the Plan.

In any event, cover ceases for each Insured Person:

- **in the event of failure to pay the premiums under the terms and conditions;**
- **in the event of a false declaration;**
- **at the initiative of the Insured Person in the event of annual cancellation of its policy;**
- **in the event of the death of the Insured Person;**
- **in the event of liquidation proceedings in relation to the Insurer;**
- **or at the latest on the date of his/ her 69th birthday.**

Please note that MediSky may also terminate the Policy according to termination right mentioned in the Master policy signed with the Insurer.

The coverage for Dependants as defined in Chapter 2 is terminated (or suspended) at the same time as the principal Insured Person's coverage.

The termination of the coverage results, both for the Insured Person and his/her family members, on the cancellation of entitlement to benefits for all medical care provided after the termination date, even if they have started or have been prescribed before this date.

CHAPTER 4 – Exclusions

14. Excluded risks and benefits

The Insurer shall not pay any benefit to any Insured Person which arises or is caused by or associated with directly or indirectly by any one of the following:

1. **ANY EXPENSE, TREATMENT, MEDICAL OR DENTAL CONDITION OR PROCEDURE RELATING THERETO NOT SPECIFICALLY STATED IN THIS POLICY AS BEING INSURED;**
2. **SUMS IN EXCESS OF THE PLAN LIMITS;**
3. **ANY SUM IN EXCESS OF EUR 500 WHERE WE HAVE NOT GIVEN PRIOR APPROVAL;**
4. **COSTS WHICH WOULD HAVE BEEN INCURRED IF THE INSURED EVENT HAD NOT OCCURRED;**
5. **COSTS OUTSIDE OF THE GEOGRAPHICAL AREA OF COVERAGE;**
6. **COSTS RELATING TO PALLIATIVE TREATMENT, IF NOT INCLUDED ON YOUR PLAN;**
7. **THE DEDUCTIBLE SPECIFIED ON THE MEMBERSHIP CERTIFICATE;**
8. **ANY CLAIM INVOLVING FRAUD, MISREPRESENTATION OR CONCEALMENT OR THEIR CONSEQUENCES;**

9. ANY CLAIM ARISING FROM:

- **SELF-INFLICTED INJURY (INCLUDING SUICIDE OR ATTEMPTED SUICIDE) AS A RESULT OF WILLFUL ACTS OR GROSS NEGLIGENCE;**
- **NEEDLESS SELF-EXPOSURE TO PERIL (EXCEPT IN AN ATTEMPT TO SAVE HUMAN LIFE) AS A RESULT OF WILLFUL ACTS OR GROSS NEGLIGENCE;**
- **TRAVEL UNDERTAKEN AGAINST MEDICAL ADVICE.**

10. TREATMENT FOR DRUG AND SUBSTANCE ABUSE (INCLUDING ALCOHOL) OR DEPENDENCY OR OTHER ADDICTIVE CONDITION AND ANY CONDITION ARISING THEREFROM;

11. CONTRACEPTION, STERILISATION (OR ITS REVERSAL), FERTILISATION, VASECTOMY, VENEREAL DISEASE, SEXUALLY TRANSMITTED INFECTIONS, GENDER REASSIGNMENT OR ANY OTHER FORM OF SEXUAL RELATED CONDITION;

12. INVESTIGATIONS AND/ OR TREATMENT FOR INFERTILITY OR FORM OF ASSISTED REPRODUCTION AND ANY SUBSEQUENT COMPLICATIONS.

13. ANY TREATMENT UNDERTAKEN SOLELY IN ORDER TO RELIEVE SYMPTOMS CAUSED BY AGEING OR ANY PHYSIOLOGICAL CAUSE SUCH AS COSMETIC SURGERY;

14. TRAVEL OUTSIDE THE AREA OF COVERAGE SPECIFIED ON THE MEMBERSHIP CERTIFICATE FOR MORE THAN THE NUMBER OF DAYS SHOWN IN THE TABLE OF BENEFITS IN ANY PERIOD OF INSURANCE;

15. CLAIMS ARISING FROM BIRTH INJURIES OR DEFECTS, HEREDITARY CONDITIONS OR CONGENITAL ILLNESS OR ANOMALIES MORE THAN 30 OR 60 DAYS FOLLOWING BIRTH ACCORDING TO THE CHOSEN PLAN;

16. ARTIFICIAL HEART IMPLANTATION;

17. ANY COSTS ARISING AFTER EXPIRY OF THE CURRENT PERIOD OF INSURANCE, UNLESS THIS POLICY HAS BEEN RENEWED FOR A SUBSEQUENT 12 MONTHS. COSTS IN EXCESS OF EUR 50,000 FOR THE LIFETIME OF EACH INSURED PERSON FOR CARE OR MEDICAL TREATMENT WHICH ARISES FROM HUMAN IMMUNODEFICIENCY VIRUS ILLNESS, INCLUDING ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) OR AIDS RELATED COMPLEX (ARC) AND ANY SIMILAR INFECTIONS, ILLNESSES, INJURIES OR MEDICAL CONDITIONS ARISING FROM THESE CONDITIONS, HOWEVER CAUSED;

18. MEDICAL TREATMENT AND CONSEQUENCES OF EXPERIMENTAL AND UNLICENSED MEDICAL TREATMENT OR DRUG THERAPY EXCEPT IN THE ATTEMPT TO SAVE HUMAN LIFE. DRUGS AND OTHER MEDICINES PURCHASED WITHOUT A PHYSICIAN'S PRESCRIPTION AND ROUTINE OR PREVENTIVE MEDICINES, VACCINATIONS AND CHECK- UPS UNLESS INCLUDED IN THE TABLE OF BENEFITS;

