# MEMBERS’ GUIDE

## (Information Booklet and
## General Terms & Conditions)

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# 1) Presentation of ASFE and its Administrator MSH INTERNATIONAL and Purpose of the insurance

## . Presentation of ASFE and its Administrator MSH INTERNATIONAL

**You have chosen an ASFE international insurance plan from Groupama Gan Vie, managed by MSH INTERNATIONAL, and we are delighted to welcome you as a member.**

**ASFE**, the Association of Services For Expatriates, was created in 1992 and is governed by the French law of 1901 on associations. Its purpose is to provide expatriates all over the world with solutions in the fields of healthcare coverage, life & disability, medical assistance/repatriation and third-party liability. Throughout this document AFSE will be referred to as "**ASFE**" or the "**Contracting association**".

**MSH INTERNATIONAL,** the designer and **Administrator** of ASFE plans, is a world leader in international benefits with over 330,000 globally-mobile individuals insured worldwide. **MSH INTERNATIONAL** provides you with the services of a dedicated team which is on hand to support and advise you day after day. **MSH INTERNATIONAL**, an organization mandated by the **Insurer** and the **Contracting Association** to administer the plan will be referred to throughout this document as "**MSH INTERNATIONAL**", "the **Administrator**", "the **Administrating Organization**" or "the **Insurer**" whenever this term is used in the context of the administrative management of the plan.

The plan is insured by **Groupama Gan Vie** – a French *société anonyme* with a capital of 1,371,100,605 euros (fully paid) - RCS Paris 340 427 616 - APE 6511 Z Head office: 8-10 rue d'Astorg - 75383 PARIS Cedex 08 - Company regulated by the French Insurance Code and subject to the Prudential Supervision Authority (ACP) - 61 rue Taitbout - 75009 Paris hereinafter referred to as "the **Insurer**".

## . Purpose of the insurance

The **ASFE Insurance plans** Nos. 210/863689 00010, 210/863689 00020, 210/863689 00030, 210/863689 00040, 210/863689 00010/D, 210/863689 00020/D, 210/863689 00030/D, 210/863689 00040/D, 210/863690 00010, 210/863690 00020, 210/863690 00030, 210/863690 00040, 210/863691 00020, 210/863691 00030, 210/863691 00040, 210/863691 00020/D, 210/863691 00030/D, 210/863691 00040/D, 210/863692 00020, 210/863692 00030, 210/863692 00040 in which you are enrolled are a type of plan known as "**open group**". They provide coverage from the 1st euro / 1st dollar / in addition to benefits provided by the **CFE** (*Caisse des Français de l'Etranger*), ***to the exclusion of any other healthcare insurance scheme.***

Their purpose, within the limit of actual costs, is the payment of **Benefits**, from the 1st euro / 1st dollar/ in addition to benefits paid by the **CFE**, as a reimbursement of medical expenses incurred by **ASFE Members** living outside their **Country of nationality**, in a private or professional capacity as well as any **Dependents** as defined below, whether or not they are residing in the same foreign country, if they are enrolled in the plan.

Your membership of these plans will be referred to throughout this document as "**Your membership**".

Each plan provides basic healthcare coverage which can be supplemented by optional benefits and 4 levels of coverage within these options (see section entitled "Coverage options").

Each plan also includes 5 coverage zones (see section entitled "Specific Country of residence and Coverage zone under the plan").

As part of your membership, your healthcare benefits are supplemented as standard by **Assistance** benefits. Europ Assistance, a company regulated by the French Insurance Code, insures and operates the **Assistance Services**.

The plans provide a very comprehensive and flexible offer tailored to individual needs. You can also supplement this coverage by purchasing life & disability benefits to protect you in the event of death or sick leave from work.

# 2) Procedures for accessing healthcare, benefits and useful services as well as how to contact us and access the Members' Area

## 2.1) ACCESSING HEALTHCARE AND BENEFITS

### . Claiming reimbursement of your routine medical expenses

Please follow these 3 steps to obtain reimbursement of your routine medical expenses:

❶ **Consult a healthcare practitioner and pay the fees.**

Details of our global **Medical network** of healthcare practitioners and hospital facilities are available at:
***www.asfe-expat.com, Members' Area, Your Healthcare/Find a facility.***
However, you are free to choose your own healthcare providers.

❷ **Go to:**

***www.asfe-expat.com, Your Reimbursements/Fill out a Claim Form.***
**to fill out a claim form online.**

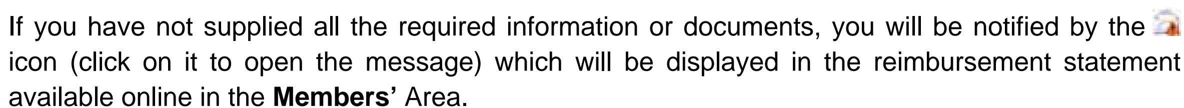
**If you are claiming a reimbursement of less than €/$300, please use the members' area:**
scan and upload all the supporting documentation (medical prescriptions, practitioners' fees and bills) directly to the secure members' area, for claims of up to €/$300 of medical expenses (or equivalent amount in the currency of payment).

**This method is simple, fast and reliable and will allow you to benefit from reduced claims processing times (4 days on average).**

**IMPORTANT: please keep the original copies of your supporting documents for 24 months following the date of treatment as they may be requested at any time during this period for monitoring purposes. If you cannot provide the requested original documents, you will be responsible for all payments made on the basis of the scanned supporting documents received.**

**If you are claiming a reimbursement of more than €/$300:**
once you have filled out your claim form online, print it out and sign it, then send it to your claims department (section '2.4) CONTACTING US') enclosing the originals of your medical prescriptions (see section entitled IMPORTANT below), practitioners' fees and bills, as well as the pharmacy price labels for drugs purchased in France.

The documents to be enclosed with your claim must show the first and last name(s) of the patient, the date, amount and details of the treatment together with the name, address and telephone number of the practitioner, hospital, laboratory or pharmacist.

If you have not supplied all the required information or documents, you will be notified by the  icon (click on it to open the message) which will be displayed in the reimbursement statement available online in the **Members'** Area.

We recommend that you group your claims together to avoid receiving reimbursements of very small amounts and include several treatments and/or different **Dependents** on the same claim form.

**❸ You will receive your reimbursement by check, to a credit card or by wire transfer to the account of your choice and in the currency of your bank account.**

If the currency of your bank account is not the same as the one you used to pay for your healthcare, the exchange rate used to calculate your reimbursements will be the one issued by the Compagnie Financière Edmond de Rothschild on the last day of the month preceding the date of your treatment.

**IMPORTANT**

**If you are sending original documents, remember to keep photocopies for your records.**

**To qualify for Benefits, claims for the reimbursement of medical expenses must be received no later than 24 months following the date of treatment. If there is a disagreement over the amount reimbursed, the Member must notify us within 6 months of the date shown on the reimbursement statement.**

**It is specified that Benefits will be paid directly to Members or, if Prior approval has been obtained, to the healthcare provider. Direct payments are never made for dental and vision care.**

## Frequently asked questions about the reimbursement of your routine medical expenses

- **What supporting documents do I need to provide and what is the procedure to follow when making a claim for reimbursement?**

  In the event of an **Illness** or **Accident** covered by the insurance, the **Member** should send the **Administrator** (MSH INTERNATIONAL) the duly completed claim form together with the practitioner's fees and prescriptions, dated, paid invoices showing the first and last names of the person receiving the treatment, the type of **Illness**, the nature and date of the visits and the treatment given. The prescriptions must clearly show the name and price of the drugs.

  We reserve the right to request any other supporting documentation which we consider necessary and to require the person receiving the treatment to submit to a medical examination carried out by our **Medical advisor**. In accordance with the opinion given by the **Medical advisor**, only expenses deemed to be medically necessary and appropriate will be covered. If the person receiving the treatment refuses to submit to this medical examination, they will lose any right to benefits in respect of the disputed reimbursement.

If there is a disagreement over the medical necessity and appropriateness of the treatment, the **Medical advisor** and the **Member's Doctor** will together choose a 3rd **Doctor** to arbitrate. The decision of the arbitrating **Doctor** will be final. Arbitration fees will be shared equally between the **Member** and the **Administrator**.

- **Are there any special procedures for healthcare received in France?**

If the healthcare is dispensed in France, the **Member** must enclose the prescription, pharmacy price labels, medical claim form or, if this form is not available, an invoice containing a description of the treatment and, where applicable, any reimbursement statements already issued by other organizations showing their **membership** number.

- **How can I check my benefits online?**

You can check details of the benefits provided under your plan at any time by going to the **Members**' Area:
***www.asfe-expat.com, Members' Area, Your Enrollment,***
***Your benefits: download your benefits***

- **Where can I find the names of qualified Doctors, clinics and hospitals worldwide?**

You can access our global **Medical network** of healthcare providers at:
***www.asfe-expat.com, Members' Area, Your Healthcare/Find a facility.***

Get information on your country and the required specialty, contact details for recommended **Doctors** and facilities, languages spoken, services available in **Hospitals**, whether or not they accept **Precertification** agreements, etc.

You are, however, free to choose your own doctor or healthcare facility (except in the United States where healthcare providers must belong to MSH INTERNATIONAL's global **Medical network**, if you want to receive the best possible level of reimbursement of your treatment).

Your claims department would be pleased to advise on your choice of healthcare provider. To avoid having to make a cash advance if you are hospitalized, or if your medical expenses are more than €/ $ 400, you should first contact our **Precertification** teams.

- **I am unsure about the diagnosis or treatment I got from my Doctor / hospital facility. How do I get a second opinion?**

Send an email to one of our **Medical advisors** at the following address: medical@msh-intl.com or contact your claims department (section '2.4) CONTACTING US').

- **What is the procedure if I require Emergency hospitalization in my country of expatriation or if I'm traveling or on vacation outside my country of expatriation?**

Present your ASFE - MSH INTERNATIONAL card on arrival at the hospital and ask them to contact one of our claims departments. You are covered worldwide for **Emergency** care only if it follows an **Accident** or **Unforeseen illness** requiring surgery or **Medical treatment** that cannot wait until repatriation to the **Main country of residence,** or the worsening of a serious **Illness** which poses an immediate and serious threat to your health if this care is dispensed outside the selected coverage zone. All the numbers you need to contact us 24/7 are shown on your card.
Please note that your MSH INTERNATIONAL card is neither proof of direct payment of your treatment nor proof of insurance. Please contact us for **confirmation of coverage.**

- **What is the deadline for submitting a claim for reimbursement?**

  All claims for healthcare reimbursements should be sent to MSH INTERNATIONAL within 24 months of the date of treatment (unless your plan states otherwise). Claims received after this 24-month period will not be processed.

- **Do I need to translate my documents into English/French or convert the currency for my claim to be processed?**

  No. Our multicultural teams can process claims written in any language and in more than 150 currencies.

- **If I submit a claim for reimbursement in a currency other than the currency of my bank account, what exchange rate is applied?**

  The exchange rate used to calculate your reimbursements is the one issued by the Compagnie Financière Edmond de Rothschild on the last day of the month preceding the date of your treatment.

- **How do I know when I've been reimbursed?**

  You will be sent an email alert once your claim for reimbursement has been processed. You can check your reimbursement statements for the last 24 months at:
  ***www.asfe-expat.com, Members' Area, Your Reimbursements / Your Reimbursement Notices.***

- **I don't understand or I don't agree with the reimbursement I've received. What should I do?**

  Go to:
  ***www.asfe-expat.com, Members' Area, Contact us / Submit an inquiry***
  or contact your claims department (section '2.4) CONTACTING US') to clear up any misunderstanding.

  In the event of a disagreement over the amount of the payment, the **Member** must notify us within 6 months of the date of issue of the reimbursement statement.

## . Requesting prior approval for major or long-term healthcare treatments or procedures

**- What do we mean by a Request for prior approval?**

The purpose of a **Request for prior approval** is to find out from MSH INTERNATIONAL, before undergoing a medical procedure or commencing long-term treatment, whether you are covered for this treatment or procedure and under what conditions. You may be required to make an advance payment.

**- In what circumstances do I need to request prior approval?**

You should send your **Request for prior approval** to your claims department for the following types of healthcare:

**. hospitalization:**

The patient should send the **Request for prior approval**, completed and signed by the practitioner to the **Administrator** (MSH INTERNATIONAL) at least 10 DAYS before admission to hospital. If the costs are incurred in France, **Members** who have French nationality should use the **Request for prior approval** from French Social Security.

In an obvious **Emergency** situation, the **Request for prior approval** should be sent to the **Administrator** (MSH INTERNATIONAL) within 2 DAYS of admission to **Hospital**, indicating the urgent nature of the hospitalization.

If the hospital stay is extended beyond 30 DAYS, the **Request for prior approval** must be renewed within the FIRST 10 DAYS following expiration of that period.

**. Routine healthcare dispensed as a series of treatments or which is costly:**

Medical treatments or consultations dispensed as a series of treatments if the number of sessions exceeds 10, are subject to the prior approval procedure, particularly in respect of paramedical practitioners (physical therapy, nursing care, **Orthoptics**, **Speech therapy**, childbirth preparation classes, etc.) or **Alternative medicine** (**Acupuncture, Osteopathy, Chiropractic, Homeopathy and** nutrition) and **Specialist** treatments and procedures.

You should also send your **Request for prior approval** to your claims department for the following costly treatments:

**. dentures - crowns - bridges, bone grafts, Periodontics and Dental surgery involving more than 3 teeth,**

**. dental implants and Orthodontics,**

**. refractive laser surgery,**

**. medical Prostheses other than dentures (orthopedics, hearing aids, etc.),**

**. attempts at Medically assisted reproduction,**

**. diagnosis of chromosomal abnormalities,**

**. stays in a medical center,**

**. surgical procedures on an outpatient basis.**

The patient should send the **Request for prior approval**, completed and signed by the practitioner to the **Administrator** (MSH INTERNATIONAL) at least 10 DAYS before commencing the treatment or undergoing the procedure. If the treatment or procedure is to be carried out by a paramedical practitioner, the prescription from the prescribing **Doctor** should be sent along with the **Request for prior approval**.

This approval is only valid for treatment commencing in the month following approval and within the limits set out in the approval.

**. Maternity**

You should submit a **Request for prior approval** by sending us a declaration of **Pregnancy**, with the expected date of delivery, before the end of the third month.

**- What is the Request for prior approval used for?**

This document is essential in order to:

. approve the proposed treatment with respect to the condition,

. provide you with information regarding the amount that will be reimbursed,

. issue the appropriate **Precertification agreement** so that no cash advance is required.

It also allows us to negotiate rates with hospitals or healthcare practitioners.

If you have any questions regarding the **Request for prior approval**, you should first contact your claims department (section '2.4) CONTACTING US').

**- How do I obtain prior approval?**

1. Send us your treatment plan by email, mail or fax including the prescription from the prescribing doctor, or the medical report, x-rays if required and/or an itemized estimate of costs.

2. On receipt of your complete request, we will inform you of the terms of your reimbursement within 72 hours.

**- For Insured members in the United States, what happens if prior approval is obtained but the Insured member then decides to be treated in a Hospital, by a Doctor or in a clinic which is not part of the UnitedHealthcare International Medical network?**

**We will reduce the amount covered under your open group Insurance plan by 20%**. A list of the **Hospitals**, clinics and **Doctors** belonging to the UnitedHealthcare International **Medical network** is available online. For more information, please refer to the section entitled "Important information regarding care received in the USA".

In some cases, it may reasonably be impossible to get treatment in a **Hospital**, from a **Doctor** or in a clinic belonging to the UnitedHealthcare International **Medical network**. In these circumstances, we will not apply any reduction to the covered costs. For example:

• if there is no **Hospital**, **Doctor** or clinic belonging to the UnitedHealthcare International **Medical network** within a 50 kilometer radius of the **Insured member's** home; and

• where the treatment required by the **Insured member** is not available in **Hospitals**, from **Doctors** or in a clinic belonging to the local UnitedHealthcare International **Medical network**.

**IMPORTANT**

**If you fail to submit a Request for prior approval, or if it has been denied, the reimbursement of healthcare services provided under the open group plan will be reduced. For all claims for reimbursement which are subject to prior approval but for which this procedure has not been followed, the Administrator (MSH INTERNATIONAL) will apply a penalty of between 40% and 100% to the amount of the Benefit.**

**This penalty is in addition to any others which may be applicable if treatment is received in Zone 5 outside the UnitedHealthcare International Medical network.**

**You should therefore be sure always to request prior approval before incurring any expenses. We will reply within 72 hours of receipt of your complete request.**

## . Requesting a Precertification agreement for costly treatments or procedures

### - What do we mean by Precertification?

The purpose of **Precertification** is to request MSH INTERNATIONAL to pay the healthcare professional or facility on your behalf without you having to make an advance payment.

### - In what circumstances can I request a Precertification agreement?

- **For Maternity**
  If direct payment is accepted by the hospital, MSH INTERNATIONAL will send them the **Precertification** agreement one month before the expected date of delivery to cover **Maternity** costs, under the terms of your plan.

- **For hospitalization**
  MSH INTERNATIONAL settles your medical expenses directly with the hospital under the terms of your plan. You will only have to pay expenses which are not covered by the insurance (for example, telephone and television).

- **For other types of healthcare (except dental and vision)**
  MSH INTERNATIONAL may extend its system of **Precertification** to a wider range of medical treatments and procedures. Please contact us to find out if the treatment or procedure you are having qualifies for direct payment (section '2.4) CONTACTING US').

### - What is the procedure to follow for hospital Precertification?

FOR SCHEDULED HOSPITALIZATION OR MATERNITY:

➔ Contact your claims department by telephone, email or fax at least 10 days before your admission to **Hospital**, specifying the name of the **Hospital** / practitioner and their address and telephone number.

➔ Go to www.asfe-expat.com and fill out your **Precertification request** directly at:
***www.asfe-expat.com, Members' Area, Your reimbursements/Precertification and Direct Payment Request.***
Send all the documents to your claims department (section '2.4) CONTACTING US').

➔ We will then contact the **Hospital** directly and issue you with confirmation of your hospital **Pre-certification** agreement. MSH INTERNATIONAL will then make a payment to the healthcare provider subject to medical approval.

IN AN EMERGENCY:

➔ Go directly to the **Hospital**

➔ Present your ASFE - MSH-INTERNATIONAL card to the admissions department at the **Hospital**

➔ Ask them to contact us no later than 48 hours following your admission.

We will issue them with confirmation of the hospital **Precertification**.

**IMPORTANT**

**On arrival at the Hospital, please present your ASFE - MSH INTERNATIONAL card: it will help facilitate administrative procedures.**

**Whatever country you are in, try to seek treatment within the public or state-approved sector where possible or contact us for details of medical facilities whose prices meet our criteria for "Usual, customary and reasonable costs".**

## . Important information regarding care received in the USA

**FOR MEMBERS WHO SELECTED THE USA COVERAGE ZONE**

**If you have opted for the USA coverage zone** and require treatment or hospitalization there, or need to see a local **Doctor**, your plan enables you to benefit from specific agreements set up by MSH INTERNATIONAL with 2 local partners: **UnitedHealthcare** and **Express Scripts.**

These agreements mean you can:
- access a selection of top-quality **Hospitals** and healthcare practitioners with UnitedHealthcare and well-known pharmacies with **Express Scripts**,
- avoid having to make a cash advance to medical practitioners of the UnitedHealthcare **Medical network**, by presenting your UnitedHealthcare card before commencing any medical treatment or undergoing a procedure,
- have your medical prescriptions covered directly by the insurance when you take them to a pharmacy belonging to the Express Scripts **Medical network** by presenting your Express Scripts card before your prescription is delivered.

**The UnitedHealthcare / MSH INTERNATIONAL card for your healthcare in the United States**

In the weeks following your enrollment, you will receive two UnitedHealthcare cards. These cards will be in the name of the primary **Member** but will also cover all the **Dependents**.

Be sure to present your card to practitioners within the UnitedHealthcare International **Medical network** to avoid having to make an advance payment for your medical expenses.

➔ Find a practitioner belonging to the UnitedHealthcare International **Medical network**:
- Click on the following link:
https://www.providerlookuponline.com/uhc/po7/Search.aspx
- Enter your location criteria

**IMPORTANT**

**Your coverage in the USA always gives you the freedom to choose which Hospital is best suited to your treatment (including those outside the UnitedHealthcare International Medical network). However, if you choose to be treated in the United States in a Hospital or by a Doctor or clinic that is not part of the UnitedHealthcare International Medical network, any payments we make will be reduced by 20%.**

**However, if it is physically impossible for you to be treated by a member of the UnitedHealthcare International Medical network, for geographical reasons or in an Emergency, the 20% reduction in the level of reimbursement specified in the plan will not be applied.**

**This penalty is in addition to any others that may be applicable if treatment was received without a Request for prior approval being submitted or if it was denied.**

**These exceptions include cases where:**

- there is no **Hospital**, **Doctor** or clinic belonging to the UnitedHealthcare International **Medical network** within a 50 kilometer radius of the **Insured member's** home; and
- the treatment required by the **Insured member** is not available in **Hospitals** or from **Doctors** or clinics belonging to the local UnitedHealthcare International **Medical network**.

**The Express Scripts pharmacy card for your healthcare in the United States**

This card will be sent out to you in the weeks following your enrollment and can be used immediately. It covers the cost of your medical prescriptions at pharmacies belonging to the Express Scripts **Medical network.**

➔ Find a pharmacy belonging to the Express Scripts **Medical network**:
- Click on the following link to find the pharmacy nearest to you:
https://www.express-scripts.com/NATPLSNOFORM/

- Enter your location criteria

**IMPORTANT**

**Your coverage in the United States always gives you the freedom to choose which pharmacy is most convenient for the purchase of your Prescription drugs (including those outside the Express Scripts Medical network). However, if you decide to buy your Prescription drugs in the United States at a pharmacy that is not part of the Express Scripts Medical network, any payments we make will be reduced by 20%.**

**However, if it is physically impossible for you to use a pharmacy belonging to the Express Scripts Medical network, for geographical reasons or in an Emergency, the 20% reduction in the level of reimbursement specified in the plan will not be applied.**

**These exceptions include cases where:**

- there is no pharmacy belonging to the Express Scripts **Medical network** within a 50 kilometer radius of the **Insured member's** home; and
- the drugs required by the **Insured member** are not available in pharmacies belonging to the local Express Scripts **Medical network**.

**This penalty is in addition to any others that may be applicable if treatment was received without a Request for prior approval being submitted or if it was denied.**

**FOR MEMBERS WHO DID NOT SELECT THE USA COVERAGE ZONE**

**If you have not opted for the United States Coverage zone but need local Emergency treatment** following an **Accident** or **Unforeseen illness** requiring surgery or **Medical treatment** that cannot wait until repatriation to your **Main country of residence,** or the worsening of a serious **Illness** which poses an immediate and serious threat to your health during a business trip or vacation not exceeding 60 days, we recommend, before incurring any expenses, that you contact our North American claims department in Calgary, Canada. Contact details are as follows:

ASFE / MSH INTERNATIONAL
Suite 300, 999 8th Street S.W.
Calgary, Alberta T2R 1N7. CANADA
Tel: +1 403 538 2365 / Fax: +1 403 265 9425 / adminamerica@asfe-expat.com

**IMPORTANT**

**Treatment received in the United States, even in an Emergency, will not be covered if we know that the Insured member traveled to the United States for the sole purpose of receiving treatment, if the symptoms of the disease were known to the recipient of the treatment before they enrolled in the plan or if the treatment is not subsequent to an Accident or Sudden and unexpected Illness requiring surgery or Medical treatment that cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness which poses an immediate and serious threat to the health of the insured member.**

**These provisions also apply where the treatment is dispensed in a Coverage zone which is higher than the one selected.**

## . Methods of reimbursement and any bank charges which may apply

You will receive your reimbursement either:

- directly onto a credit card (recommended method),
- by check,
- or by wire transfer to the account of your choice and in the currency of your bank account.

**Advantages of reimbursement directly onto a credit card**
This form of reimbursement, available in more than 40 currencies, is faster and more reliable, whatever your country of expatriation, particularly for currencies considered difficult for interbank transfers (Brazilian real, Malaysian ringgit, Russian ruble, etc.). This system is totally secure and your bank details remain completely confidential. To take advantage of this service or for more information, contact your claims department (section '2.4) CONTACTING US').

**Bank charges which may apply**
You will have no wire transfer fees to pay (other than the account maintenance fee) if the currency of your account and your reimbursement is the same as the currency of the country where your account is held.

## . Reimbursement currencies

We will reimburse you in the currency you specified in your claim, unless it is illegal to make a payment in that currency under international banking regulations. In this case, we will reimburse you in the currency you normally use to pay your **Premium**.

If the currency of your bank account is not the one you used to pay for your treatment, the exchange rate used to calculate your reimbursements will be the one published by the Compagnie Financière Edmond de Rothschild on the last day of the month preceding the date of treatment.

**IMPORTANT**

**Payments cannot be made, either directly or indirectly, to a country which is subject to sanctions such as those imposed, for example, by the United Nations, the Office of Foreign Assets Control of the US Treasury (OFAC) or the European Union.**

## . Reimbursement of costly treatments or procedures

In some cases, we may issue a **Letter of guarantee** to the **Insured member**, **Doctor** or **Hospital**. This indicates our agreement to cover all or part of the incurred medical expenses under the terms of the plan. In this case, we pay the **Insured member**, **Doctor**, **Hospital** or clinic the agreed amount on receipt of the request and a copy of the corresponding invoice, once the treatment has been dispensed.

- ⇨ Some **Doctors**, **Hospitals** or clinics may agree to send the bill directly to us. If the treatment is covered, **the Doctor, Hospital** or clinic should send us the original bill and we will pay them directly.

- ⇨ If the **Doctor**, **Hospital** or clinic prefers to bill the **Insured member** directly and the **Doctor**, **Hospital** or clinic is not paid, the **Insured member** must then send us the original bill and we will make a payment directly to the **Doctor**, **Hospital** or clinic under the terms of the plan.

- ⇨ If the **Doctor**, **Hospital** or clinic bills the **Insured member** directly and the **Member** then pays them, the **Member** can send us the original bill and proof that payment has been made to the **Doctor**, **Hospital** or clinic. We will then reimburse the **Member** under the terms of the plan.

In all cases, we will of course pay the costs covered under the plan. If some of the costs are not covered under the plan, we will inform the **Member**.

## . Reimbursement of treatments or procedures costing less than €/$300

Claims can be submitted electronically (see section entitled 'Claiming reimbursement of your routine medical expenses') for all bills under €/$300 (or equivalent amount in the currency of payment).
**This method is simple, fast and reliable and will allow you to benefit from reduced claims processing times (4 days on average).**

**IMPORTANT: please keep the original copies of your supporting documents for 24 months following the date of treatment as they may be requested at any time during this period for monitoring purposes. If you cannot provide the requested original documents, you will be responsible for all payments made on the basis of the scanned supporting documents received.**

For bills over or equal to €/$300, the original document must also be sent to us by mail. You will find the address in section '2.4) CONTACTING US'.

## . Amount of reimbursements

Medical expenses are reimbursed within the limits of costs actually incurred, **Usual, customary and reasonable costs** in the relevant country and the limits specified under the plan (see below for an explanation of the concept of **Usual, customary and reasonable costs**).

**Cumulative insurance:**

**The reimbursements from any basic health insurance scheme, from the Insurer and from any other organization cannot exceed the amount of costs actually incurred. Cumulative insurance operates within the limits of each type of coverage regardless of the date of enrollment.**

**Within these limits, the Member can claim reimbursement from the provider of their choice.**

**ON PAIN OF FORFEITURE, THE MEMBER MUST DECLARE ANY CUMULATIVE INSURANCE ARRANGEMENTS. THIS OBLIGATION REMAINS IN FORCE DURING THE ENTIRE PERIOD OF MEMBERSHIP. THE LIMITING OF REIMBURSEMENTS TO COSTS ACTUALLY INCURRED IS DETERMINED BY THE INSURER FOR EACH SERVICE, TREATMENT OR PROCEDURE COVERED.**

## Third party liability - Subrogation:

**It is specified that the Insurer does not waive the rights and actions available to them under Article L 121-12 of the French Insurance Code relating to any subrogatory remedy they may seek from a responsible third party.**

The primary **Member** or one of their **Dependents** must provide all the required information if they are entitled to claim compensation from a third party.

The insured person and the third party cannot under any circumstances, and without an agreement in writing from the **Administrator**, reach an agreement or oppose the right of the **Administrator** to recover any amounts due. Otherwise, the **Administrator** will be entitled to recover the amounts paid and terminate membership of the plan.

The **Member** and the **Dependents** recognize the **Insurer's** right of **Subrogation**.

## . Usual, customary and reasonable costs and controlled medical expenses

**Usual, reasonable and customary costs which will be reimbursed under the plan are defined as reasonable medical expenses commonly charged in the relevant country for the specific treatment received, in accordance with standard medical and generally accepted procedures. Medical expenses deemed to be excessive, unreasonable or unusual considering the country in which they were incurred, will not be covered or the amount of benefits paid will be limited.**

**In order to ensure the sustainability of your plan and to better control increases in healthcare expenditure, we strive to make our Members aware of the value of controlling medical expenses.**

**Preventive measures**

- Make sure you get all the vaccinations recommended for your country of destination before you leave.
- Take a look at the medical information we provide at:
  *www.asfe-expat.com,* ***Members'*** *Area, Your Healthcare,*
  including recommendations for preventing certain **Illnesses** (malaria etc.).
- Get a pre-expatriation check-up for the whole family before you leave, as well as regular **Health check-ups**; some health concerns can be incompatible with certain climates. Remember, this benefit is not always available under the plan.

**Useful tips to help you control costs**

- Try, where possible, to use public sector or state-approved healthcare providers.
- If your **Spouse** is covered under another healthcare plan, send their medical expenses claims to their provider first.
- Avoid giving any information in advance about the plan's level of coverage, especially to dentists and opticians, in order to avoid rates being automatically adjusted to the upper limit.
- Limit the number of visits to different practitioners for the same health concern.

**Top-quality medical Services at a "Usual, customary and reasonable cost"**

- Healthcare costs vary greatly from country to country, and even between practitioners or medical facilities in the same town: some of them can charge up to 10 times more than others, while offering the same quality of **Service**.
- To help combat this type of practice, and based on our in-depth knowledge of local healthcare systems, we have produced a comparative chart of "**Usual, customary and reasonable costs**". This is a scale of charges which we consider to be reasonable according to the type of medical care and the country.
- Before seeking treatment, please feel free to contact our medical teams for details of "**Usual, customary and reasonable costs**" for a particular medical **Service.**

**Use the MSH INTERNATIONAL Medical network as much as possible (particularly in the United States)**

You are free to choose your healthcare provider but, by opting for the MSH INTERNATIONAL Medical network (accessible in the **Members'** Area/'Your Healthcare / Find a facility'), you can geo-locate the healthcare providers nearest to you and receive top-quality care anywhere in the world at reasonable rates. That way, you will benefit from the best quality of care possible while minimizing the risk of exceeding the limits of your coverage.

For **Members** who have selected the **Coverage zone** which includes the United States, we would remind you that care provided within the **Medical network** will be reimbursed at a higher rate than care received outside the **Medical network**.

## . Strict compliance with procedures for claiming reimbursement

**Members** and **Dependents** covered under the plan are required to adhere strictly to the procedures for claiming reimbursement described in this **Members' Guide**. Otherwise, we will not settle the claim submitted by you or your **Dependents**.

## 2.2) DEDUCTIBLES AND CO-PAYMENTS (CONTRIBUTION TO COSTS)

If you have opted for a **Deductible,** it will be shown on your **Certificate of enrollment**. This allows you to benefit from a lower level of **Premium** than you would have paid without the **Deductible**.
Here is a reminder of the different amounts of **Deductible** available under this plan:

| Deductible in €(EURO) | Deductible in $ (US DOLLAR) |
|---|---|
| €350 | $500 |
| €750 | $1,000 |
| €2,000 | $2,500 |
| €4,000 | $5,000 |

### . How Deductibles operate

The **Deductible** is the amount you must pay towards your medical expenses, per **Insurance year**, before we can begin to reimburse you. It is the amount payable by the **Member** and any **Dependents** covered under the plan which is deducted from the sum to be reimbursed, applicable **per person** and per **Insurance year**. If this option is selected, it will be specified on the **Certificate of enrollment**.

If your claim for reimbursement exceeds the total amount of your **Deductible,** or the remaining amount of your **Deductible** (if you have already submitted claims which did not reach the annual amount), we will reimburse the cost of covered treatments exceeding the amount of the selected annual Deductible. Once the annual amount of the **Deductible** has been reached, all healthcare expenses covered under the plan will be reimbursed within the limits of the benefits purchased.

The amount of the **Deductible** applies separately to each **Member** listed in the **Application for coverage** and for each **Insurance year**. It is the responsibility of the **Member** and any **Dependents** to pay the amount of the **Deductible** directly to the **Doctor**, **Hospital** or clinic. If necessary, we will inform you of the amount to be paid to the health practitioner.

**IMPORTANT**

**It is important that you send us ALL your claims for reimbursement, even if the amount of the claim does not reach that of the selected Deductible. In this case, we will not process the claim but it will be taken into account when calculating if your annual Deductible has been reached.**

**We must therefore receive all your claims for reimbursement, even before the total amount of the annual Deductible has been reached.**

## . Reimbursements with the application of the Deductible

**If we make a payment directly to the Member or to any Dependents:**
**-** we will deduct the appropriate **Deductible** from the amount paid.

**If we make a payment directly to the healthcare practitioner:**
- we will pay the healthcare practitioner the full amount of costs incurred in respect of treatment received, within the limits of the benefits provided and the treatments covered under the plan, less the amount of the **Deductible**. The **Member** will pay the amount of the **Deductible** directly to the healthcare provider.

## . Changing the Deductible

You can request a change in the level of the **Deductible** on each **Annual renewal date** of your plan**. It is possible to make a single change to increase or decrease the selected level of Deductible, or to add or waive an existing Deductible once only during the entire life of the plan.**

If you want to opt to waive or reduce your **Deductible**, we may ask you to complete a **Medical health questionnaire** and we may apply new specific restrictions or exclusions.

If you opt to add a **Deductible** or want to increase the level of the **Deductible**, this will reduce the amount of your **Premium**. Conversely, if you opt to waive a **Deductible** or want to reduce the level of the **Deductible**, this will increase the amount of your **Premium**.