19. COSMETIC SURGERY OR REMEDIAL SURGERY, REMOVAL OF FAT OR OTHER SURPLUS BODY TISSUE AND ANY CONSEQUENCES OF SUCH MEDICAL TREATMENT, WEIGHT LOSS OR WEIGHT PROBLEMS/ EATING DISORDERS, WHETHER OR NOT FOR PSYCHOLOGICAL PURPOSES, UNLESS REQUIRED AS A DIRECT RESULT OF AN ACCIDENT OR SURGERY FOR CANCER WHICH OCCURS DURING THE PERIOD OF INSURANCE;

20. SURGERY TO CORRECT SHORT OR LONG SIGHT OR ANY OTHER EYE DEFECT, UNLESS CAUSED AS A RESULT OF AN ACCIDENT OR ILLNESS OCCURRING DURING THE PERIOD OF INSURANCE;

21. INVESTIGATIONS INTO OR TREATMENT OF SLEEP APNOEA, SNORING, OR OTHER SLEEP-RELATED BREATHING PROBLEMS;

22. MEDICAL TREATMENT PERFORMED BY A MEDICAL PRACTITIONER, PHYSICIAN OR CONSULTANT WHO IS RELATED TO THE INSURED PERSON, UNLESS PREVIOUSLY APPROVED BY US;

23. MEDICAL TREATMENT ASSOCIATED WITH CRYOPRESERVATION, IMPLANTATION OR REIMPLANTATION OF LIVING CELLS OR LIVING TISSUE WHETHER AUTOLOGOUS OR PROVIDED BY A DONOR, OTHER THAN FOR TISSUE TRANSPLANTS AS DEFINED, AND NOT EXCEEDING THE POLICY LIMITS;

24. CLAIMS ARISING AS A RESULT OF THE INSURED PERSON'S PARTICIPATION IN PROFESSIONAL SPORT (NOT INCLUDING RECREATIONAL OR AMATEUR PARTICIPATION) OR ANY HAZARDOUS/ EXTREME SPORT OR ACTIVITY, I.E. SUCH AS: MOTOR SPORTS, AERIAL SPORTS, SCUBA DIVING BELOW 30 METERS OR WHERE A PADI CERTIFICATE IS NOT HELD, ANY ACTIVITY INVOLVING ANIMALS, 25. SPEED COMPETITION FREE CLIMBING OR MOUNTAINEERING (WITH OR WITHOUT ROPES) TREKKING ABOVE 2,500 METERS, MARTIAL ARTS, BUNGEE, JUMPING, PARACHUTING, BASE JUMPING, SKIING OFF-PISTE AND RACING OF ANY FORM (OTHER THAN ON FOOT). IF A HAZARDOUS SPORT OR ACTIVITY IS NOT SPECIFIED IN THIS LIST, THE INSURED PERSON MUST CONTACT US TO ASCERTAIN IF IT IS ACCEPTABLE FOR INSURANCE BEFORE COVER WILL APPLY;

26. ANY CLAIM ARISING WHEN THE INSURED PERSON IS UNDER MILITARY AUTHORITY OR IS ENGAGED IN ACTIVITIES INVOLVING THE USE OF FIREARMS OR PHYSICAL COMBAT OR IN AN AREA OF MILITARY CONFLICT, EXCEPT IN CONNECTION WITH TOURIST TRIPS MADE ON A PRIVATE BASIS DURING LEAVE;

27. ANY EXPENSES RELATING TO SEARCH AND RESCUE OPERATIONS TO FIND AN INSURED PERSON IN MOUNTAINS, AT SEA, IN THE DESERT, IN THE JUNGLE AND SIMILAR REMOTE LOCATIONS INCLUDING AIR / SEA RESCUE CHARGES FOR EVACUATION TO SHORE FROM A VESSEL OR FROM THE SEA;

28. ACCOMMODATION AND TREATMENT COSTS IN A NURSING HOME, HYDRO, SPA, NATURE CLINIC, HEALTH FARM OR THE ALIKE OR A HOSPITAL WHERE THE ESTABLISHMENT CONCERNED HAS, EFFECTIVELY, BECOME THE INSURED PERSON'S HOME OR PERMANENT RESIDENCE AND THE ADMISSION IS ARRANGED WHOLLY OR PARTLY FOR DOMESTIC REASONS;

29. REHABILITATION UNLESS IT FORMS AN INTEGRAL PART OF MEDICAL TREATMENT RECEIVED AS AN INPATIENT AND IS UNDER THE CONTROL OR SUPERVISION OF A SPECIALIST AND IS UNDERTAKEN IN A RECOGNISED REHABILITATION UNIT;

30. MEDICAL TREATMENT FOR LEARNING DIFFICULTIES, HYPERACTIVITY, ATTENTION DEFICIT DISORDER, BEHAVIORAL PROBLEMS OR CHILD DEVELOPMENT;

31. MEDICAL TREATMENT FOR MENTAL OR NERVOUS DISORDERS, PSYCHIATRIC TREATMENT AND THE COSTS OF A PSYCHOTHERAPIST, PSYCHOLOGIST, FAMILY THERAPIST OR BEREAVEMENT COUNSELLOR;

32. ANY CLAIM IN ANY WAY CAUSED OR CONTRIBUTED TO BY THE USE OR RELEASE OR THE THREAT THEREOF OF ANY NUCLEAR WEAPON OR DEVICE OR CHEMICAL OR BIOLOGICAL AGENT;