## . Co-payment: Insured member's contribution to costs (applies only to the USA Coverage zone)

If you selected the USA **Coverage zone** for your plan, a **Co-payment** (or **Insured member's** contribution to costs) applies to certain treatments or procedures covered under the plan for medical care received in the USA.

The **Co-payment** (or **Insured member's** contribution to costs) is a fixed amount determined in the plan **per treatment, procedure or visit** which is payable by the **Member** and any **Dependents**, applicable to each **Dependent** listed on the **Application for coverage,** for each treatment, procedure or visit.

It is the responsibility of the **Member** and any **Dependents** to pay the amount of the **Co-payment** directly to the **Doctor**, **Hospital** or clinic.

For details of the treatments or procedures affected, please refer to section **'4) Healthcare Benefits in detail: Healthcare Benefits Schedule'** of this **Members' Guide**.

## 2.3) ACCESSING SERVICES INCLUDED UNDER YOUR PLAN

Top-quality services worldwide and day-to-day advice to help facilitate your healthcare procedures.

**A personalized relationship from a dedicated team**

. Available 24/7 from 4 claims departments: Calgary, Paris, Dubai and Shanghai.
. Multicultural: over 40 languages and 60 nationalities.
. In-depth knowledge of the specific features of local healthcare systems.
. Full-time **Medical advisors** on hand to offer you medical expertise.

**Efficient services**

. Direct **Precertification** in the event of hospitalization or costly treatments worldwide.
. Claims processed within 5 working days in more than 150 currencies.
. Direct payment procedure available worldwide.
. Second medical opinion if you are unsure of the diagnosis you have been given.

**An effective global medical network**

You are entirely free to choose your healthcare provider but, where possible, you should try to use healthcare practitioners and hospital facilities belonging to the MSH INTERNATIONAL **Medical network**.

Thanks to our **Medical network** of more than 850,000 healthcare providers, you can benefit from top-quality care all around the world at reasonable and customary or preferential rates. You can find their contact details at: ***www.asfe-expat.com, Members' Area, Your healthcare / Find a facility.***

**A multicultural medical team**

The MSH INTERNATIONAL medical team includes 20 **Medical advisors** who speak fluent English and at least one other language (Spanish, Chinese, French, Arabic, etc.), making it easier for you to communicate with the **Hospitals**.

Our **Doctors** are on hand to:

. give you an explanation of the treatment recommended by your practitioner,
. provide you with a second medical opinion if you are unsure of the diagnosis you have been given,
. provide you with an opinion on usual, customary and reasonable healthcare costs charged in your **Main country of residence**,
. help you choose practitioners or medical facilities where the fees charged are below or close to our upper reimbursement limits.

You can reach them by email at: medical@msh-intl.com or contact your claims department (section '2.4) CONTACTING US').

**IMPORTANT**

**Any information you send us will be handled with strict confidentiality. Only our medical teams have access to this dedicated email inbox.**

**Communication materials to help with your administrative procedures and keep you up to date**

**Personalized tracking of your healthcare procedures**

- A 'Welcome Package' containing all the information you need is mailed to you when you enroll in the plan. This includes your **Insurance card**, the **Members' Guide**, online services, etc. You will also receive confirmation of your enrollment by email.
- Email alerts when we receive a claim for reimbursement and when a new reimbursement statement is available online in the **Members'** Area.
- Topical emails keeping you up to date with important information.

**Prevention and healthcare advice**

- Fact sheets with healthcare information and advice at:
  ***www.asfe-expat.com, Members' Area/Your healthcare***
- A quarterly newsletter containing all our latest news and services and information on your healthcare.

**IMPORTANT**

**When you enrolled in the plan, you received a welcome letter along with your MSH INTERNATIONAL card. Keep it safe; it will help facilitate your dealings with healthcare professionals.**

## 2.4) CONTACTING US

If you have any questions please contact your claims department, available 24/7.

**USEFUL TIP**
To find out where your nearest claims department is located, go to:
***www.asfe-expat.com, Members' Area, Contact us/Our Contact Details.***

Here you can also access our contact details worldwide in the event of hospital precertification outside your usual coverage zone.

Our sales team is also on hand to make any changes to your plan (adding benefits, changing to a new plan, etc.). by telephone on +33 (0)1 44 20 48 77 or by email at: contact@asfe-expat.com.

## 2.5) ACCESSING THE MEMBERS' AREA

The **Members'** Area contains all the information you will need about your plan and offers many useful services to make your life simpler…

Features available online

In the **Members'** Area, at www.asfe-expat.com, in just a few clicks you can:

➔ view and download details of your benefits, the **Members' Guide** and your insurance card;

➔ submit a claim for reimbursement and request hospital precertification;

➔ check the progress of your claims in real time:
- get an email alert when we receive your claim and when your reimbursement statement is available online,
- view your reimbursement statements from the last 24 months;

➔ wherever you are in the world, find:
- a **Doctor** and/or healthcare facility near your home,
- detailed health information and essential vaccinations for a particular country;

➔ update your personal details (mailing address, email address, password, etc.);

➔ get the latest health information from our newsletters;

➔ submit an inquiry.

Updating your email address
Remember to provide or update your email address in the 'Your Details' section to sign up for reimbursement alerts by email.

Get your login details in just 3 clicks

1. Go to www.asfe-expat.com, **Members'** Area.
2. On the authentication page, click on 'Get your login details'.
3. Enter the required information and click on 'Send'.

You will receive your login and password directly by email.

Secure connection

Access to the **Members'** Area is secure and your details and transactions are guaranteed to be completely confidential.

**IMPORTANT**
**For your login to be successful, you need to provide your last name and the email address you gave us when you enrolled. Otherwise, please feel free to contact us by email or telephone.**

**FREQUENTLY ASKED QUESTIONS ABOUT USING THE MEMBERS' AREA**

**- How do I change my personal contact details (email address, password etc.)?**
You can change your contact details online at:
***www.asfe-expat.com, Members' Area, Your Enrollment, Your Details.***

**- How do I change my password?**
Once you are logged into the **Members'** Area, click on the 'Your Details' section to change your password.

**- I've lost my ASFE - MSH INTERNATIONAL card. How do I get a new one?**
. Go to:
***www.asfe-expat.com, Members' Area, Insurance ID card.***
. Print out your personalized e-card.
Or
. Contact your claims department to get a new card (section '2.4) CONTACTING US').

## 3) Definitions of Healthcare Benefits

**The words and phrases below are defined as shown. When these words and phrases are used with these meanings, they will appear in bold throughout this Members' Guide (Information Booklet and General Terms & Conditions).**

| | |
|---|---|
| ACCIDENT | Any bodily injury not intended by the person who suffered it, resulting from sudden action by an external cause. It is the **Insured member's** responsibility to provide proof of the **Accident** and the direct cause-and-effect relationship between it and the costs incurred. |
| ACUPUNCTURE | Branch of **traditional Chinese medicine** which consists of inserting needles into specific points on the patient's body to relieve various illnesses or to create an analgesic effect. |
| ADMINISTRATOR OF THE PLAN (ADMINISTRATING ORGANIZATION) | Refers to MSH INTERNATIONAL, a French insurance broker registered with ORIAS under number 07 002 751, who manages the ASFE plans. |
| AGGREGATE LIMIT (ON HEALTHCARE BENEFITS) | The **Benefits schedule** for the plan stipulates 2 types of benefit limits:<br><br>- the **Aggregate limit** for healthcare benefits refers to the maximum amount the **Administrator** will pay in respect of all healthcare benefits (hospitalization & **Routine healthcare** as well as the dental and vision options and **Maternity,** if selected), per recipient of the healthcare per **Insurance year**, for the selected level of healthcare coverage;<br><br>- in addition to this **Aggregate limit**, there are also, for certain benefits, (**Routine healthcare** + vision/dental options and **Maternity**) or certain treatments or procedures (consultations, **Vaccinations**, lenses, frames, etc.) upper limits which are expressed as a value and/or as a number of days or number of treatments or procedures/sessions which are applied either per **Insurance year,** for the life of the plan, per treatment, per procedure or consultation or per day.<br><br>All upper limits apply per recipient of the healthcare and per **Insurance year,** unless otherwise stated in the **Benefits schedule.** |
| ALTERNATIVE MEDICINE | In the plan this refers to: **Homeopathy**, **Acupuncture** and **Traditional Chinese Medicine**. |
| ANNUAL RENEWAL DATE | Each anniversary of the effective date of enrollment in the plan. |
| APPLICATION FOR COVERAGE | Refers to the physical document confirming the **Member's application for coverage** under the plan, and any other statement made by the primary member for themselves or for any **Dependents** listed on the **Application for coverage**. |
| BENEFITS SCHEDULE | Document indicating, in respect of the level of healthcare coverage selected by the **Member** for themselves and any **Dependents**, details of the benefits provided under the plan, showing the upper limits, limits on the number of treatments or procedures, consultations and/or days covered for a given period of time and the **Waiting periods**, **Deductibles**, percentages of the member's contributions to costs or **Co-payments** |

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| | which apply to them. |
| BONE DENSITY TEST | Medical examination to measure bone density by assessing bone mineral content (mainly calcium), which is most commonly performed using a special type of x-ray of the lumbar spine and/or femoral neck. It is used in screening for osteoporosis. |
| CANCELATION PERIOD | A **Cancelation period** is granted to a person who has just enrolled in an insurance plan with optional membership. A member may reverse their decision to enroll in an insurance plan for a period of 14 calendar days from the date on which their **Certificate of enrollment** is sent out, without having to provide reasons or pay penalties (see section entitled 'Canceling your membership before it takes effect: the **Cancelation period**'). |
| CERTIFICATE OF ENROLLMENT | Single document, issued only at the time of enrollment confirming the **Member's** enrollment in the plan and specifying, as well as the name and address of the **Member**, and those of any insured **Dependents**, the **Effective date of enrollment,** the benefits selected, the **Selected coverage zone**, the chosen **Deductible** and the corresponding **Premium**. The **Certificate of Enrollment** corresponds to the special conditions of enrollment in the plan. |
| CERTIFICATE OF INSURANCE | Document whose purpose is to serve as proof of insurance cover for the person presenting it. It contains the following information: name of the **Member** and any **Dependents**, **Effective date of enrollment** in the plan, number and type of enrollment selected, **Insurer** of the plan, benefits, **Selected coverage zone** and chosen **Deductible**. |
| CERTIFICATE OF TERMINATION | Document provided to confirm the end of membership of the plan. This certificate is usually required by the **Member**'s new health insurer if they switch to another health insurance plan. |
| CFE | **C**aisse des **F**rançais de l'**E**tranger**,** French Social Security body whose purpose and mission is to insure expatriates worldwide. |
| CHILDBIRTH COMPLICATIONS | Term used to refer to the following conditions that may occur during childbirth and for which an obstetric procedure is essential: fetal distress during labor, retained placenta and postpartum hemorrhage. They also include C-section if it is **Medically required**. **Childbirth complications** are only covered if the person receiving the care has **Maternity** coverage. |
| CHILDBIRTH WITHOUT COMPLICATIONS | This refers to childbirth not requiring any additional **Emergency** surgery: fetal distress during labor, retained placenta and postpartum hemorrhage. C-sections which are not **Medically required** will be classed as **Childbirth without complications**. |
| CHIROPRACTIC | Therapeutic approach which aims to treat a variety of conditions by |

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| | manipulation. |
| COMMON-LAW MARRIAGE | Union characterized by a continuous, stable, shared life between two persons of the opposite or same sex who are living together as a couple. |
| COMMON-LAW SPOUSE | Person under the age of 66 on the date of enrollment regardless of their status (or under the age of 71 on the date of enrollment if they are in paid employment) who is living in a common-law marriage with the **Member**, whether or not they are in paid employment, if and only if:<br>- the **Member** and their **Common-law spouse** share the same home and are free from any other ties of a similar nature (i.e. both partners are single, widowed or divorced and are not bound by a civil partnership),<br>- an affidavit signed by each applicant certifying that the **Common-law marriage** is well established is sent to the **Administrator** of the plan.<br><br>**If there are several common-law spouses, only the eldest will be recognized.** |
| CONTRACTING ASSOCIATION | ASFE. Legal entity which provides the plan to its **Members** and agrees to fulfill the corresponding obligations. |
| CO-PAYMENT | Fixed amount specified in the plan per treatment, procedure or visit which is payable by the **Member** and their **Dependents**. It is applicable per person. |
| COUNTRY OF NATIONALITY | Any country for which the **Insured member** holds a valid passport and of which they are a citizen, national or subject, as specified in the **Application for coverage**. |
| DATE OF TERMINATION | Date on which the benefits provided under the insurance plan come to an end, on the initiative of the **Member**, the **Insurer** or the **Contracting association** (see section entitled 'Cessation of membership and end of coverage' (**right of Withdrawal** and termination)'). |
| DEDUCTIBLE | Refers to the amount payable by the **Member** and any **Dependents** which is deducted from the reimbursable amount. It is applicable per person and per **Insurance year**. If this option is selected it will be specified on the **Certificate of enrollment**. |
| DENTAL SURGERY | Refers to any **Dental surgical procedure** with anesthesia including dental extraction and bone or gum grafts. |
| DENTURES AND DENTAL IMPLANTS | Refers to appliances used for fixed reconstruction or repair, bridges, crowns, dentures and implants, inlays, onlays, inlay cores and any auxiliary treatment required. |
| DEPENDENT | The following are classed as dependents if they are enrolled in the plan: the **Member's Spouse**, **Civil partner** or **Common-law spouse** and **Dependent children** as defined in this section. |

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|---|---|
| DEPENDENT CHILDREN | Children of the **Member**, their **Spouse**, **Partner** or **Common-law spouse**:<br>- under the age of 20,<br>- under the age of 26 (*) if they are in full-time education and are covered under a 1st euro plan,<br>(*): if the child is covered by the plan in addition to **CFE** benefits, they will be considered dependent until the day before their 20th birthday. For children in full-time education over the age of 20 (and until their 26th birthday) under a 1st euro plan, a school certificate is required at the time of enrollment and subsequently at the beginning of each academic year. |
| | |
| DOCTOR | Health professional holding a degree of Doctor of Medicine who is authorized to practice medicine under the laws of the country where the treatment is administered, within the limits of the license they have been granted and who is not a family member of the person covered under this plan. |
| EFFECTIVE DATE OF BENEFITS | Date specified on the **Certificate of enrollment** on which the benefits provided under the plan take effect, after application of the **Waiting periods.** |
| EFFECTIVE DATE OF ENROLLMENT | Date specified on the **Certificate of enrollment** on which the benefits provided under the plan take effect. |
| EMERGENCY | Refers to the medical condition or symptoms resulting from an **Illness** or injury occurring suddenly and which clearly requires immediate treatment, usually within 24 hours of onset, without which there would be a risk of endangering the health of the affected person. |
| EMERGENCY DENTAL AND VISION CARE WITH HOSPITALIZATION | Term referring to extremely urgent dental and vision care dispensed following a serious **Accident** or the sudden onset of an infection requiring hospitalization. Treatment must be administered within 24 hours of the **Accident** or infection. This benefit does not cover routine **Dental surgery**, routine dental care, **Dentures**, routine vision care, vision correction, laser vision correction and **Orthodontics** and **Periodontics**. These treatments are covered under the optional Dental/Vision benefits. |
| EMERGENCY DENTAL AND VISION CARE WITHOUT HOSPITALIZATION | Term referring to extremely urgent dental and vision care not requiring hospitalization but which must be administered as an emergency to relieve pain which is hard to tolerate. This benefit does not cover routine Dental surgery, routine dental care, Dentures, routine vision care, vision correction, laser vision correction and Orthodontics and Periodontics. These treatments are covered under the optional Dental/Vision benefits. |
| EMERGENCY TREATMENT | Refers to **Emergency** treatment received outside the **Selected** |

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|---|---|
| OUTSIDE THE COVERAGE ZONE | **coverage zone**, during a trip for the purposes of either business or leisure.<br><br>Coverage is acquired for a maximum of 60 days per trip and a maximum of 90 days per Insurance year and is also limited to the **Aggregate limit** and only covers treatment required in the event of an **Accident** or the onset of a sudden, unexpected and unforeseen **Illness**, requiring surgery or **Medical treatment** that cannot wait until repatriation to the **Main country of residence** or the worsening of a serious **Illness** representing an immediate and serious danger to the health of the **Member** and/or their **Dependents**.<br><br>Treatment dispensed by a **General practitioner** or a **Specialist** must begin within 24 hours of the event which triggered the claim.<br><br>**The following are therefore not covered by this benefit: non-urgent therapeutic treatment which did not result from an accident or unforeseen Illness requiring surgery, or Medical treatment that cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness representing an immediate and serious danger to the health of the Member and follow-up care, even in cases where the Member or their Dependents were not able to travel to a country within their Selected coverage zone**.<br><br>**Costs related to Pregnancy, Maternity, childbirth or any other Complication during Pregnancy or childbirth are also excluded from the benefit.**<br><br>It is recommended that members and any dependents contact the **Administrator**, MSH INTERNATIONAL, if trips of more than 60 days are planned outside the **Selected coverage zone**. |
| FERTILITY TREATMENT | Fertility treatment means all methods of **Medically assisted reproduction** (MAR), also known as medically assisted procreation (MAP), enabling a couple diagnosed as infertile to have a child. The methods covered under the plan are: in vitro fertilization (IVF), artificial insemination, hormone treatments and tubal surgery. |
| GENERAL PRACTITIONER | A **General practitioner** is responsible for the long-term monitoring, well-being and primary general medical care of a community. The care provided is not limited to groups of **Illnesses** related to a single organ, age group or gender. The **General practitioner** is often consulted to diagnose symptoms before treating the condition or referring the patient to a **Specialist**. |
| HEALTH CHECK-UPS | **Health check-ups,** examinations or **Laboratory tests** carried out at any time in life in the absence of any apparent clinical symptoms (please refer to the healthcare benefits schedule to find the list of examinations covered under this benefit). |
| HOME COUNTRY | Country for which the **Insured member** has a valid passport and/or to |