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33. ANY CLAIM WHATSOEVER RESULTING FROM WAR, INVASION, ACT OF FOREIGN ENEMY, HOSTILITIES (WHETHER WAR BE DECLARED OR NOT), ACT OF TERRORISM, CIVIL WAR, REBELLION, REVOLUTION, INSURRECTION, MILITARY OR USURPED POWER OR TAKING PART IN CIVIL COMMOTION OR RIOT OF ANY KIND. EXCEPTION: WE WILL PAY UP TO A MAXIMUM OF EUR 50,000 FOR EACH INSURED PERSON PER INSURED EVENT PROVIDED THAT THE INSURED PERSON IS AN INNOCENT BYSTANDER, AND HAS NOT BEEN AN ACTIVE PARTICIPANT, AND HAS NOT ACTED RECKLESSLY OR PUT THEMSELVES IN DANGER BY ENTERING A KNOWN AREA OF CONFLICT;

(FOR THE PURPOSE OF THIS EXCLUSION, AN ACT OF TERRORISM MEANS AN ACT, INCLUDING BUT NOT LIMITED TO THE USE OF FORCE OR VIOLENCE AND / OR THE THREAT THEREOF, OF ANY PERSON OR GROUP(S) OF PERSONS, WHETHER ACTING ALONE OR ON BEHALF OF OR IN CONNECTION WITH ANY ORGANISATION(S) OR GOVERNMENT(S), COMMITTED FOR POLITICAL, RELIGIOUS, IDEOLOGICAL OR SIMILAR PURPOSES OR REASONS INCLUDING THE INTENTION TO INFLUENCE ANY GOVERNMENT AND / OR TO PUT THE PUBLIC, OR ANY SECTION OF THE PUBLIC, IN FEAR).

34. ANY EXPENSE WHICH AT THE TIME OF HAPPENING IS COVERED BY, OR WOULD, BUT FOR THE EXISTENCE OF THIS POLICY, BE COVERED BY ANY OTHER EXISTING PRIVATE INSURANCE POLICY. IF THERE IS ANY OTHER COVER IN FORCE WHICH MAY PAY IN RESPECT OF THE EVENT FOR WHICH THE INSURED PERSON IS CLAIMING, THE INSURED PERSON MUST TELL US AT THE TIME HE/ SHE FIRST CONTACTS US;

35. ANY LOSSES WHICH ARE NOT COVERED BY THE TERMS AND CONDITIONS OF THIS POLICY (EXAMPLES OF LOSSES: WE WILL NOT PAY FOR LOSS OF EARNINGS DUE TO BEING UNABLE TO WORK AS A RESULT OF ILLNESS OR INJURY).

SPECIFIC EXCLUSION TO SECTION 3.1.3 - ORGAN AND TISSUE TRANSPLANT:

36. THE COSTS ASSOCIATED WITH LOCATING A REPLACEMENT ORGAN OR TISSUE (AS DEFINED) OR ANY COSTS INCURRED FOR THE REMOVAL OF THE ORGAN OR TISSUE FROM THE DONOR, TRANSPORTATION COSTS OF THE ORGAN OR TISSUE AND ALL ASSOCIATED ADMINISTRATION COSTS, ALL COSTS ASSOCIATED WITH ORGANS OR TISSUE NOT SPECIFIED WITHIN THE MEANING OF WORDS OF ORGAN TRANSPLANT OR TISSUE TRANSPLANT.

SPECIFIC EXCLUSIONS TO SECTION 3.1.8 – MATERNITY CARE :

37. TERMINATIONS OF PREGNANCY, OTHER THAN MISCARRIAGE, ECTOPIC PREGNANCY AND STILLBIRTH;

38. ELECTIVE CAESAREAN SECTION DELIVERIES IF IT IS NOT MEDICALLY NECESSARY AND THE TREATMENT CONSEQUENT OF SUCH DELIVERIES;

39. ANTE-NATAL CLASSES, MID-WIFERY COSTS WHEN NOT DIRECTLY ASSOCIATED WITH THE DELIVERY;

40. COMPLICATIONS WHICH MAY ARISE DURING OR AS A RESULT OF A PLANNED HOME BIRTH DELIVERY;

41. THE TRANSFER OF A PREGNANT WOMAN TO HOSPITAL TO GIVE ROUTINE CHILDBIRTH, UNLESS IT IS MEDICALLY NECESSARY DUE TO MEDICAL COMPLICATIONS.

SPECIFIC EXCLUSIONS TO SECTION 3.1.6 AND 3.1.5 – REABILITATION AND NURSING AT HOME:

42. MENTAL ILLNESS, PSYCHIATRIC OR PSYCHOLOGICAL DISORDERS

SPECIFIC EXCLUSION TO SECTION 3.1.3 – ORGAN AND TISSUE TRANSPLANT :

43. THE COSTS ASSOCIATED WITH LOCATING A REPLACEMENT ORGAN OR TISSUE (AS DEFINED) OR ANY COSTS INCURRED FOR THE REMOVAL OF THE ORGAN OR TISSUE FROM THE DONOR, TRANSPORTATION COSTS OF THE ORGAN OR TISSUE AND ALL ASSOCIATED ADMINISTRATION COSTS. ALL COSTS ASSOCIATED WITH ORGANS OR TISSUE NOT SPECIFIED WITHIN THE MEANING OF WORDS OF ORGAN TRANSPLANT OR TISSUE TRANSPLANT. SPECIFIC EXCLUSION APPLYING TO SECTION 3.2.1 - EMERGENCY MEDICAL TRANSFER, EVACUATION AND REPATRIATION:

44. ANY SUBSEQUENT TRANSFER COSTS ARISING OUT OF THE SAME INSURED EVENT ONCE WE HAVE RETURNED THE INSURED PERSON TO THEIR PLACE OF RESIDENCE

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CHAPTER 5 – Claims handling and administration

1. Plan administrator

VYV International Benefits (the "Insurer") has appointed MediSky International to act as the provider of certain third-party administration services in Europe including management of claims and their administration, pre-authorizations (the "Services") in relation to certain international health insurance plans designed by MediSky International and to be issued and underwritten by VYV International Benefits (the "Insurer").