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|---|---|
| | which they would wish to be repatriated if necessary. |
| HOME HOSPITALIZATION | **Home hospitalization** is an alternative to conventional hospitalization and allows the patient to be cared for in their own home. |
| HOMEOPATHY | Therapeutic method consisting of prescribing a highly diluted and energized form of a substance capable of producing similar complaints to those experienced by the patient. |
| HOSPITAL | Refers to a care facility or a medical institution which is registered or approved as a medical or surgical **Hospital** under local regulations in the country in which it is located and where the **Insured member** receives daily treatment or is under the supervision of a **Doctor** or a qualified nurse.<br><br>The following are not classed as **Hospitals**: wellness and fitness centers, spas, nursing homes, retirement homes and convalescent homes. |
| (HOSPITAL) DAY CARE | See under **Outpatient hospitalization**. |
| ILLNESS | Any deterioration in the state of health certified by a competent medical authority. |
| IMMEDIATE CARE OF NEWBORNS | Refers to all tests and examinations carried out immediately following birth to assess the functional integrity of the newborn (organs and bone structure). All other complementary preventive diagnostic procedures (including swabs, determination of blood group and hearing tests) are not covered by the mother's insurance, unless, of course, the child has been added to the plan as an eligible **Dependent**. All of these other **Medically required** examinations or treatments are covered under the conditions of the benefits purchased in respect of the newborn. |
| INCREASED HEALTH RISK | Persons with an **Increased health risk** are those who are sick, who have been sick or are particularly susceptible to being sick and who present a risk of **Illness** (morbidity) or death (mortality) greater than that of the average person of the same age. These individuals cannot therefore be insured under the standard terms and conditions. |
| INSURED MEMBER OR DEPENDENT | Refers generically to the **Member** and other persons covered under their plan. They receive the **Benefits** provided by the **Insurer** in respect of claims made and covered under the plan. |
| INSURER | For the purposes of the plan, Groupama Gan Vie, a company regulated by the French Insurance code, is the **Insurer** of the benefits provided under the plan. |
| INSURANCE YEAR | The **Insurance year** covers the period from the **Effective date of enrollment** in the plan until the 365th day following this date, with automatic renewal on each anniversary date. |

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| INTENSIVE CARE | Refers to a specialized hospital department the purpose of which is to care for patients in a critical condition, that is, who are presenting with failure of one or more of their vital functions, or who are at risk of developing severe complications. The service has highly specialized technical resources. These are in continuous use by a multidisciplinary team in order to identify, prevent and correct acute and presumably reversible imbalances related to the underlying condition (**Illness**, surgery, trauma and intoxication). This type of facility includes **Intensive care** units, critical care units, intensive therapeutic services units or intensive treatment units. |
| INTERNAL AND EXTERNAL SURGICAL AND MEDICAL PROSTHESES AND DEVICES | Refers to any appliance, prosthesis or device required or used during surgery or considered to be **Medically required** for the treatment. |
| LABORATORY TESTS | Examinations, including x-rays and blood tests, carried out to determine the origin of the symptoms presented or to monitor the status of the condition. |
| LOCAL TRANSFER BY AMBULANCE | Refers to transportation by ambulance of a patient, required in cases of **Medical necessity** or **Emergency**, to the **Hospital** or the nearest licensed medical facility best suited to the situation. This **Service** is provided by the **Assistance company**. |
| MAIN COUNTRY OF RESIDENCE/COUNTRY OF EXPATRIATION | **Country of residence** indicated by the **Insured member** in their **Application for coverage** and shown on their **Certificate of enrollment**, or confirmed in writing to the **Insurer** during the life of the plan, in which the primary **Member** resides for at least six months of the year. The country specified in this way must correspond to the **Main country of residence** recognized by the authorities of that country (in particular, the tax authorities). The **Main country of residence** is used to determine the minimum **Coverage zone** which needs to be selected on enrollment in the plan. |
| MATERNITY | Non-pathological **Pregnancy,** childbirth and its consequences. **Maternity** is classed neither as an **Illness** nor an **Accident**. |
| MEDICAL ADVISOR | **Doctor** working for a public or private organization (insurance company, **Healthcare** insurance provider, etc.) who is responsible for providing a medical opinion on the cases submitted to them. |
| MEDICAL (HEALTH) QUESTIONNAIRE | In the context of an **Application for coverage** under the insurance plan, a set of questions on the health of the **Member** and any **Dependents** which enables the **Insurer's Medical advisor** to assess their state of health and set the terms of the insurance. In case of increased risk for the **Insurer**, the completion of the **Medical health questionnaire** may result in an additional **Premium** being applied to the member or one of their dependents, an exclusion from one or more of the benefits or a total refusal of the **Application for coverage** under the plan. |

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| MEDICAL IMAGING | MRI, radiology, scans, tomography etc. **Medical imaging** is used for clinical purposes in order to provide a diagnosis or propose a treatment. There are several **medical imaging** techniques: radiology, ultrasound, magnetic resonance imaging (MRI), endoscopy, scanner, laser, tomography, etc. |
| MEDICAL NETWORK | Means all **Hospitals** or associated care facilities and healthcare practitioners officially listed by your **plan Administrator** (MSH INTERNATIONAL) or by the service partners selected by them (such as UnitedHealthcare and Express Scripts in the United States) in order to receive treatment which is covered under the plan. |
| MEDICAL TREATMENT | Refers to any surgery or **Medical treatment** performed by a **Doctor**, considered to be **Medically required,** in order to diagnose, cure or alleviate an **Illness** or injury. |
| MEDICALLY ASSISTED REPRODUCTION | See under **Fertility treatment.** |
| MEDICALLY REQUIRED / MEDICAL NECESSITY / ABSOLUTE NECESSITY | Refers in respect of this plan to treatment, services, supplies and equipment recommended by a qualified healthcare professional which are defined from a medical point of view as appropriate and necessary.<br><br>To qualify, they must meet the following criteria:<br>- be necessary in order to diagnose or treat an **Illness** and/or injury suffered by a patient;<br>- be appropriate to the diagnosis, symptoms or treatment of the patient (in the sense of taking into account patient safety and the cost of the treatment)<br>- comply with medical and scientific standards and knowledge at the time of administration of the treatment;<br>- not be provided primarily for the patient’s comfort and/or that of their **Doctor**;<br>- be clinically justified in terms of scale, duration, and demonstrated and proven medical effect, frequency, level and type;<br>- be dispensed in an appropriate healthcare facility and room and be of the appropriate quality to treat the patient's medical condition. |
| MEMBER | Person who is a member of ASFE who has submitted an **Application for coverage** under the plan which has been accepted in writing as defined in the section ‘Your enrollment in the plan and persons insured’ for themselves and any **Dependents** and who has agreed to fulfill the corresponding obligations, including payment of the **Premium** specified at the time of enrollment in the plan. |
| MEMBERS’ GUIDE (INFORMATION BOOKLET AND GENERAL TERMS & CONDITIONS) | Document defining the benefits, exclusions and conditions of use of the insurance plan (including all information on reimbursement procedures). It should be read in conjunction with **the Certificate of enrollment** and the **Benefits schedule**. For ease of use, it will here be referred to as the **Members’ Guide**. |

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| OPEN GROUP INSURANCE PLAN | Refers to insurance plans in which enrollment is available on an individual and voluntary basis. Individuals then form a group through a **Contracting association** and enroll in the insurance plan. |
| ORTHODONTICS | **Orthodontics** is a dental specialty dedicated to the correction of improper positioning of the jaws and teeth in order to optimize the closure of the mouth (occlusion), to ensure proper functioning and alignment. |
| ORTHOPTICS | Paramedical specialty aiming to evaluate and measure ocular deviation and ensure rehabilitation of the eyes in case of binocular vision disorders: strabismus, heterophoria (deviation of the visual axes) or convergence insufficiency. |
| OSTEOPATHY | Manual therapeutic method using techniques of spinal or muscular manipulation of the musculoskeletal and myofascial system in order to alleviate certain functional disorders. |
| OUTPATIENT SURGERY | Surgery performed in a healthcare facility or medical office where the patient is admitted and discharged on the same day. |
| PALLIATIVE CARE | With respect to a progressive and incurable **Illness**, this refers to a treatment which does not significantly improve or cure the condition but aims to relieve the physical and psychological suffering related to the symptoms of the **Illness** and maintain relative 'quality of life'. Outpatient and inpatient care administered following a diagnosis which confirms the terminal and incurable nature of the **Illness** is covered under this benefit as is the reimbursement of physical care, the cost of a room in a **Hospital** or hospice, nursing care and prescription drugs. |
| PARTNER | Person under the age of 66 at the time of enrollment regardless of their status (or under 71 at the time of enrollment if in paid employment) bound to the **Member** by a civil partnership agreement. A civil partnership is a contract signed by two adult persons of the opposite or same sex in order to share their life together (Article 515-1 of the French Civil Code). |
| PERIOD OF BENEFITS/PERIOD OF COVERAGE | Continuous period of 365 days during which the **Member** and any **Dependents** are covered by virtue of enrollment in the plan. It starts from the effective date of enrollment in the plan as specified on the **Certificate of insurance** (other than in cases of early termination under the rules of the plan). |
| PERIODONTICS | Dental treatment prescribed for disorders of the structures supporting the teeth (particularly the gums). |

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| PHYSICAL THERAPY WITH A PRESCRIPTION | All treatment dispensed by a licensed physical therapist for which a **Doctor's** prescription is issued before the start of treatment. Coverage is limited to the number of sessions and the specific reimbursement limit applicable to this type of treatment, as specified in the **Benefits schedule.** If more sessions are required, a report justifying the need to extend the treatment must be produced. Physical therapy excludes certain treatments including mud therapy, Pilates, relaxation massage, Rolfing, MILTA therapy and all other methods which are not recognized by the scientific medical community. |
| PHYSICAL THERAPY WITHOUT A PRESCRIPTION | All treatment dispensed by a licensed physical therapist for which a **Doctor's** prescription is not issued before the start of treatment. Coverage is limited to the number of sessions and the specific reimbursement limit applicable to this type of treatment, as specified in the **Benefits schedule**. Physical therapy excludes certain treatments including mud therapy, Pilates, relaxation massage, Rolfing, MILTA therapy and all other methods which are not recognized by the scientific medical community. |
| PHYSIOTHERAPY | **Physiotherapy,** for the purposes of the plan, is all treatment which can be dispensed by a licensed physical therapist. This excludes, for the purposes of the plan, certain treatments such as mud therapy, Pilates, massage, Rolfing and MILTA therapy. |
| POSTNATAL CARE | All post-partum medical care received by the mother in a period of up to six weeks after the birth. |
| PRECERTIFICATION | **Precertification** agreement formalized in writing and issued to the **Insured member** by the **Insurer** or the **Administrator** before incurring certain types of medical expenses or accessing **Services** such as hospitalization, medical treatments provided as a series of treatments or **Prostheses** of any kind (on presentation of an appropriate detailed and circumstantial medical report and a fully costed estimate). |
| PRE-EXISTING MEDICAL CONDITION | Pre-existing conditions: any **Illness**, disorder or injury or associated symptoms which developed before the date of enrollment in the plan, of which the **Member** or their **Dependents** were aware, or of which they could reasonably have been aware and which we have not expressly agreed to cover. |
| PREGNANCY | Period between the date of conception and the date of delivery. |
| PREMIUM | Amount paid by the **Member** in return for benefits provided by the **Insurer**. |
| PREMIUM NOTICE | A **Premium notice** (sometimes also called a renewal notice) is a document which specifies the amount of your insurance **Premiums** and the period covered. The payment of the insurance **Premium** is made on the date specified in the **Premium notice**. |

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| PRENATAL CARE | Refers to all standard, customary screening and follow-up examinations during **Pregnancy**. For women over the age of 35, **Prenatal care** may include:<br>- amniocentesis and DNA tests if directly linked to amniocentesis covered under the insurance plan;<br>- tests for Spina Bifida;<br>- triple (Bart's) or quadruple tests. |
| PRESCRIPTION DRUGS | Refers to all products (including hypodermic needles, insulin and syringes), the delivery of which requires a prescription issued by a **Doctor** to treat an **Illness** whose diagnosis has been confirmed or with the aim of compensating for a deficiency in a substance which is essential to the body. These **Prescription drugs** must have a proven medical effect on the **Illness** being treated and be approved by the regulatory authorities and pharmaceutical supervisory bodies of the country in which they were prescribed. |
| PRIMARY CARE/ROUTINE HEALTHCARE | All healthcare **Services** provided by healthcare professionals excluding hospitalization or stays in healthcare or socio-medical facilities. It includes, for example, consultations in a private medical practice or health center, laboratory tests, x-rays taken in the doctor's office etc. Consultations carried out in **Hospitals** but not involving hospitalization (also known as 'outpatient' consultations) are generally classed as **Primary care**. |
| PRIVATE ROOM | **Service** offered by healthcare facilities, allowing an inpatient to be accommodated in a single room. **Deluxe and VIP rooms and suites are not covered.** |
| PSYCHIATRIC TREATMENT AND CARE | Management and care of a person who is suffering from a severe mental health problem, requiring hospitalization in a specialized unit. |
| PSYCHIATRY | **Psychiatry** is the medical treatment of mental **Illness**, whatever the cause: psychological, neurological or psychosocial. The psychiatrist is not a psychoanalyst, psychologist or psychotherapist (unless they have had additional training), but their medical degree enables them to prescribe medication or decide on psychiatric hospitalization. Consultations with and prescriptions from a **Psychiatrist** are covered under this plan (subject to a **Waiting period** of 12 months). |
| REHABILITATION IMMEDIATELY FOLLOWING HOSPITALIZATION | Rehabilitation directly following hospitalization, commenced within a maximum of 30 days of the end of the stay in hospital, dispensed as a combination of therapies, which may include occupational therapy, physical therapy and **Speech therapy** in order to restore function and/or normal shape after an injury or serious **Illness**. |
| REQUEST FOR PRIOR APPROVAL | Before incurring certain medical expenses or commencing some types of treatment or **Services** such as hospitalization, medical treatments |

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| | provided as a series of treatments or **Prostheses** of any kind, the **Insured member** must first request and obtain the agreement of the **Insurer** or the **Administrator** to obtain a **Precertification** agreement (on presentation of a detailed and circumstantial medical report as appropriate and a fully costed estimate). |
| ROUTINE DENTAL CARE | All **Routine dental care** including an annual dental check-up, root canal work, scaling, sealing of fissures, treatment of tooth decay (amalgam), application of fluoride and dental x-rays, excluding tooth whitening treatments. |
| ROUTINE HEALTHCARE | Treatments, excluding **Routine dental care** and vision care (except under certain packages, see **Benefits schedule**) performed by a **General practitioner** or **Specialist** who is a qualified doctor of medicine and is licensed to practice medicine under the laws the country where the treatment is administered in their medical or surgical office and which do not require the patient to be admitted to **Hospital**. |
| SELECTED COVERAGE ZONE | Refers to the **Coverage zone** selected by the **Member** for themselves and their **Dependents**, and for which the appropriate **Premium** has been fixed by the **Insurer** based on **Usual, customary and reasonable healthcare costs** charged in this group of countries. Subject to payment of the appropriate **Premium**, the member may opt for a **Selected coverage zone** for themselves and their Dependents which is higher than that corresponding to their **Main country of residence**. They cannot, however, opt for a **Selected coverage zone** lower than that corresponding to their **Main country of residence**.<br>The plan offers 5 coverage zones (see section entitled ‘Specific country of residence and Coverage zone under the plan’). |
| SEMI-PRIVATE ROOM | **Service** offered by healthcare facilities, allowing an inpatient to be accommodated in a double room. **Deluxe and VIP rooms and suites are not covered.** |
| SERVICE | All **Services** specified in the **Benefits schedule** of the plan. |
| SPECIALIST | Refers to a qualified **Doctor** who is officially licensed, trained and approved in the country where the treatment is administered and where they practice and who has the additional experience and qualifications required to practice a recognized medical specialty: techniques for diagnosis, treatment and prevention specific to a particular field of medicine. |
| SPEECH THERAPY | **Speech therapy** is a paramedical discipline which treats persons presenting with disorders related to communication and the spoken or written language by means of speech rehabilitation. |
| SPOUSE | **Spouse** who is not legally separated or divorced, whether or not they are in paid employment, and under the age of 66 on the date of enrollment (or under the age of 71 at the time of enrollment if in paid employment).<br>To facilitate the reading of this **Members’ Guide**, the term ‘**Spouse**’ will refer generically to the **Spouse**, partner or **Common-law spouse** of the |