2. General processes

Your dedicated client service team

You can contact MediSky Customer Care Department (coordinating and assistance centre for Insured Persons):

By phone: +48 22 826 11 46 or by email: customer-care@medisky.pl

MediSky International Sp. z o.o. Ul. Trębacka 4, 00-074 Warszawa, Polska

For any **emergency medical transfer, evacuation and repatriation** assistance:

The Insured Person should contact MediSky International Assistance or have the latter contacted by a third party as soon as the situation leads it to believe that it will be necessary for **emergency medical transfer, evacuation and repatriation** MediSky International assistance's team can be contacted 24/7 by phone: **+ 33 5 86 85 00 56** or **+ 48 573 973 133**

The Insured Person should indicate:

- the assistance agreement number: **FRIB1903001**;
- the insurance policy number;
- name and surname of the Insured Person;
- an address and contact telephone number, as well as the details of people caring or looking after Beneficiary;
- allow doctors to access personal data of the insured person.

Highly qualified staff are available to answer your requests regarding your coverage, prior agreement requests, reimbursement of medical expenses, invoices and any general administrative queries (membership card, etc.). MediSky International staff are highly knowledgeable in matters involving foreign social security and your healthcare plan and can provide assistance. Your dedicated Client Service Team is also mentioned on your membership card.

3. Claims procedures

You shall be reimbursed for all medical costs related to the benefits of the chosen insurance plan.

For reimbursement of your medical expenses, you must send us the following documents:

- All related documents issued by your treating doctor – medical report or referral letter;
- Detailed invoice for the medical services;
- Receipt of payment ;
- Fully completed Claim Form.

The validity of a claim is up to 24 months from the date of the medical service.

We work with international translators, so it is not mandatory that the claims are submitted in English. The advantage of submitting the claims in English is the faster processing of the claim.

No copies, photocopies or duplicates of invoices for any outpatient treatment above € 500 per invoice will be accepted. You must retain the originals for 24 months from the date of treatment. During this period, we may ask to receive the originals, failing which the reimbursement paid may be challenged.

If You fail to respond to requests for additional documents and/ or fails to return management forms duly completed, the request shall be placed on hold unless otherwise agreed by Us.

Any information supplied by You which proves to be erroneous, falsified or exaggerated or any fraudulent actions or deliberate misconduct by You shall incur your direct liability and repayment of the sums unduly paid by Us based on this incorrect data.

4. Pre-authorisation

The Insured Person must bear in mind that We must be contacted at least 48 hours for Our pre-authorization before the Insured Person incurs costs for Treatment of any kind which are likely to exceed € 500 on completion of Treatment otherwise, We may not pay the claim. This sum includes Inpatient, Day-care and Outpatient Treatment, as well as transportation and ancillary costs.

If the Treatment scheduled is eligible for cover, We can confirm the level of benefit applicable to the medical provider/s and authorize Treatment, subject to the terms and conditions stated under the present General Conditions document. When the Claim is subsequently fully validated, We will arrange for In-Patient costs to be settled directly to the medical provider/s, as long as the medical provider accepts

It is important to note that if We authorize Treatment which ultimately transpires to have been related to a condition excluded by the policy, for example, Treatment for an undeclared and unaccepted Pre-existing Medical Condition, the Insured Person will be responsible for all costs, including those settled by Us. In such cases, the Insured Person must repay Us all costs We have paid.

The Insured Person must make no admission of liability, offer, promise or payment without Our prior consent. We must be telephoned first.

In case of an emergency, if the Insured Person is physically prevented from contacting Us immediately, the Insured Person or someone designated by him/ her must contact Us within 48 hours.

In respect of any other costs, the Insured Person will be required to reimburse to Us, within one month of Our request to the Insured Person, any costs or expenses We have paid out on the Insured Person's behalf which are not covered under the Policy.

As often as We require, the Insured Person shall submit to medical examination at Our expense. In the event of the death of an Insured Person We shall be entitled to have an autopsy carried out at Our expense (where this is not forbidden by local law). The Insured Person must supply Us with a written statement substantiating their Claim, together with (at his/ her own expense) all original invoices, certificates, information, evidence and receipts that We require.

Where you receive Treatment as an Outpatient, and where costs are below € 500 and do not require pre- authorization, the costs must be paid for in full by you at the time of receiving the Treatment. You must then submit a Claim to Us for reimbursement. Please ensure that a Claim form is fully completed by the Insured Person and the treating Physician. Submit this with the original receipts and all other information supporting your Claim, including but not limited to x-rays, test results, medical reports etc.

5. Medical examination

We reserve the right to have the health status of the Insured Person and the medical care provided checked. We may request, if necessary, any document, examination or medical act to assess the benefits.