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| | **Member**. |
| SUBROGATION | Refers to the rights which the **Administrator** (MSH INTERNATIONAL) can exercise to recover any expenses or costs from another insurance company, national health insurance scheme or any source linked to the reimbursement of treatment insured under this plan. |
| TERMINATION | **Termination** is the formal process by which the **Insurer**, the **Contracting association** or the **Member** puts an end to the plan or enrollment in the plan which binds them. |
| TRADITIONAL CHINESE MEDICINE | Asian therapeutic method which does not strictly differentiate between the mind and body and is based on a holistic approach to the person. The treatment is based on five main pillars: **Acupuncture**, diet, drug therapy with vegetable, mineral and animal substances, massage and movement. |
| TREATMENT OF CANCER (ONCOLOGY) | Refers to fees payable to **Specialists**, examinations, radiotherapy costs, chemotherapy and hospital charges incurred in connection with the treatment of a malignant tumor, tissue or cells, characterized by the uncontrolled growth and spread of malignant cells invading the tissues. |
| UCR | Abbreviation of 'Usual, Customary, and Reasonable', see definition of **Usual, Customary and Reasonable Costs**. |
| UNFORESEEN ILLNESS | Any deterioration in the state of health certified by a competent medical authority which is sudden, unexpected and requires the intervention of a **Doctor** in less than 48 hours. |
| USUAL, CUSTOMARY AND REASONABLE COSTS | **Usual, customary and reasonable costs** which will be reimbursed under the plan are defined as reasonable medical expenses commonly charged in the relevant country for the specific treatment received, in accordance with standard and generally accepted medical procedures.<br><br>Medical expenses deemed to be excessive, unreasonable or unusual considering the country in which they were incurred, will not be covered or the amount of benefits paid will be limited.<br>**The abbreviation UCR will be used in this Members' Guide for ease of reference**. |
| VACCINATIONS | Refers to all vaccines and boosters required by the health authorities of the country in which the **Vaccination** is administered and any medically required **Vaccinations** for travel to a foreign country as well as malaria prevention treatment. The cost of the consultation and the purchase of the vaccine are included. |
| WAITING PERIOD | Period specified in the plan and shown in the Benefits schedule, during which membership is active but the benefits are not yet accessible.<br>The Waiting periods apply from the Effective date of enrollment of each person insured under the plan. |

# 4) Healthcare Benefits in detail: Healthcare benefits schedule

## 4.1) FOR MEMBERS WHO DID NOT SELECT THE USA COVERAGE ZONE

**PRIMARY BENEFIT HEALTH: HOSPITALIZATION + ROUTINE HEALTHCARE FOR INSURED MEMBERS WITH A PLAN IN ZONE 1, 2, 3 or 4 (excluding USA)**

| A CHOICE OF 4 LEVELS OF COVERAGE | Quartz | Pearl | Sapphire | Diamond |
|---|---|---|---|---|
| **Aggregate limit** on healthcare benefits (€) | €400,000 | €800,000 | €1,600,000 | €2,400,000 |
| **Aggregate limit** on healthcare benefits ($) | $500,000 | $1,000,000 | $2,000,000 | $3,000,000 |
| **HOSPITALIZATION** | **Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year** | | | |
| ***No Waiting period for Hospitalization benefit with the exception of Psychiatric treatment and care (12 months)*** | | | | |
| **Aggregate coverage of hospital expenses** | | | | |
| Hospitalization | We will cover hospital expenses if:<br><br>- One or more **Members** of the plan is in **Hospital**, whether on an Outpatient basis or for several consecutive days,<br>- The need for hospitalization was established by a **General practitioner** or **Specialist,**<br>- The duration of your stay is medically appropriate and approved following a **Request for prior approval**<br>- Your treatment is administered or monitored by a **General practitioner** and/or **Specialist**.<br>If you need to stay in **Hospital** longer than the period specified in the prior approval agreement, or if changes are made to your treatment, your **General practitioner** or **Specialist** must send us a medical report as soon as possible.<br><br>This medical report must include:<br>- The diagnosis,<br>- The treatment you have already received,<br>- The treatment you require,<br>- The additional length of time you will need to stay in **Hospital**.<br>**We do not cover hospital expenses if hospitalization is due to one or more of the following reasons:**<br>**- Convalescence**<br>**- Pain management (except for Palliative care),**<br>**- Paramedical care with no Specialist treatment, except for Palliative care dispensed in a care facility,**<br>**- Personal assistance services, such as assistance with mobility, washing, preparing meals, etc.**<br>**- Treatment that could be classed as Routine healthcare.** | | | |
| **Hospital** room covered | **Semi-private room** (lower standard) 100% UCR up to €50 /day/ $60 | **Private room** (lower standard) 100% UCR up to €100 /day/ $125 | **Private room** (lower standard) 100% UCR up to €150/day/ $190 | **Private room** (lower standard), up to 100% UCR |
| | The type of room and the amount per night that we will cover under each package is shown in this **Benefits schedule.** | | | |

| | Quartz | Pearl | Sapphire | Diamond |
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| Room and board fees for a parent staying in **Hospital** with a dependent child under the age of 18 | 100% UCR up to €300 / $375 per year | 100% UCR up to €400 / $500 per year | 100% UCR up to €700 / $875 per year | 100% UCR |
| | We will cover reasonable room and board fees for a parent staying in the same **Hospital** as their **Dependent** child under the age of 18, in the event of hospitalization lasting more than one day and up to the maximum amount specified in this **Benefits Schedule**. | | | |
| **Outpatient hospitalization** (including **Outpatient surgery**) | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will pay all covered hospital expenses for hospitalization which does not require the person receiving the treatment to stay overnight. | | | |
| **Emergency hospitalization** within the **Selected coverage zone and in lower Coverage zones** | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover treatment administered following admission to a **Hospital** or medical day center, following the onset of a sudden and unforeseen medical condition requiring immediate treatment within 24 hours for the sole purpose of preventing a life-threatening risk.<br><br>All **Services** provided in the Emergency room which are not followed by admission to hospital will be covered under **Routine healthcare**.<br>We must be notified of any **Emergency hospitalization** within 48 hours of admission. | | | |
| **Emergency hospitalization** within a **higher Coverage zone than the Selected coverage zone**, for trips of less than 60 consecutive days | 100% UCR up to 60 days/year | 100% UCR up to 60 days/year | 100% UCR up to 60 days/year | 100% UCR up to 60 days/year |
| | We will cover all **Emergency hospital** expenses **(only if they are the result of an Accident or a sudden, unexpected and unforeseen Illness requiring surgery or Medical treatment that cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness representing an immediate and serious danger to the health of the Insured member)** in a country located in a **Coverage zone** higher than the **Selected coverage zone** during trips of less than 60 consecutive days and an aggregate limit of 90 days per insurance year. **Travel for medical reasons, and consequently all scheduled treatment in a Coverage zone** higher than **the Selected coverage zone, is also excluded (unless the Medical advisor rules otherwise).**<br><br>It is recommended that **Members** and any **Dependents** contact the **Administrator**, MSH INTERNATIONAL, if trips of more than 60 days are planned in a **higher Coverage zone than the Selected coverage zone** so that the level of coverage under your plan can be adjusted. | | | |
| **Healthcare covered under your Hospitalization benefits** | | | | |
| **Intensive care** | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover hospital expenses in case of treatment in a general or cardiac **Intensive care** unit (including a Critical care unit) for patients presenting with organ failure or who are at risk of severe complications. | | | |
| Surgical procedures including fees, operating room and anesthesia | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover the following costs in the event of hospitalization:<br>- Operating room<br>- Recovery room<br>- Drugs and dressings used in the operating room and the recovery room<br>- Drugs and dressings used during your stay in **Hospital**<br>We will cover the fees for surgeons and anesthetists and the care required immediately before and after the operation (on the same day). This also includes operations performed on an **Outpatient** basis. | | | |

## Healthcare covered under your Hospitalization benefits (continued)

| | Quartz | Pearl | Sapphire | Diamond |
|---|---|---|---|---|
| Consultations **with General practitioners** and **Specialists** during hospitalization covered under this plan (excluding **Physiotherapy** and **Alternative medicine**) and including **Specialist** treatments and procedures. | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover consultations with **General practitioners** or **Specialists** during your stay in **Hospital** following a covered Event. | | | |
| **Emergency dental and vision care with hospitalization** | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover **Emergency** dental and vision care received in **Hospital** if it is **Medically required** following an **Accident** requiring hospitalization. This care must be administered within 24 hours of the **Accident**. This benefit does not cover routine **Dental surgery**, routine dental care, **Dentures**, implantology, routine vision care, vision correction, laser vision correction, **Orthodontics** or **Periodontics.** These treatments are only covered under the optional benefit Health+. | | | |
| **Laboratory tests,** MRI, x-rays, scans and tomography performed during hospitalization covered under the plan | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover all expenses related to:<br>- **Medical imaging**, such as x-rays, scans, MRI, etc.<br>- tests such as blood tests or urine samples,<br>- diagnostic tests such as electrocardiograms,<br>if these examinations are prescribed by your **General practitioner** or **Specialist** to help diagnose or assess your health during your stay in hospital. | | | |
| **Prescription drugs** | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover the cost of any drugs prescribed by the **General practitioner** or **Specialist** in charge of your treatment during your hospitalization. | | | |
| Renal dialysis | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover the cost of renal dialysis, with the exception of transportation costs to and from the care facility where the dialysis is carried out. | | | |
| **Oncology (treatment of cancer)** | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover the cost of any medically justified treatment you receive in the **Treatment of cancer**, including chemotherapy, radiotherapy, **Oncology**, diagnostic tests and drugs, as part of hospitalization (on both an inpatient and outpatient basis). Remote follow-up examinations will be covered under '**Routine healthcare**'. | | | |
| | **Quartz** | **Pearl** | **Sapphire** | **Diamond** |
| Treatment of AIDS | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover any costs related to the treatment of HIV. | | | |
| **Internal surgical and medical prostheses and devices** | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover costs related to **Prostheses, devices or appliances** fitted during a surgical procedure. | | | |

| | Quartz | Pearl | Sapphire | Diamond |
|---|---|---|---|---|
| **External surgical and medical prostheses and devices** (for each **Prosthesis** and limited to 2 **Prostheses**) | 100% UCR up to €1,200 / $1,500 | 100% UCR up to €1,800 / $2,250 | 100% UCR up to €2,500 / $3,100 | 100% UCR |
| | We will cover:<br><br>• **Essential Prostheses or devices** immediately following surgery if medically required.<br>• **Medically required Prostheses or devices** during the short-term recovery process.<br>For adults and children over the age of 20, we will cover one external prosthesis per **Insurance year**, and for children up to the age of 20, we will cover the first prosthesis and a maximum of two changes of prosthesis. Within the limit of the maximum amount specified per period under the plan. | | | |
| **Palliative care** | 100% UCR up to €10,000 / $12,500 | 100% UCR up to €15,000 / $19,000 | 100% UCR up to €25,000 / $31,000 | 100% UCR |
| | If a **Member** is diagnosed with a terminal **Illness** and can no longer be treated with a view to being cured, we will cover:<br><br>- the cost of a room in a **Hospital** or hospice (even if palliative home care is also covered)<br>- nursing costs<br>- **Prescribed drugs** | | | |
| Medical expenses for an organ transplant (including for the organ donor: coverage of medical expenses and transportation to the place of hospitalization) | **Not covered** | 100% UCR up to €3,000 / $3,750 per year | 100% UCR up to €4,500 / $5,600 per year | 100% UCR up to €6,000 / $7,500 per year |
| | We will cover medical expenses related to a **Member** receiving an organ transplant from a verified and certified donor.<br><br>We will also cover medical expenses for a bone marrow donation (using either your own bone marrow or that of a compatible donor) or a stem cell donation, with or without chemotherapy, when these procedures are carried out as part of the treatment of cancer.<br><br>We will cover the following donor expenses for each event requiring an organ donation, whether or not the donor is covered under the plan:<br>- transporting the donated organ,<br>- tissue compatibility tests,<br>- the donor's operation and **Hospital** costs.<br>**We do not cover 'anti-rejection' drugs.** | | | |
| **Physiotherapy**/physical therapy, **Chiropractic** and **Osteopathy** | **Not covered** | 100% UCR up to €2,000 / $2,500 per year | 100% UCR up to €3,500 / $4,400 per year | 100% UCR |
| | We will cover consultations, treatments and procedures in **Physiotherapy**/physical therapy, **Chiropractic** and **Osteopathy** prescribed during your hospitalization. | | | |
| **Psychiatric treatment and care**<br>**Waiting period of 12 months** | **Not covered** | 100% UCR up to €3,500 / $4,400 (limited to 10 days per year) | 100% UCR up to €7,000 / $8,750 (limited to 20 days per year) | 100% UCR (limited to 30 days per year) |
| | After expiration of the 12-month **Waiting period**, we will cover **Psychiatric treatments and care** in **Hospital** (on an inpatient or outpatient basis), including room and board fees (within the limits specified in the section **'Hospital** Room coverage') to treat the covered event.<br><br>By covered event, we mean any treatment of mental **Illnesses** and disorders with respect to this benefit. | | | |

## Healthcare covered under your Hospitalization benefits (continued)

| | Quartz | Pearl | Sapphire | Diamond |
|---|---|---|---|---|
| Care of newborns (the **Member** has 30 days to enroll their newborn child in the plan without being asked to complete **a Health questionnaire**. After this period, a **Health questionnaire** will be required). The limits listed on the right apply from the 1st to the 90th day of the child's life in respect of medical expenses if he or she has been enrolled in the plan. | 100% UCR up to €30,000 / $38,000 per year | 100% UCR up to €60,000 / $75,000 per year | 100% UCR up to €125,000 / $155,000 per year | 100% UCR |
| | We will cover the care of newborns:<br><br>- For all care required for the newborn within 90 days of birth. This replaces all other coverage under the plan (routine care during the first 7 days will be covered under the **Maternity** option (**Health+Child**) if selected)<br>- Only if the children covered under this plan have been enrolled as Dependents within 30 days of their birth.<br>**We do not cover the care of children born via a surrogate mother.** | | | |

## Healthcare following covered Hospitalization

| | Quartz | Pearl | Sapphire | Diamond |
|---|---|---|---|---|
| **Home hospitalization** (on prescription) | **Not covered** | 100% UCR up to €1,500 / $1,900 per year | 100% UCR, up to 10 days / year | 100% UCR, up to 30 days / year |
| | We will cover nursing care at home following hospitalization covered under the plan, where such care:<br><br>- is prescribed by your **Specialist**,<br>- commences immediately after you leave **Hospital**,<br>- reduces the duration of your stay in **Hospital**,<br>- is provided as medical care and does not constitute personal assistance. | | | |
| Reconstructive surgery following an **Accident** occurring during the **Period of coverage** | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover the cost of reconstructive surgery which is **Medically required** and approved by our **Medical advisor** following a covered **Accident** or **Illness** occurring during the period of the insurance. | | | |
| **Immediate rehabilitation following a stay in hospital** and commenced within 30 days of hospitalization | 100% UCR up to 20 days per year | 100% UCR up to 20 days per year | 100% UCR up to 30 days per year | 100% UCR up to 30 days per year |
| | We will cover any rehabilitation, including room and board fees and treatments such as physical therapy, occupational therapy or **Speech therapy** following a covered event such as a cardiovascular **Accident**.<br>**We do not cover rehabilitation expenses or treatment which do not follow hospitalization covered under the plan.**<br>We will cover rehabilitation:<br>- if you obtained confirmation of our prior approval before commencing the treatment<br>- which commences a maximum of 30 days following hospitalization.<br>We must have received all the medical data from your **Doctor** or surgeon, including the diagnosis, treatment received and planned and your future date of discharge before agreeing to cover you under this benefit. | | | |