6. False declaration

DECLARATIONS MADE BY INSURED PERSONS TO MEDIHELP/ MEDISKY AND TO THE INSURER SERVE AS A BASIS FOR THE COVER. INDEPENDENTLY OF CAUSES OF NULLITY, THE COVER GRANTED TO THE INSURED PERSON BY THE INSURER SHALL BE NULL AND VOID IN CASES OF CONCEALMENT OR WILLFUL MISREPRESENTATION BY THE INSURED PERSON, WHEN THE RELUCTANCE OF MISREPRESENTATION CHANGES THE SUBJECT OF RISK OR DECREASES IN THE OPINION OF THE INSURER, EVEN THOUGH THE RISK OMITTED OR DISTORTED BY THE INSURED PERSON WAS IMMATERIAL TO THE CLAIM.

THE PREMIUMS PAID REMAIN EARNED BY THE INSURER WHO IS ENTITLED TO THE PAYMENT OF ALL PREMIUMS DUE, AS DAMAGES.

CHAPTER 6 – Premiums

1. Premiums rates and calculation basis

Insurance premium shall be calculated upon the assessment of the risk and its amount depends on the chosen plan, the country of residence age of the Insured and deductible option. The premiums amount, net of taxes, are set out on the Insurance certificate issued to the Insured Person.

The premiums may be revised according to the provisions of Chapter 3, Article 6 - Alterations. The rates may be revised each 1st January according to the technical results of the policy. However, the revision of the rates is effective at the contract anniversary date.

When a new rate for premiums is established by the Insurer, MediSky is required to inform the Insured Person three (3) months before their entry into force.

In case of disagreement, the Insured Person may request the termination of his/ her membership certificate by registered mail within two (2) months from the notification made by MediSky. The cancellation will take effect with January 1st of the following year after receiving the registered letter from the Insured Person.

2. Premiums payment

The premiums are paid annually, semi-annually or quarterly in advance, directly by the Insured Person. Taxes and charges, if relevant, as established by the applicable laws, will be added to the amount of the premium, and have to be paid in full by the Insured Person.

Should the Insured Person fail to pay all premiums within the month following their due date, the coverage is suspended for THIRTY (30) days after issuance by the Insurer of a registered letter stating the formal notice provided in the French Mutual insurance companies code. If, beyond that period, the Insured Person has not made the requested payment, the Policy may be terminated without any further formality within TEN (10) following days.

CHAPTER 7 – Definitions

The following definitions apply to benefits included in your Plan and to some other commonly used terms. The benefits you are covered for are listed in your Table of Benefits. Wherever the following words/ phrases appear in your contract documents, they will always be defined as follows.

Annual Renewal Date: every January 1st; the day after the expiry date as shown on the Certificate of Insurance.

Ambulance Services means the necessary medical transportation to or from the nearest suitable Hospital.

Area of coverage means Turkey and the European Union countries (including the following overseas territorial collectivises: Guadeloupe, French Guiana, Martinique and Réunion), Liechtenstein, the Principalities of Monaco and Andorra, San Marino, Vatican City. Switzerland and the United Kingdom are excluded from the Area of Coverage.

Benefits Plan: the schedule detailing those benefits applicable to the plan you have selected and which should be read in conjunction with the Insurance certificate.

Bodily Injury means physical damage or harm caused to the body as a result of an accident.

Claim means your request for payment of benefits under the Policy concluded on the basis of MediSky Healthcare Plan programme.

Commencement Date means the date on which the insurance protection becomes effective, as specified on the Membership Certificate, not earlier than the date of payment of insurance premium.

Complications of Maternity means post-partum hemorrhage, retained placenta, medically necessary cesarean section, ectopic pregnancy, miscarriage, stillbirth.

Co-payment means the amount as specified in the Table of Benefits that the Insured Person must pay in respect of each Treatment before any claim under the Policy will be paid.

Country of Residence means the country where the Insured Person has his/ her primary and/ or secondary home(s), as stated on the Application Form and specified on the Membership Certificate.

Date of Entry means the date cover on MediSky Healthcare Plan first starts.

Day-care means Treatment provided in a Hospital where an Insured Person is admitted but it is not Medically Necessary to stay in the hospital for one or more nights.

Deductible means the amount as specified in the Table of Benefits that the Insured Person must pay in any one Period of Insurance before any benefit under this Policy is payable. **On plan Honey, Marigold and Saffron, the deductible is applied only on In-Patient benefits.**

Dependant means as indicated on the Application or Membership Certificate the Insured Person's legal spouse (or partner of the same or opposite sex who, at the time of the Insured Event, has been living with the Insured Person for more than six continuous months) who
is not legally separated from him/ her, and the Insured Person's child, including illegitimate children (step-child, foster child or legally adopted child) aged under 19 on the date when the Insured Person has been granted an insurance protection on the basis of the Healthcare Plan programme for the first time or at any subsequent renewal of the Policy (or less than 25 years old if it is evidenced that such child is continuing in full-time education) and is financially dependent on the Insured Person for support.

Diagnose means the determination by a qualified medical practitioner of which disease or condition explains a person's symptoms and signs.

Emergency Dental Treatment means Treatment necessary as a result of an Accident by an extra-oral impact, received within 48 hours from the date and time of the Accident for the immediate relief of pain caused by natural teeth being lost or damaged in the Accident.

Emergency Medical Transfer or Evacuation means the emergency transportation when approved by Our 24-hour Assistance Centre, and medical care during such transportation, to move an Insured Person who suffers a critical medical condition to the nearest suitable Hospital where appropriate care and facilities are available, which may not necessarily be in the Insured Person's Country of Residence.

Emergency Outpatient Treatment means Treatment Medically Necessary as a result of an Accident or sudden Illness, received in a Casualty / Emergency room within 48 hours of the accident or onset of the Illness, but which does not require admission to Hospital as an Inpatient or Day-care patient.

Emergency Treatment means Treatment that commences within 24 hours of an Illness or Accident happened causing direct threat to health and requiring urgent medical attention.

Home means the Insured Person's primary and / or secondary home(s) within the Country or Countries of Residence as stated on the Application Form and shown in the Membership Certificate.

Hospital means any establishment which is licensed as a medical or surgical hospital in the country where it operates and where the patient is permanently supervised by a medical practitioner. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.

Illness means any sickness, disease, disorder or alteration in the Insured Person's medical condition diagnosed by a Physician.

Insurance Certificate/ membership certificate: special conditions forming part of the Insured Person's Policy, stating the names of the Insured Persons, the area of coverage, the period of insurance, the level of coverage and chosen deductible and any optional extensions selected, and any special provisions which apply to the Policy.

Insured Person: refers to the main Insured Person and his/ her dependants as stated on the Insurance Certificate issued to the Insured Person.

Insurer: the insurance company that provides the insurance cover. With nearly 4 million people covered, MGEN, established in 1946, is a mutual and a major player in social protection and ranks number one in Healthcare Insurance in France. MGEN's headquarters are located in France. VYV IB is acting on behalf of MGEN to provide this Health Insurance Plan. MGEN, SIREN number 775 685 399, regulated by the provisions of Tome II of the French mutual insurance companies code - 3-7 Square Max Hymans, 75748 PARIS Cedex 15, France.

Immunisations and Boosters means medication required for immunisations and necessary boosters which are a regulatory requirement in the Country of Residence or other similar medications.

Injury: physical damage or harm caused to the body as a result of an accident.

Individual Benefit Limit: the maximum amount that we will cover for selected benefits.

Inpatient means Treatment provided in a Hospital where an Insured Person is admitted and, out of medical necessity, occupies a bed for one or more nights but not exceeding 12 months in total for any one Insured Event.

In-Patient Cash-benefit means a daily cash benefit that is paid by Us, if You have received Treatment in a Hospital, You have stayed overnight and you have not received any charges from the Hospital.

Insured Event means an Accident or Illness or also pregnancy and childbirth or in case the selected insurance option covers also benefits stated in Article 6 – also death of Insured Person, occurred during the Period of Insurance within the Area of cover which entitles the Insured Person to receive benefits under the Policy concluded in the frame of the Healthcare Plan programme; Insured Event is deemed to include Accident or Illness occurring outside the Area of cover for the purposes of Emergency Treatment only within the applicable Limit.

Insured Person(s) means a party (together with Dependants) to whom an insurance protection has been granted on the basis of Policy concluded in the frame of MediSky Healthcare Plan for the purpose of obtaining insurance protection for itself or itself and its Dependants (in such a case Insured Person is at the same time a Policyholder or for the benefit of another person.

Insurer: the insurance company that provides the insurance cover. With nearly 4 million people covered, MGEN, established in 1946, is a mutual and a major player in social protection and ranks number one in Healthcare Insurance in France. MGEN's headquarters are located in France. VYV IB is acting on behalf of MGEN to provide these Insurance Healthcare Plans. MGEN, SIREN number 775 685 399, regulated by the provisions of Tome II of the French mutual insurance companies code - 3-7 Square Max Hymans, 75748 PARIS Cedex 15, France.

Limitation Period is the period beyond which a party's rights may no longer be invoked.

Insurance Plan: level of benefits as detailed on the Insurance Certificate.

Main Member: an individual member who We have agreed to cover under the policy.

Medical Advisor means the Medical Practitioner We choose to advise on Claims under the Policy concluded on the basis of MediSky Healthcare Plan programme.

Medical Expenses means expenses incurred for Treatment following an Accident or Illness as a result of an Insured Event.

Medically Necessary means the appropriate provision of diagnostics or treatments to diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

MediHelp: the Intermediary having subscribed with MGEN a Master policy for individuals in order to provide this insurance policy.

MediSky International sp. z o. o. with its registered seat in Warsaw, Trębacka 4 street, entered into a registry of entrepreneurs of the National Court Register kept by the District Court of the capital city of Warsaw in Warsaw, XII Commercial Division of the National Court Register under KRS no 0000628122, NIP 5252669863 - the insurance agent, entered into the registry of insurance agents under the number 11232800/A.
MediSky is the Plan administrator of the policy.

Mental Health Disorders: any disorder associated with substantial distress or impairment which impacts the insured's ability to function in a major life activity, such as employment. These disorders must meet international criteria classification**.**

MGEN, Siren number 775 685 399. Head office: 3-7 Square Max Hymans, 75748 PARIS Cedex 15, France. Mutual governed by the provisions of Tome II of the French mutual insurance companies code. Mutual authorised to do business on a Freedom of Services basis.

Newborn Care: costs of treatment for a newborn baby up to 30 days after the date of birth**.**

Organ Transplant means medical Treatment incurred in respect of kidney, heart, heart-lung, liver, pancreas transplants, and does NOT include the implantation of an artificial heart.

Outpatient means medical Treatment provided to the Insured Person or recommended by a Physician when it is not medically necessary for an Insured Person to be admitted as an Inpatient or Day-care patient in a Hospital or any other facility for medical care.

Overall Maximum Limit: the maximum we will pay for all benefits in total, per insured person, per contract year.

Palliative means Treatment where the diagnosed condition of an Insured Person has a prognosis of a terminal illness and is without cure. The primary purpose of this treatment is for the relief of symptoms rather than to cure the Illness or Injury causing the symptoms.