## Assistance included with Hospitalization benefits: provided by the Assistance company

| | |
|---|---|
| **Medical evacuation**: **local Transfer by ambulance** or air ambulance to the nearest suitable hospital facility in your **Country of expatriation** or in a neighboring country, or to your usual place of residence | If a required treatment is not available locally, we will organize and pay for the evacuation of the **Member** to the nearest medical center which is able to provide the required **Medical treatment**.<br>The evacuation will be carried out primarily by road ambulance or by air if your location is:<br>- inaccessible by road,<br>- accessible by air where such a flight represents no danger whatsoever. |
| Medical assistance | Liaising between the **Doctors** of our **Assistance provider** and the local **Doctors**, or your treating Doctor. |

| ROUTINE HEALTHCARE | Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year | | | |
|---|---|---|---|---|
| | **Quartz** | **Pearl** | **Sapphire** | **Diamond** |
| **Aggregate limit on ROUTINE HEALTHCARE benefits in €/ $** | **€10,000 $12,500** | **€20,000 $25,000** | **€30,000 $38,000** | **unlimited** |
| Consultations with **General practitioners** and **Specialists** (other than dentists, ophthalmologists and psychiatrists) and **Specialist** procedures | 100% UCR up to €80 / $100 per treatment, procedure or consultation | 100% UCR up to €130 / $160 per treatment, procedure or consultation | 100% UCR up to €180 / $225 per treatment, procedure or consultation | 100% UCR |
| | We will cover consultations with **General practitioners** and **Specialists** (other than dentists, psychiatrists and ophthalmologists) and **Specialist** treatments or procedures.<br>We will cover these consultations under **Routine healthcare**, whether carried out in a medical office, in the home or in hospital (excluding during periods of hospitalization). | | | |
| **Emergency** vision care without hospitalization | **Not covered** | **Not covered** | 100% UCR up to €500 / $625 per year | 100% UCR up to €750 / $ 950 per year |
| | We will cover under this benefit **Emergency** vision consultations related to disorders of the eye such as cataracts, retinal detachment, etc. which do not require hospitalization. Any vision care expenses which can be classed as **Routine healthcare** will be covered under the Health+ option if selected, and will not be covered if you have not purchased this option. | | | |
| **Emergency** dental care without hospitalization | **Not covered** | **Not covered** | Levels of coverage and limit shared with 'Emergency Vision care without hospitalization' | Levels of coverage and limit shared with 'Emergency Vision care without hospitalization' |
| | We will cover consultations for **Emergency** dental care, such as sudden toothache that does not require hospitalization. Any dental expenses which can be classed as **Routine healthcare** will be covered under the Health+ option if selected, and will not be covered if you have not purchased this option.<br>Dental care performed during a consultation with a stomatologist will be covered only under the Health+ option. | | | |
| Prescribed sessions of **Speech therapy**, **Orthoptics**, occupational therapy and nursing | 100% UCR up to €500 / $625 per year | 100% UCR up to €1,000 / $1,250 per year | 100% UCR up to €1,500 / $1,900 per year | 100% UCR |

| care | We will cover prescribed sessions of **Speech therapy**, **Orthoptics**, occupational therapy and nursing care.<br>We will cover these sessions under **Routine healthcare**, whether carried out in a medical office, in the home or in hospital (excluding during periods of hospitalization). | | | |
|---|---|---|---|---|
| **Physical therapy, Osteopathy** and **Chiropractic <u>on</u> prescription** | 100% UCR up to €1,000 / $1,250 per year limited to 10 sessions per year | 100% UCR up to €2,000 / $2,500 per year limited to 15 sessions per year | 100% UCR up to €3,500 / $4,400 per year limited to 25 sessions per year | 100% UCR limited to 30 sessions per year |
| | We will cover consultations in physical therapy, **Osteopathy** and **Chiropractic** prescribed as **Routine healthcare**. The limit on the number of sessions includes all specialties combined. | | | |
| **Physical therapy, Osteopathy** and **Chiropractic <u>without</u> a prescription** | 100% UCR up to 5 sessions with a maximum of €50 / $60 per session | 100% UCR up to 10 sessions, with a maximum of €100 / $125 per session | 100% UCR up to 20 sessions with a maximum of €150 / $190 per session | 100% UCR up to 30 sessions |
| | We will cover consultations in physical therapy, **Osteopathy** and **Chiropractic** for which you do not have a prescription. The limit on the number of sessions includes all specialties combined. | | | |

| **ROUTINE HEALTHCARE** | **Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year** | | | |
|---|---|---|---|---|
| | **Quartz** | **Pearl** | **Sapphire** | **Diamond** |
| **Homeopathy, Acupuncture and Traditional Chinese medicine** | 100% UCR up to 3 sessions per year, with a maximum of €50 / $60 per session | 100% UCR up to 5 sessions per year, with a maximum of €100 / $125 per session | 100% UCR up to 7 sessions per year, with a maximum of €150 / $190 per session | 100% UCR up to 10 sessions per year |
| | We will cover consultations in **Acupuncture**, **Homeopathy and Traditional Chinese medicine**. The limit on the number of sessions includes all specialties combined. | | | |
| **Laboratory tests**, MRI, x-rays, scans, tomography and physical diagnostic examinations on an outpatient basis | 100% UCR up to €2,000 / $2,500 per year | 100% UCR up to €3,500 / $4,400 per year | 100% UCR up to €7,500 / $9,400 per year | 100% UCR |
| | We will cover all types of **Laboratory tests** and medical examinations recognized by the medical scientific community, such as x-rays, scans, MRI, blood tests, etc. which are prescribed by a **General practitioner** or **Specialist** for diagnostic purposes or as part of your medical care. | | | |
| **Prescription drugs** | 100% UCR up to €700 / $875 per year | 100% UCR up to €1,300 / $1,600 per year | 100% UCR up to €2,000 / $2,500 per year | 100% UCR |
| | We will cover (under **Routine healthcare**) the cost of drugs:<br><br>- prescribed by your **General practitioner** or **Specialist**,<br>- which are used only in case of illness or injury. | | | |
| **Psychiatry**<br><br>***Waiting period of 12 months*** | **Not covered** | 100% UCR Max 3 sessions / year | 100% UCR Max 5 sessions / year | 100% UCR Max 10 sessions / year |
| | We will cover, after expiration of the 12-month Waiting period, consultations with psychiatrists within the limit of the number of consultations specified in your **Benefits schedule.** | | | |

| | Quartz | Pearl | Sapphire | Diamond |
|---|---|---|---|---|
| **Vaccinations** and preventive treatments prescribed for adults and children aged 20 and over | 100% UCR up to €200 / $250 per year | 100% UCR up to €350 / $440 per year | 100% UCR up to €500 / $625 per year | 100% UCR |
| | We will cover mandatory or recommended vaccinations and preventive treatments prescribed for expatriation, such as antimalarials or the yellow fever vaccine. | | | |
| **Vaccinations** and preventive treatments prescribed for children under the age of 20 | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover all vaccines and preventive treatments prescribed for children under 20 who are enrolled in the plan. | | | |
| Prescribed medical equipment | 100% UCR up to €500 / $625 per year | 100% UCR up to €1,000 / $1,250 per year | 100% UCR up to €1,500 / $1,900 per year | 100% UCR up to €2,500 / $3,100 per year |
| | We will cover, within the limits specified in the **Benefits schedule**, the cost of equipment and medical, orthopedic and hearing **Prostheses.** This would include, for example, the purchase of a hearing aid if a hearing problem is diagnosed by a **General practitioner** or **Specialist**. **It does not include any consumables (batteries, repairs, etc.) related to the covered equipment.** | | | |
| **Wellbeing & Wellness** | | | | |
| **Health check-up** | **Not covered** | 100% UCR up to €150/ $190 every 3 years | 100% UCR up to €500 / $625 every 3 years | 100% UCR up to €1,000 / $1,250 every 3 years |
| | We will cover one **Health check-up** for every **Member** over the age of 20. The purpose of this **Health check-up** is to review the state of health and focus on prevention. It is limited to the following tests:<br>• Blood tests (complete blood count, biochemical **Laboratory tests**, lipid profile, and thyroid, liver and kidney function)<br>• Cardiovascular examination (physical examination, electrocardiogram and blood pressure)<br>• Neurological examination (physical examination)<br>• X-ray of the lungs | | | |
| **Preventive Package covering all the procedures listed below** | **Not covered** | 100% UCR up to €500 / $625 | 100% UCR up to €800 / $1,000 | 100% UCR |
| Cervical screening (1 per year) | We will cover one cervical screening per year for **Members** aged 16 and over. | | | |
| Mammogram for women aged 45 and over (every 2 years) | We will cover one mammogram for breast cancer screening or diagnostic purposes from age 45. This test is carried out as a preventive measure without the presence of any symptoms or pain. If a mammogram is prescribed by a **General practitioner** or **Specialist** as a **Medical necessity**, it will be covered, if it is carried out in addition to the preventive examination, under **'Laboratory tests**, MRI, x-rays, scans, tomography and physical diagnostic procedures on an outpatient basis.' | | | |
| Prostate cancer screening, for men aged 45 and over (every year) | We will cover an annual screening for prostate cancer for men aged 45 and over. | | | |
| Screening for oral cancer (every 5 years) | We will cover screening for oral cancer every 5 years, for all **Members**. | | | |
| Screening for skin cancer (every 5 years) | We will cover screening for skin cancer every 5 years, for all **Members**. | | | |
| Colonoscopy, from age 50 (every 5 years) | We will cover colonoscopy every 5 years, for all **Members** aged 50 and over. | | | |
| Annual screening for fecal occult blood | We will cover an annual screening for fecal occult blood, for all **Members**. | | | |

| | | | | |
|---|---|---|---|---|
| **Bone density test,** for women aged 45 and over (every 5 years) | We will cover a **Bone density test** every 5 years for all **Members** aged 45 and over. | | | |
| Dietitian | **Not covered** | **Not covered** | 100% UCR maximum 2 sessions / year, up to €150 / $190 per consultation | 100% UCR maximum 3 sessions / year, up to €200 / $250 per consultation |
| | We will cover, within the limits specified in the **Benefits schedule**, consultations with a dietitian with a recognized qualification in the country in which they are practicing. We will only cover the consultation itself **and will not cover any weight loss treatments or, for example, costs related to food supplements.** | | | |
| Nicotine replacement | **Not covered** | 100% UCR up to €50 / $60 per year | 100% UCR up to €75 / $90 per year | 100% UCR up to €100 / $125 per year |
| | We will cover the following costs related to smoking cessation support:<br>- Nicotine patches<br>- Nicotine gum<br>- Nicotine tablets | | | |

## OPTIONAL BENEFIT HEALTH+: DENTAL + VISION

| **A CHOICE OF 4 LEVELS OF COVERAGE** | **Quartz** | **Pearl** | **Sapphire** | **Diamond** |
|---|---|---|---|---|
| **DENTAL** | **Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year** | | | |
| ***Waiting period:***<br>***- 3 months for dental care and Periodontics,***<br>***- 6 months for Dentures, dental implants, bone grafts and dental surgery***<br>***- 12 months for Orthodontics*** | | | | |
| **Annual aggregate limit** on dental benefits in € / $ for the procedures listed below (excluding Orthodontics which has its own limit) | 100% UCR up to €250 / $310 per tooth and €1,000 / $1,250 per year | 100% UCR up to €400 / $500 per tooth and €1,500 / $1,900 per year | 100% UCR up to €500 / $625 per tooth and €2,000 / $2,500 per year | 100% UCR up to €600 / $750 per tooth and €3,500 / $4,400 per year |
| **Routine dental care** (up to the annual aggregate limit above) | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | We will cover, after expiration of the 3-month **Waiting period**, consultations with a qualified dentist who is authorized to practice in the country where they are located, as well as all treatments or procedures carried out during these consultations and listed below:<br><br>- Scaling<br>- Treatment of tooth decay (amalgam)<br>- Sealing of fissures<br>- Dental x-rays<br>- Inlays / onlays<br>- Fluoride application.<br><br>**Tooth whitening is not covered by the Plan.** | | | |
| **Dentures and dental implants** | 100% UCR | 100% UCR | 100% UCR | 100% UCR |

| | | | | |
|---|---|---|---|---|
| (up to the annual aggregate limit above) | After expiration of the 6-month **Waiting period**, we will cover inlay cores, posts, bridges, crowns, dentures and implant supports. Facets are not covered. | | | |
| **Dental surgery** (up to the annual aggregate limit above) | 100% UCR | 100% UCR | 100% UCR | 100% UCR |
| | After expiration of the 6-month **Waiting period**, we will cover any surgical procedures, with or without anesthesia, including tooth extraction, bone or gum grafts and the fitting of implants. | | | |
| **Periodontics** (up to the annual aggregate limit above) | **Not covered** | 100% UCR | 100% UCR | 100% UCR |
| | After expiration of the 3-month **Waiting period**, we will cover all treatments of disorders of the retaining tissue of the tooth, including the gum. | | | |
| **Orthodontics** up to age 16 | **Not covered** | 100% UCR up to €800 / $1,000 per year for 2 years | 100% UCR up to €1,200 / year / $1,500 per year for 2 years | 100% UCR up to €1,500 / year / $1,900 per year for 2 years |
| | We will cover **Orthodontics**, after expiration of the 12-month **Waiting period,** for any treatment commenced before the age of 16 and for a maximum of 2 consecutive years. | | | |
| **VISION** | **Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year** | | | |
| ***Waiting period: 6 months*** | | | | |
| Lenses and frames, limited to one pair every 2 years | 100% UCR up to €100 / $125 | 100% UCR up to €250 / $310 | 100% UCR up to €400 / $500 | 100% UCR up to €600 / $750 |
| | We will cover, after expiration of the **Waiting period**, the cost of prescription lenses and frames with vision correction, limited to one pair every 2 years. Protective glasses (sunglasses or other types) without vision correction are not covered. | | | |
| Cost of surgical treatments for visual corrections (myopia, hyperopia, astigmatism and keratoconus) | **Not covered** | **Not covered** | Level of coverage and limit shared with 'Lenses and frames' benefit | Level of coverage and limit shared with 'Lenses and frames' benefit |
| | We cover, after expiration of the **Waiting period**, the cost of the surgical treatment of myopia, hyperopia, astigmatism and keratoconus. This benefit can be used **only once per eye for the duration of the plan.** | | | |
| Corrective contact lenses including disposable lenses | 100% UCR up to €100 / $125 per year | 100% UCR up to €200 / $250 per year | 100% UCR up to €300 / $375 per year | 100% UCR up to €400 / $500 per year |
| | We will cover, after expiration of the **Waiting period**, the cost of corrective contact lenses on prescription. | | | |
| Consultations with ophthalmologists or optometrists | 100% UCR Maximum 1 per year, limited to €80 / $100 | 100% UCR Maximum 1 per year, limited to €130 / $160 | 100% UCR Maximum 1 per year, limited to €180 / $225 per year | 100% UCR Maximum 1 per year |
| | We will cover, after expiration of the **Waiting period**, an annual vision test with an ophthalmologist or optometrist. Disorders of the eye such as cataracts, retinal detachment, glaucoma, AMD, etc. are covered under **Routine healthcare** or hospitalization if necessary. | | | |

## OPTIONAL BENEFIT HEALTH+CHILD: MATERNITY available if the OPTIONAL BENEFIT HEALTH+(DENTAL + VISION) has been purchased

| A CHOICE OF 4 LEVELS OF COVERAGE | Quartz | Pearl | Sapphire | Diamond |
|---|---|---|---|---|
| **MATERNITY** | **Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year** | | | |
| ***Waiting period:***<br>***- 10 months for Maternity***<br>***- 12 months for Fertility treatment*** | | | | |
| **MATERNITY** | **Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year** | | | |
| **Maternity** and childbirth preparation classes, prenatal and postnatal care received by the mother and **Immediate care of newborns** | 100% UCR up to €3,500 / $4,400 per year | 100% UCR up to €5,000 / $6,250 per year | 100% UCR up to €8,000 / $10,000 per year | 100% UCR up to €11,000 / $13,800 per year |
| | We will cover the cost of **Maternity** and childbirth after expiration of the 10-month **Waiting period**. This includes:<br><br>- the cost of hospitalization, anesthesia and surgical fees for **Childbirth without complications**<br>- **Postnatal care** required immediately following **Childbirth without complications** (removal of stitches following an episiotomy, etc.)<br>- childbirth preparation classes<br>- diagnostic tests for chromosomal disorders<br>- routine care of the newborn within 7 days following birth<br>Treatments due to the following conditions are not covered under this benefit but are covered under Hospitalization:<br>- Abnormal growth of cells in the uterus (molar **Pregnancy**)<br>- The fetus growing outside the uterus (ectopic **Pregnancy**). | | | |
| **Childbirth without complications**<br>(single or multiple births) | Level of coverage and limit shared with the benefit above | Level of coverage and limit shared with the benefit above | Level of coverage and limit shared with the benefit above | Level of coverage and limit shared with the benefit above |
| | We will cover the cost of midwives or other **Specialists** for home births or in a birth center after expiration of the 10-month **Waiting period**. | | | |
| **Childbirth complications**<br>(C-sections are only covered if they represent an **Absolute necessity)** | Annual limit for **Maternity** benefit doubled | Annual limit for **Maternity** benefit doubled | Annual limit for **Maternity** benefit doubled | Annual limit for **Maternity** benefit doubled |
| | Please contact us for prior approval as soon as possible. If you need **Emergency** admission for an event related to your **Pregnancy** or the birth, please contact us within 48 hours of your admission to **Hospital**.<br>We will cover room and board fees, obstetrician fees and all other medical costs for delivery by C-section, after expiration of the 10-month **Waiting period,** if the C-section is recognized as medically required; for example if the birthing process is not progressing normally (dystocia, fetal distress, bleeding, etc.).<br>Note: if we are unable to determine that the C-section was not medically required/justified, we will cover you up to the limit of the **Maternity** benefit. | | | |

| Fertility treatment<br>Waiting period: 12 months | Not covered | 100% UCR €900 / $1,100 per attempt (limited to €3,600 / $4,400 for the entire life of the plan) | 100% UCR €1,200 /$ 1,500 per attempt (limited to €4,800 / $ 6,000 for the entire life of the plan) | 100% UCR €1,500 / $ 1,900 per attempt (limited to €6,000 / $ 7,600 for the entire life of the plan) |
|---|---|---|---|---|
| | We will cover, after expiration of the 12-month **Waiting period**, the cost of pharmacy items, **Laboratory tests**, follow-up examinations and fertilization involved in **Fertility treatment**. For the purposes of this plan, fertility treatment means all of the following methods of **Medically Assisted Reproduction**:<br><br>- In vitro fertilization (IVF),<br>- Artificial insemination,<br>- Hormone treatments,<br>- Tubal surgery. | | | |