Period of Insurance means the period specified on the Membership Certificate for which the appropriate premium has been paid.

Physician means a legally licensed Medical Practitioner who is a doctor recognized by the law of the country where Treatment covered under the Policy is provided and who, by rendering such Treatment is practicing within the scope of his/ her license and training.

Physiotherapy means Treatment recommended by a Physician for medical reasons following an insured incident and provided by a licensed Physiotherapist.

Policyholder means a natural or moral person or a legal entity having no legal personality who is a party to the Policy concluded for the benefit of Insured Persons as well as a natural person who concluded the Policy to obtain an insurance protection for itself or for itself and its Dependants.

Policy Limits means the financial limits of our liabilities towards Insured Persons' for specific benefits (applicable per Insured Event, per year of insurance, or lifetime, indicated in the Table of Benefits.

Plan: level of benefits (as detailed on the Insurance certificate.

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Pre-existing Conditions: any condition or illness:
(i) which had existed or was in existence prior to the original commencement date of this Policy or reinstatement (whichever is later), or (ii) for which the Insured Person has experienced symptoms or displaying signs of (even if the Insured Person has not consulted a medical practitioner) prior to the original commencement date of this Policy, or (iii) where diagnostic tests showed the pathological existence of the condition or illness prior to the original commencement date of this Policy.

Prescribed Medicines: refers to medication whose sale and use is legally subject to prescription by a physician. Products which can be bought without a medical prescription are not included in this definition and are not eligible for reimbursement.

Rehabilitation means Treatment(s) designed to facilitate recovery from Injury, Illness, or disease (excluding mental illness or disorders) so as to regain maximum self-sufficiency, form and function in as near normal manner as possible.

Renewal Date means each January 1st.

Renewal of the Policy means conclusion of Policies on the basis of MediSky Healthcare Plan for the second and following Insurance Periods as well as granting insurance protection for the second and following Insurance Periods.

Routine Vaccinations mean vaccinations provided up to 10 years of age and may include Diptheria, Hepatitis A & B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, varicella, Haemophilus Influenza B, Rotavirus, Meningococcus and Pneumoccocal Conjugate.

Spouse: is the person married to the Insured Person, who is not separated or divorced according to a judgement with the status of res judicata. This is a legally registered union between two people of different gender. In this policy, a civil partner is treated as a spouse.

Subrogation: Our right to act as your substitute to pursue any rights you may have against a third party who is liable for a claim paid by Us under the policy.

Table of Benefits means the document attached to the Policy, stating *inter alia* the benefits provided under the respective programmes and financial limits for these benefits.

Tissue Transplant means medical Treatment incurred in respect of bone marrow and cornea transplants.

Replacement tissue means biomaterial available for the repair or replacement of biological tissues.

Treatment means any Medically Necessary surgical procedure or medical intervention which is required to cure an Injury or Illness or to provide relief of a Chronic Condition.

Waiting period is a period of time commencing on the start date of the contract, during which you are not entitled for particular benefits.

We or Us / Our means the Insurer, MGEN, mutual insurance companies that provides the insurance cover. Established in 1946, the Insurer is a mutual and a major player in social protection and ranks number one in Healthcare Insurance in France. MGEN head office is 3-7 Square Max Hymans, 75748 PARIS Cedex 15, France (MGEN, SIREN number 775 685 399, regulated by the provisions of Tome II of the French mutual insurance companies code).

VYV International Benefits, 7 Square Max Hymans, 75648 Paris Cedex 15, France, RCS Paris 813 36 1441 ORIAS 16002500.

Annex 1 – Table of benefits

Insurance Plans	YELLOW	SUNRISE	HONEY	MARIGOLD	SAFFRON
Area of coverage	**Europe** + 30 000 EUR (30 days) for emergency hospitalization outside Europe Free access in any clinic/ hospital	**Europe** + 30 000 EUR (30 days) for emergency hospitalization outside Europe Free access in any clinic/ hospital	**Europe** + 30 000 EUR (30 days) for emergency hospitalization outside Europe Free access in any clinic/ hospital	**Europe** + 30 000 EUR (30 days) for emergency hospitalization outside Europe Free access in any clinic/ hospital	**Europe** + 30 000 EUR (30 days) for emergency hospitalization outside Europe Free access in any clinic/ hospital
Overall maximum limit	**€ 500 000**	**€ 1 200 000**	**€ 1 500 000**	**€ 1 750 000**	**€ 2 000 000**
Deductible *(amount that you will pay once/ year, before the insurance will start cover you)*	€ 75/ € 150 / € 250 / € 500 / € 1 000 / € 2 500 / € 4 500 (for all the benefits)	€ 75/ € 150 / € 250 / € 500 / € 1 000 / € 2 500 / € 4 500 (for all the benefits)	€ 300 / € 625 / € 1 250 / € 2 500 / € 6 250	€ 300 / € 625 / € 1 250 / € 2 500 / € 6 250	€ 300 / € 625 / € 1 250 / € 2 500 / € 6 250
Hospitalization *(emergency/ programmed)*	Full cover (*all the expenses involved in hospitalization are full covered except the cost of the Surgical fees (including anaesthesia and theatre charges - operating room) - € 30 000 / year)	Full cover	Full cover	Full cover	Full cover
Rehabilitation (pre-authorisation)	Not covered	€ 2,000 (after a surgery)	Full cover (30 days/ each medical condition)	Full cover (30 days/ each medical condition)	Full cover (30 days/ each medical condition)
Advanced imaging *(MRI, CT, PET)*	Full cover (hospitalization/ in-patient + ambulatory/ out-patient)	Full cover (hospitalization/ in-patient + ambulatory/ out-patient)	Full cover (hospitalization/ in-patient + ambulatory/ out-patient)	Full cover (hospitalization/ in-patient + ambulatory/ out-patient)	Full cover (hospitalization/ in-patient + ambulatory/ out-patient)
Cancer treatment *(surgery, hospitalization, ambulatory, medicines, treatments, therapies)*	Full cover	Full cover	Full cover	Full cover	Full cover
Transplant medical services	Full cover (hospitalization); € 20 000 (ambulatory)	Full cover (hospitalization); € 25 000 (ambulatory)	Full cover (hospitalization); € 30 000 (ambulatory)	Full cover (hospitalization); € 45 000 (ambulatory)	Full cover (hospitalization); € 45 000 (ambulatory)
Maternity	Not covered	Not covered	**5 000 EUR** *(In-Patient + Out-Patient) +* ***300 EUR****/ night (maternity cash benefit) * 1 year waiting period*	**6 000 EUR** *(In-Patient + Out-Patient) +* ***350 EUR****/ night (maternity cash benefit) * 1 year waiting period*	**7 000 EUR** *(In-Patient + Out-Patient) +* ***350 EUR****/ night (maternity cash benefit) * 1 year waiting period*
Complications of pregnancy	Not covered	Not covered	Full cover ** 1 year waiting period*	Full cover ** 1 year waiting period*	Full cover ** 1 year waiting period*

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Newborn care	Not covered	Not covered	Full cover	Full cover	Full cover
Prosthesis	Full cover	Full cover	Full cover	Full cover	Full cover
Durable medical equipment *(limb/ ear)*	Not covered	Not covered	€ 2 500	€ 2 500	€ 2 500
Hereditary and congenital conditions	Full cover in the first 60 days after birth (hospitalization)	Full cover in the first 60 days after birth (hospitalization)	Full cover in the first 90 days after birth (hospitalization)	Full cover in the first 90 days after birth (hospitalization)	Full cover in the first 90 days after birth (hospitalization)
HIV/ AIDS	€ 50 000 / lifetime	€ 50 000 / lifetime	€ 50 000 / lifetime	€ 50 000 / lifetime	€ 50 000 / lifetime
Home nursing *(after hospitalization)*	€ 1 000	€ 5 000	Full cover (30 days/ after each hospitalization case)	Full cover (30 days/ after each hospitalization case)	Full cover (30 days/ after each hospitalization case)
Hospice and palliative care	Not covered	Not covered	€ 10 000	€ 20 000	€ 30 000
Cash-benefit *(public system hospitalization - in the country where you pay the taxes)*	€ 100 / night (max. 10 nights/ year)	€ 100 / night (max. 10 nights/ year)	€ 120 / night	€ 150 / night	€ 150 / night
Out-patient surgery	Not covered	Full cover	Full cover	Full cover	Full cover
Ambulatory consultations *(recommended with presumptive diagnosis)*	Not covered	€ 1 000	€ 5 000	Full cover	Full cover
Prescribed medicines	Not covered (ambulatory) (full covered during hospitalization)				
Laboratory analysis, X-rays, diagnostic tests	Not covered	€ 2 000			
Physiotherapy	Not covered	€ 1 800			
Therapist consultations and complementary medicine	Not covered	Not covered			
Speech therapy *(after an accident/ stroke)*	Not covered	Not covered			
Emergency out-patient room	€ 500	Full cover	Full cover		
Psychiatric treatment	Not covered	Not covered	30 days - hospitalization; € 3 000 (20 visits - ambulatory)	60 days - hospitalization; € 3 000 (30 visits - ambulatory)	60 days - hospitalization; € 3 000 (30 visits - ambulatory)
Routine health check and vaccinations	Not covered	€ 100 (Prevention - after 1 year waiting period)	€ 500 (Prevention - after 1 year waiting period); € 200 (vaccinations)	€ 500 (Prevention - after 1 year waiting period); € 350 (vaccinations)	€ 500 (Prevention); € 350 (vaccinations)
Emergency dental treatment *(in case of an accident/ trauma)*	Not covered	Not covered	€ 500	€ 1 000	€ 1 000
Dental treatment *(prevention, routine and major restorative,)*	Not covered	Not covered	Not covered	Not covered	€ 1 000 maximum limit Prevention € 200, Routine and Major

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					Restorative € 200 / tooth - maximum 4 teeth ** waiting period 6 months*
Vision benefits	Not covered	Not covered	Not covered	Not covered	One annual vision/eye test
	Not covered	Not covered	Not covered	Not covered	Glasses or contact lenses where prescribed by an ophthalmologist only - Maximum € 200
Air evacuation/ Repatriation *(life threatening situation)*	Not covered	€ 10 000 (repatriation of mortal remains); € 25 000 (air evacuation)	€ 10 000 (repatriation of mortal remains); Full cover (air evacuation)	€ 10 000 (repatriation of mortal remains); Full cover (air evacuation)	€ 10 000 (repatriation of mortal remains); Full cover (air evacuation)
Local road ambulance	Full cover	Full cover	Full cover	Full cover	Full cover
Local air ambulance	Full cover	Full cover	Full cover	Full cover	Full cover
Lump sum in case of death	€ 5 000	€ 5 000	€ 5 000	€ 10 000	€ 15 000
MediSky Assistance	Customer Care Department (9:00 - 17:30, L-V)				