### 4.2) FOR MEMBERS WHO SELECTED THE USA COVERAGE ZONE

## PRIMARY BENEFIT HEALTH: HOSPITALIZATION + ROUTINE HEALTHCARE FOR MEMBERS WITH A PLAN IN ZONE 5 (USA)

| **A CHOICE OF 3 LEVELS OF COVERAGE** | **Pearl** | | **Sapphire** | | **Diamond** | |
|---|---|---|---|---|---|---|
| **Aggregate limit on** healthcare benefits in €/ $ | $1,000,000 | | $2,000,000 | | $3,000,000 | |
| **Co-payment, per hospitalization** | **In network** **$400** | **Out-of-network** **$800** | **In network** **$200** | **Out-of-network** **$400** | **In network** **$100** | **Out-of-network** **$200** |
| **HOSPITALIZATION** | **Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year** | | | | | |
| ***No Waiting period for Hospitalization benefit with the exception of Psychiatric treatment and care (12 months)*** | | | | | | |
| **Aggregate coverage of hospital expenses** | | | | | | |
| Hospitalization | We will cover hospital charges if:<br><br>- One or more **Members** of the plan is in **Hospital**, whether on an **Outpatient** basis or for several consecutive days,<br>- The need for hospitalization was established by a **General practitioner** or **Specialist,**<br>- The duration of your stay is medically appropriate and approved following a **Request for prior approval,**<br>- Your treatment is administered or monitored by a **General practitioner** and/or **Specialist**.<br><br>If you need to stay in **Hospital** longer than the period specified in the prior approval agreement, or if changes are made to your treatment, your **General practitioner** or **Specialist** must send us a medical report as soon as possible.<br><br>This medical report must include:<br>- The diagnosis,<br>- The treatment you have already received,<br>- The treatment you require,<br>- The additional length of time you will need to stay in **Hospital**.<br>**We do not cover hospital charges if hospitalization is due to one or more of the following reasons:**<br>**- Convalescence**<br>**- Pain management (except for Palliative care),**<br>**- Paramedical care with no Specialist treatment, except for Palliative care dispensed in a care facility,**<br>**- Personal assistance services, such as assistance with mobility, washing, preparing meals, etc.**<br>**- Treatment that could be classed as Routine healthcare.** | | | | | |
| **Hospital** room covered | **Private Room** (and lower standard), 80% UCR | **Private Room** (and lower standard), 60% UCR | **Private Room** (and lower standard), 90% UCR | **Private Room** (and lower standard), 70% UCR | **Private Room** (and lower standard), 100% UCR | **Private Room** (and lower standard**),** 80% UCR |
| | The type of room and the amount per night that we will cover under each package is shown in this **Benefits schedule.** | | | | | |
| Room and board fees for a parent staying in **Hospital** with a Dependent child under the age of 18 | 80% UCR up to $500 per year | 60% UCR up to $500 per year | 90% UCR up to $875 per year | 70% UCR up to $875 per year | 100% UCR | 80% UCR |
| | We will cover reasonable room and board fees for a parent staying in the same **Hospital** as their **Dependent** child under the age of 18, in the event of hospitalization lasting more than one day and up to the maximum amount specified in this **Benefits Schedule**. | | | | | |
| **Outpatient hospitalization** (including **Outpatient surgery)** | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will pay all covered hospital expenses for hospitalization which does not require the person receiving the treatment to stay overnight. | | | | | |

| | Pearl In network | Pearl Out network | Sapphire In network | Sapphire Out network | Diamond In network | Diamond Out network |
|---|---|---|---|---|---|---|
| **Emergency hospitalization** within the **Selected coverage zone and in lower Coverage zones** | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover treatment administered following admission to a **Hospital** or medical day center, following the onset of a sudden and unforeseen medical condition requiring immediate treatment within 24 hours for the sole purpose of preventing a life-threatening risk.<br><br>All **Services** provided in the Emergency room which are not followed by admission to hospital will be covered under **Routine healthcare**.<br>We must be notified of any **Emergency hospitalization** within 48 hours of admission. | | | | | |
| **Healthcare covered under your Hospitalization benefits** | | | | | | |
| **Intensive care** | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover hospital expenses in case of treatment in a general or cardiac **Intensive care** unit (including a Critical care unit) for patients presenting with organ failure or who are at risk of severe complications. | | | | | |
| Surgical procedures including fees, operating room and anesthesia | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover the following costs in the event of hospitalization:<br>- Operating room<br>- Recovery room<br>- Drugs and dressings used in the operating room and the recovery room<br>- Drugs and dressings used during your stay in **Hospital**<br><br>We will cover the fees for surgeons and anesthetists, and the care required immediately before and after the operation (on the same day). This also includes operations performed on an **Outpatient** basis. | | | | | |
| Consultations with **General practitioners** and **Specialists** as part of hospitalization covered under this plan (excluding **Physiotherapy** and **Alternative medicine**) and including **Specialist** treatments and procedures. | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover consultations with **General practitioners** or **Specialists** during your stay in **Hospital** following a covered Event. | | | | | |
| **Emergency dental and vision care with hospitalization** * | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover **Emergency** dental and vision care received in **Hospital** if it is **Medically required** following an **Accident** requiring hospitalization. This care must be administered within 24 hours of the **Accident**. This benefit does not cover routine **Dental surgery**, routine dental care, **Dentures**, implantology, routine vision care, vision correction, laser vision correction, **Orthodontics** or **Periodontics.** These treatments are only covered under the optional benefit Health+. | | | | | |

| | Pearl In network | Pearl Out network | Sapphire In network | Sapphire Out network | Diamond In network | Diamond Out network |
|---|---|---|---|---|---|---|
| **Laboratory tests**, MRI, x-rays, scans and tomography carried out as part of your hospitalization covered under this plan | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover all expenses related to:<br><br>- **Medical imaging**, such as x-rays, scans, MRI, etc.,<br>- tests such as blood tests or urine samples,<br>- diagnostic tests such as electrocardiograms,<br>if these examinations are prescribed by your **General practitioner** or **Specialist** to help diagnose or assess your health during your stay in hospital. | | | | | |
| **Prescription drugs** | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover the cost of any drugs prescribed by the **General practitioner** or **Specialist** in charge of your treatment during your hospitalization. | | | | | |
| Renal dialysis | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover the cost of renal dialysis, with the exception of transportation costs to and from the care facility where the dialysis is carried out. | | | | | |
| **Oncology (treatment of cancer)** | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover the cost of any medically justified treatment you receive in the **Treatment of cancer**, including chemotherapy, radiotherapy, **Oncology**, diagnostic tests and drugs, as part of hospitalization (on both an inpatient and outpatient basis). Remote follow-up examinations will be covered under '**Routine healthcare**'. | | | | | |
| Treatment of AIDS | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover any costs related to the treatment of HIV. | | | | | |
| **Internal surgical and medical prostheses and devices** | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover costs related to **Prostheses, devices or appliances** fitted during a surgical procedure. | | | | | |
| **External surgical and medical prostheses and devices** (for each **Prosthesis** and limited to 2 **Prostheses**) | 80% UCR up to $2,250 | 60% UCR up to $2,250 | 90% UCR up to $3,100 | 70% UCR up to $3,100 | 100% UCR | 80% UCR |
| | We will cover:<br>• **Essential prostheses or devices** immediately following surgery if medically required.<br>• Medically required Prostheses or devices during the short-term recovery process.<br><br>For adults and children over the age of 20, we will cover one external prosthesis per **Insurance year**, and for children up to the age of 20, we will cover the first prosthesis and a maximum of two changes of prosthesis. Within the limit of the maximum amount specified per period under the plan. | | | | | |
| **Palliative care*** | 80% UCR up to $19,000 | 60% UCR up to $19,000 | 90% UCR up to $31,000 | 70% UCR up to $31,000 | 100% UCR | 80% UCR |
| | If a **Member** is diagnosed with a terminal **Illness** and can no longer be treated with a view to being cured, we will cover:<br>- the cost of a room in a **Hospital** or hospice (even if palliative home care is also covered)<br>- nursing costs<br>- **Prescribed drugs** | | | | | |

*** No co-payments apply on those benefits**

| | Pearl In network | Pearl Out network | Sapphire In network | Sapphire Out network | Diamond In network | Diamond Out network |
|---|---|---|---|---|---|---|
| Medical expenses for an organ transplant (including for the organ donor: coverage of medical expenses and transportation to the place of hospitalization)* | 80% UCR up to $3,750 | 60% UCR up to $3,750 | 90% UCR up to $5,600 | 70% UCR up to $5,600 | 100% UCR up to $7,500 | 80% UCR up to $7,500 |
| | We will cover medical expenses related to a **Member** receiving an organ transplant from a verified and certified donor.<br><br>We will also cover medical expenses for a bone marrow donation (using either your own bone marrow or that of a compatible donor) or a stem cell donation, with or without chemotherapy, when these procedures are carried out as part of the treatment of cancer.<br><br>We will cover the following donor expenses for each event requiring an organ donation, whether or not the donor is covered under the plan:<br>- transporting the donated organ,<br>- tissue compatibility tests,<br>- the donor's operation and **Hospital** costs.<br><br>**We do not cover 'anti-rejection' drugs.** | | | | | |
| **Physiotherapy** /physical therapy, **Chiropractic** and **Osteopathy** * | 80% UCR up to $2,500 per year | 60% UCR up to $2,500 per year | 90% UCR up to $4,400 per year | 70% UCR up to $4,400 per year | 100% UCR | 80% UCR |
| | We will cover consultations, treatments and procedures in **Physiotherapy**/physical therapy, **Chiropractic** and **Osteopathy** prescribed during your hospitalization. | | | | | |
| **Psychiatric treatment and care**<br><br>***Waiting period of 12 months*** | 80% UCR up to $4,400 (limited to 10 days per year) | 60% UCR up to $4,400 (limited to 10 days per year) | 90% UCR up to $8,750 (limited to 20 days per year) | 70% UCR up to $8,750 (limited to 20 days per year) | 100% UCR (limited to 30 days per year) | 80% UCR (limited to 30 days per year) |
| | After expiration of the 12-month **Waiting period**, we will cover **Psychiatric treatments and care** in **Hospital** (on an inpatient or outpatient basis), including room and board fees (within the limits specified in the section '**Hospital** Room coverage') to treat the covered event.<br>By covered event, we mean any treatment of mental **Illnesses** and disorders with respect to this benefit. | | | | | |
| Care of newborns (the **Member** has 30 days to enroll their newborn child in the plan without being asked to complete **a Health questionnaire**. After this period, a **Health questionnaire** will be required). The limits listed on the right apply from the 1st to the 90th day of the child's life in respect of medical expenses if he or she has been enrolled in the plan. | 80% UCR up to $75,000 | 60% UCR up to $75,000 | 90% UCR up to $155,000 | 70% UCR up to $155,000 | 100% UCR | 80% UCR |
| | We will cover care of newborns:<br><br>- For all care required for the newborn within 90 days of birth. This replaces all other coverage under the plan (routine care during the first 7 days will be covered under the **Maternity** option (**Health+Child**) if selected)<br>- Only if the children covered under this plan have been enrolled as Dependents within 30 days of their birth.<br>**We do not cover the care of children born via a surrogate mother.** | | | | | |
| **Healthcare following covered Hospitalization** | | | | | | |
| **Home hospitalization** (on prescription) * | 80% UCR up to $1,900 per year | 60% UCR up to $1,900 per year | 90% UCR, up to 10 days / year | 70% UCR, up to 10 days / year | 100% UCR, up to 30 days / year | 80% UCR, up to 30 days / year |
| | We will cover nursing care at home following hospitalization covered under the plan, where such care:<br><br>- is prescribed by your **Specialist**,<br>- commences immediately after you leave **Hospital**,<br>- reduces the duration of your stay in **Hospital**,<br>- is provided as medical care and does not constitute personal assistance. | | | | | |

*** No co-payments apply on those benefits**

| | Pearl In network | Pearl Out network | Sapphire In network | Sapphire Out network | Diamond In network | Diamond Out network |
|---|---|---|---|---|---|---|
| Reconstructive surgery following an **Accident** occurring during the **Period of coverage** * | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover the cost of reconstructive surgery which is **Medically required** and approved by our **Medical advisor** following a covered **Accident** or **Illness** occurring during the period of the insurance. | | | | | |
| **Immediate rehabilitation following a stay in hospital** and commenced within 30 days of hospitalization * | 80% UCR up to 20 days per year | 60% UCR up to 20 days per year | 90% UCR up to 30 days per year | 70% UCR up to 30 days per year | 100% UCR up to 30 days per year | 80% UCR up to 30 days per year |
| | We will cover any rehabilitation, including room and board fees and treatments such as physical therapy, occupational therapy or **Speech therapy** following a covered event such as a cardiovascular **Accident**.<br><br>**We do not cover rehabilitation expenses or treatment which do not follow hospitalization covered under the plan.**<br><br>We will cover rehabilitation:<br>- if you received confirmation of our prior approval before commencing the treatment<br>- which commences a maximum of 30 days following hospitalization.<br><br>We must have received all the medical data from your **Doctor** or surgeon, including the diagnosis, treatment received and planned, and your future date of discharge before agreeing to cover you under this benefit. | | | | | |
| **Assistance included with Hospitalization benefits: provided by the Assistance company** | | | | | | |
| **Medical evacuation: local transfer by ambulance** or air ambulance to the nearest suitable hospital facility in your **Country of expatriation** or in a neighboring country, or to your usual place of residence * | If a required treatment is not available locally, we will organize and pay for the evacuation of the **Member** to the nearest medical center which is able to provide the required **Medical treatment**.<br><br>The evacuation will be carried out primarily by road ambulance or by air if your location is:<br>- inaccessible by road,<br>- accessible by air where such a flight represents no danger whatsoever. | | | | | |
| Medical assistance * | Liaising between the **Doctors** of our **Assistance provider** and the local **Doctors**, or your **treating Doctor.** | | | | | |
| **ROUTINE HEALTHCARE** | **Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year** | | | | | |
| **Aggregate limit on ROUTINE HEALTHCARE** | **$25,000** | **$25,000** | **$38,000** | **$38,000** | **unlimited** | **unlimited** |
| **Co-payment per visit, treatment or procedure** | **In network: $35** | **Out-of-network: $45** | **In network: $25** | **Out-of-network: $35** | **Out-of-network: $15** | **In network: $25** |
| Consultations with **General practitioners** and **Specialists** (other than dentists, ophthalmologists and psychiatrists) and **Specialist** procedures | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover consultations with **General practitioners** and **Specialists** (other than dentists, psychiatrists and ophthalmologists) and **Specialist** treatments or procedures.<br>We will cover these consultations under **Routine healthcare**, whether carried out in a medical office, in the home or in hospital (excluding during periods of hospitalization). | | | | | |
| **Emergency** vision care without hospitalization | **Not covered** | **Not covered** | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover under this benefit **Emergency** Vision consultations related to disorders of the eye such as cataracts, retinal detachment, etc. which do not require hospitalization. Any vision care expenses which can be classed as **Routine healthcare** will be covered under the Health+ option, if selected, and will not be covered if you have not purchased this option. | | | | | |

*** No co-payments apply on those benefits**

| | Pearl In network | Pearl Out network | Sapphire In network | Sapphire Out network | Diamond In network | Diamond Out network |
|---|---|---|---|---|---|---|
| **Emergency** dental care without hospitalization * | **Not covered** | **Not covered** | Levels of coverage and limit shared with 'Emergency Vision care without hospitalization' | Levels of coverage and limit shared with 'Emergency Vision care without hospitalization' | Levels of coverage and limit shared with 'Emergency Vision care without hospitalization' | Levels of coverage and limit shared with 'Emergency Vision care without hospitalization' |
| | We will cover consultations for **Emergency** dental care, such as sudden toothache that does not require hospitalization. Any dental expenses which can be classed as **Routine healthcare** will be covered under the Health+ option if selected, and will not be covered if you have not purchased this option. Dental care carried out during a consultation with a stomatologist will be covered only under the Health+ option. | | | | | |
| Prescribed sessions of **Speech therapy**, **Orthoptics**, occupational therapy and nursing care * | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover prescribed sessions of **Speech therapy**, **Orthoptics**, occupational therapy and nursing care. We will cover these sessions under **Routine healthcare**, whether carried out in a medical office, in the home or in hospital (excluding during periods of hospitalization). | | | | | |
| **Physical therapy, osteopathy and chiropractic on prescription** | 80% UCR limited to 15 sessions per year | 60% UCR limited to 15 sessions per year | 90% UCR limited to 25 sessions per year | 70% UCR limited to 25 sessions per year | 100% UCR limited to 30 sessions per year | 80% UCR limited to 30 sessions per year |
| | We will cover consultations in physical therapy, **Osteopathy** and **Chiropractic** prescribed as **Routine healthcare**. The limit on the number of sessions includes all specialties combined. | | | | | |
| **Physical therapy, osteopathy and chiropractic without a prescription** | 80% UCR up to 10 sessions | 60% UCR up to 10 sessions | 90% UCR up to 20 sessions | 70% UCR up to 20 sessions | 100% UCR up to 30 sessions | 80% UCR up to 30 sessions |
| | We will cover consultations in physical therapy, **Osteopathy** and **Chiropractic** for which you do not have a prescription. The limit on the number of sessions includes all specialties combined. | | | | | |

| **ROUTINE HEALTHCARE** | **Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year** | | | | | |
|---|---|---|---|---|---|---|
| **Homeopathy, Acupuncture and Traditional Chinese medicine** | 80% UCR up to 5 sessions per year | 60% UCR up to 5 sessions per year | 90% UCR up to 7 sessions per year | 70% UCR up to 7 sessions per year | 100% UCR up to 10 sessions per year | 80% UCR up to 10 sessions per year |
| | We will cover consultations in **Acupuncture**, **Homeopathy and Traditional Chinese medicine**. The limit on the number of sessions includes all specialties combined. | | | | | |
| **Laboratory tests**, MRI, x-rays, scans, tomography and physical diagnostic examinations on an outpatient basis | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover all types of **Laboratory tests** and medical examinations recognized by the medical scientific community, such as x-rays, scans, MRI, blood tests, etc. which are prescribed by a **General practitioner** or **Specialist** for diagnostic purposes or as part of your medical care. | | | | | |
| **Prescription drugs** | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover (under **Routine healthcare**) the cost of drugs:<br><br>- prescribed by your **General practitioner** or **Specialist**,<br>- which are used only in case of illness or injury. | | | | | |

| | Pearl<br>In network | Pearl<br>Out network | Sapphire<br>In network | Sapphire<br>Out network | Diamond<br>In network | Diamond<br>Out network |
|---|---|---|---|---|---|---|
| **Psychiatry**<br><br>***Waiting period of 12 months*** | 80% UCR<br>Maximum of 3 consultations / year | 60% UCR<br>Maximum of 3 consultations / year | 90% UC<br>Maximum of 5 consultations / year | 70% UCR<br>Maximum of 5 consultations / year | 100% UCR<br>Maximum of 10 consultations / year | 80% UCR,<br>Maximum of 10 consultations / year |
| | We will cover, after expiration of the 12-month Waiting period, consultations with psychiatrists within the limit of the number of consultations specified in your **Benefits schedule.** | | | | | |
| **Vaccinations** and preventive treatments prescribed for adults and children aged 20 and over | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover mandatory or recommended vaccinations and preventive treatments prescribed for expatriation, such as antimalarials or the yellow fever vaccine. | | | | | |
| **Vaccinations** and preventive treatments prescribed for children under the age of 20 | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover all vaccines and preventive treatments prescribed for children under 20 who are enrolled in the plan. | | | | | |
| Prescribed medical equipment | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover, within the limits specified in the **Benefits schedule**, the cost of equipment and medical, orthopedic and hearing **Prostheses.** This would include, for example, the purchase of a hearing aid if a hearing problem is diagnosed by a **General practitioner** or **Specialist**. **It does not include any consumables (batteries, repairs, etc.) related to the covered equipment.** | | | | | |

## Wellbeing & Wellness

| | Pearl | | Sapphire | | Diamond | |
|---|---|---|---|---|---|---|
| **Co-payment, per consultation** | **In network** **$35** | **Out-of-network** **$45** | **In network** **$25** | **Out-of-network** **$35** | **Out-of-network** **$15** | **In network** **$25** |
| **Health check-up** | 80% UCR up to $190 every 3 years | 60% UCR up to $190 every 3 years | 90% UCR up to $625 every 3 years | 70% UCR up to $625 every 3 years | 100% UCR up to $1,250 every 3 years | 80% UCR up to $1,250 every 3 years |
| | We will cover one **Health check-up** for every **Member** over the age of 20. The purpose of this **Health check-up** is to review the state of health and focus on prevention. It is limited to the following tests:<br><br>• Blood tests (complete blood count, biochemical **Laboratory tests**, lipid profile and thyroid, liver and kidney function)<br>• Cardiovascular examination (physical examination, electrocardiogram and blood pressure)<br>• Neurological examination (physical examination)<br>• X-ray of the lungs | | | | | |
| **Preventive Package covering all the procedures listed below** | 80% UCR up to $625 | 60% UCR up to $625 | 90% UCR up to $1,000 | 70% UCR up to $1,000 | 100% UCR | 80% UCR |
| Cervical screening (1 per year) | We will cover one cervical screening per year for **Members** aged 16 and over. | | | | | |
| Mammogram for women aged 45 and over (every 2 years) | We will cover one mammogram for breast cancer screening or diagnostic purposes from age 45. This test is carried out as a preventive measure without the presence of any symptoms or pain. If a mammogram is prescribed by a **General practitioner** or **Specialist** as a **Medical necessity**, it will be covered, if it is carried out in addition to the preventive examination, under **'Laboratory tests**, MRI, x-rays, scans, tomography, and physical diagnostic procedures on an outpatient basis.' | | | | | |
| Prostate cancer screening, for men aged 45 and over (every year) | We will cover an annual screening for prostate cancer for men aged 45 and over. | | | | | |
| Screening for oral cancer (every 5 years) | We will cover screening for oral cancer every 5 years, for all **Members**. | | | | | |
| Screening for skin cancer (every 5 years) | We will cover screening for skin cancer every 5 years, for all **Members**. | | | | | |
| Colonoscopy, from age 50 (every 5 years) | We will cover colonoscopy every 5 years, for all **Members** aged 50 and over. | | | | | |
| Annual screening for fecal occult blood | We will cover an annual screening for fecal occult blood, for all **Members**. | | | | | |
| **Bone density test,** for women aged 45 and over (every 5 years) | We will cover a **Bone density test** every 5 years for all **Members** aged 45 and over. | | | | | |
| Dietitian | **Not covered** | **Not covered** | 90% UCR, max 2 sessions / year | 70% UCR, max 2 sessions / year | 100% UCR, 3 sessions / year | 80% UCR, 3 sessions / year, |
| | We will cover, within the limits specified in the **Benefits schedule**, consultations with a dietitian holding a recognized qualification in the country in which they are practicing. We will only cover the consultation itself, and will not cover any weight loss treatments or, for example, costs related to food supplements. | | | | | |
| Nicotine replacement | 100% UCR $60 per year | 100% UCR $60 per year | 100% UCR $90 per year | 100% UCR $90 per year | 100% UCR $125 per year | 100% UCR $125 per year |
| | We will cover the following costs related to smoking cessation support:<br>- Nicotine patches<br>- Nicotine gum | | | | | |

| | |
|---|---|
| | - Nicotine tablets |

## OPTIONAL BENEFIT HEALTH+: DENTAL + VISION

| A CHOICE OF 3 LEVELS OF COVERAGE | Pearl | | Sapphire | | Diamond | |
|---|---|---|---|---|---|---|
| **DENTAL** | **Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year** | | | | | |
| ***Waiting period:***<br>***- 3 months for dental care and Periodontics,***<br>***- 6 months for Dentures, dental implants, bone grafts and dental surgery,***<br>***- 12 months for Orthodontics*** | | | | | | |
| | **In network** | **Out network** | **In network** | **Out network** | **In network** | **Out network** |
| **Annual aggregate limit** on dental benefits for the procedures listed below (excluding Orthodontics which has its own limit) | 80% UCR up to $500 per tooth and $1,900 per year | 60% UCR up to $500 per tooth and $1,900 per year | 90% UCR up to $625 per tooth and $2,500 per year | 70% UCR up to €500 / $625 per tooth and $2,500 per year | 100% UCR up to $750 per tooth and $4,400 per year | 80% UCR up to $750 per tooth and $4,400 per year |
| ***Waiting period:***<br>***- 3 months for dental care and Periodontics,***<br>***- 6 months for Dentures, dental implants and bone grafts***<br>***- 12 months for Orthodontics*** | | | | | | |
| **Co-payment per consultation** | **In network** | **Out-of-network** | **In network** | **Out-of-network** | **Out-of-network** | **In network** |
| | **$35** | **$45** | **$25** | **$35** | **$15** | **$25** |
| **Routine dental care** (up to the annual aggregate limit above) | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | We will cover, after expiration of the **3-month Waiting period**, consultations with a qualified dentist who is authorized to practice in the country where they are located, as well as all treatments or procedures carried out during these consultations and listed below:<br>- Scaling<br>- Treatment of tooth decay (amalgam)<br>- Sealing of fissures<br>- Dental x-rays<br>- Inlays / onlays<br>- Fluoride application.<br><br>**Tooth whitening is not covered by the Plan.** | | | | | |
| **Dentures and dental implants** (up to the annual aggregate limit above) | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | After expiration of the 6-month **Waiting period**, we will cover inlay cores, posts, bridges, crowns, dentures and implant supports. **Facets are not covered.** | | | | | |
| **Dental surgery** (up to the annual aggregate limit above) | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | After expiration the 6-month **Waiting period**, we will cover any surgical procedures, with or without anesthesia, including tooth extraction, bone or gum grafts and the fitting of implants. | | | | | |
| **Periodontics** (up to the annual aggregate limit above) | 80% UCR | 60% UCR | 90% UCR | 70% UCR | 100% UCR | 80% UCR |
| | After expiration of the 3-month **Waiting period**, we will cover all treatments of disorders of the retaining tissue of the tooth, including the gum. | | | | | |
| **Orthodontics** up to age 16 | 80% UCR up to $1,000 per year for 2 years | 60% UCR up to $1,000 per year for 2 years | 90% UCR up to $1,500 per year for 2 years | 70% UCR up to $1,500 per year for 2 years | 100% UCR up to $1,900 per year for 2 years | 80% UCR up to $1,900 per year for 2 years |

| | | | | | | |
|---|---|---|---|---|---|---|
| | We will cover **Orthodontics**, after expiration of the 12-month **Waiting period** for any treatment commenced before the age of 16 and for a maximum of 2 consecutive years. | | | | | |
| **VISION** | **Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year** | | | | | |
| ***Waiting period: 6 months*** | | | | | | |
| | **Pearl** | | **Sapphire** | | **Diamond** | |
| **Co-payment per consultation** | **In network** | **Out-of-network** | **In network** | **Out-of-network** | **Out-of-network** | **In network** |
| | **$35** | **$45** | **$25** | **$35** | **$15** | **$25** |
| Lenses and frames, limited to one pair every 2 years | 80% UCR up to $310 per year | 60% UCR up to $310 per year | 90% UCR up to $500 per year | 70% UCR up to $500 per year | 100% UCR up to $750 per year | 80% UCR up to $750 per year |
| | We will cover, after expiration of the **Waiting period**, the cost of prescription lenses and frames with vision correction, limited to one pair every 2 years. Protective glasses (sunglasses or other types) without vision correction are not covered. | | | | | |
| Cost of surgical treatments for visual corrections (myopia, hyperopia, astigmatism and keratoconus) | **Not covered** | **Not covered** | Level of coverage and limit shared with ‘Lenses and frames’ benefit | Level of coverage and limit shared with ‘Lenses and frames’ benefit | Level of coverage and limit shared with ‘Lenses and frames’ benefit | Level of coverage and limit shared with ‘Lenses and frames’ benefit |
| | We will cover, after expiration of the **Waiting period**, the cost of the surgical treatment of myopia, hyperopia, astigmatism and keratoconus. This benefit can be used only once per eye for the duration of the plan. | | | | | |
| Corrective contact lenses including disposable lenses | 80% UCR up to $250 per year | 60% UCR up to $250 per year | 90% UCR up to $375 per year | 70% UCR up to $375 per year | 100% UCR up to $500 per year | 80% UCR up to $500 per year |
| | We will cover, after expiration of the **Waiting period**, the cost of corrective contact lenses on prescription. | | | | | |
| Consultations with ophthalmologists or optometrists | 80% UCR, limited to one consultation per year | 60% UCR, limited to one consultation per year | 90% UCR, limited to one consultation per year | 70% UCR, limited to one consultation per year | 100% UCR, limited to one consultation per year | 80% UCR, limited to one consultation per year |
| | We will cover, after expiration of the **Waiting period**, an annual vision test with an ophthalmologist or optometrist. Disorders of the eye such as cataracts, retinal detachment, glaucoma, AMD, etc. are covered under **Routine healthcare** or hospitalization if necessary. | | | | | |

## OPTIONAL BENEFIT HEALTH+CHILD: MATERNITY
## available if the OPTIONAL BENEFIT HEALTH+ (DENTAL + VISION) has been purchased

| A CHOICE OF 3 LEVELS OF COVERAGE | Pearl | | Sapphire | | Diamond | |
|---|---|---|---|---|---|---|
| **MATERNITY** | **Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year** | | | | | |
| ***Waiting period:*** ***- 10 months for Maternity and 12 months for Fertility treatment*** | | | | | | |
| | **In network** | **Out-of-network** | **In network** | **Out-of-network** | **Out-of-network** | **In network** |
| **Co-payment per consultation** | **$35** | **$45** | **$25** | **$35** | **$15** | **$25** |
| **Maternity** and childbirth preparation classes, prenatal and postnatal care received by the mother and **immediate care of newborns** | 80% UCR up to $6,250 per year | 60% UCR up to $6,250 per year | 90% UCR up to $10,000 per year | 70% UCR up to $10,000 per year | 100% UCR up to $13,800 per year | 80% UCR up to $13,800 per year |
| | We will cover the cost of **Maternity** and childbirth after expiration of the 10-month **Waiting period**.<br>This includes:<br><br>- the cost of hospitalization, anesthesia and surgical fees for **Childbirth without complications,**<br>- **Postnatal care** required immediately following **Childbirth without complications** (removal of stitches following an episiotomy, etc.),<br>- childbirth preparation classes,<br>- diagnostic tests for chromosomal disorders,<br>- routine care of the newborn within 7 days following birth<br><br>Treatments due to the following conditions are not covered under this benefit but are covered under Hospitalization:<br>- Abnormal growth of cells in the uterus (molar **Pregnancy**)<br>- The fetus growing outside the uterus (ectopic **Pregnancy**). | | | | | |
| **Childbirth without complications** (single or multiple births) | Level of coverage and limit shared with the benefit above | Level of coverage and limit shared with the benefit above | Level of coverage and limit shared with the benefit above | Level of coverage and limit shared with the benefit above | Level of coverage and limit shared with the benefit above | Level of coverage and limit shared with the benefit above |
| | We will cover the cost of midwives or other **Specialists** for home births or in a birth center after expiration of the 10-month **Waiting period**. | | | | | |
| **Childbirth complications** (C-sections are only covered if they represent an **Absolute necessity)** | Annual limit for Maternity benefit doubled | Annual limit for Maternity benefit doubled | Annual limit for Maternity benefit doubled | Annual limit for Maternity benefit doubled | Annual limit for Maternity benefit doubled | Annual limit for Maternity benefit doubled |
| | Please contact us for prior approval as soon as possible. If you need **Emergency** admission for an event related to your **Pregnancy** or the birth, please contact us within 48 hours of your admission to **Hospital**.<br><br>We will cover room and board fees, obstetrician fees and all other medical costs for delivery by C-section, after expiration of the 10-month **Waiting period,** if the C-section is recognized as medically required, for example if the birthing process is not progressing normally (dystocia, fetal distress, bleeding, etc.).<br>Note: if we are unable to determine that the C-section was not medically required/justified, we will cover you up to the limit of the **Maternity** benefit. | | | | | |
| **Fertility treatment** ***Waiting period: 12 months*** | 80% UCR up to $1,100 per attempt (limited to $4,400 for the entire life of the plan) | 60% UCR up to $1,100 per attempt (limited to $4,400 for the entire life of the plan) | 90% UCR up to $1,500 per attempt (limited to $6,000 for the entire life of the plan) | 70% UCR up to $1,500 per attempt (limited to $6,000 for the entire life of the plan) | 100% UCR up to $1,900 per attempt (limited to $7,600 for the entire life of the plan) | 80% UCR up to $1,900 per attempt (limited to $7,600 for the entire life of the plan) |
| | We will cover, after expiration of the 12-month **Waiting period**, the cost of pharmacy items, **Laboratory tests**, follow-up examinations and fertilization involved in **Fertility treatment**. For the purposes of this plan, **Fertility treatment** means all of the following methods of **Medically Assisted Reproduction**:<br>- In vitro fertilization (IVF),<br>- Artificial insemination,<br>- Hormone treatments,<br>- Tubal surgery. | | | | | |

## 5) Details of exclusions from Healthcare Benefits (what is not covered)

**Although it covers most Medically required medical treatments, your plan does not cover expenses related to the medical treatments and procedures listed below, unless otherwise stated in the Benefits schedule or in any other written endorsement. If you are in doubt regarding any of the exclusions listed below, you should always contact us before starting any medical treatment or procedure.**

**The following are excluded from the insurance:**

- **costs incurred before the effective date of the plan and after coverage has ceased;**
- **travel and accommodation expenses related to healthcare;**
- **any medical or surgical expenditure not prescribed by a qualified medical authority (practitioners, therapists, clinics, Hospitals and medical centers) who/which are not recognized:**

**by the authorities in force in the country where the treatment takes place as having particular expertise in the treatment of the relevant Accident or Illness,**
**by the Medical advisor as being properly qualified, competent and authorized to prescribe treatment and who have been notified in writing by him or her;**

- **non-prescription drugs;**
- **treatments, consultations and Drugs prescribed by the Member, their Dependents or any member of their family;**
- **costs deemed unnecessary and/or inappropriate by the Insurer's Medical advisor;**
- **in the event of hospitalization, additional expenses with no direct medical purpose such as charges for telephone, television, internet access, newspapers, taxi fares, meals for visitors etc.;**
- **costs deemed to be excessive, unreasonable or unusual considering the country in which they were incurred. Therefore, only Usual, Customary and Reasonable costs will be covered and reimbursed under the plan, i.e. reasonable medical expenses which are commonly charged in the relevant country for the specific treatment received, according to standard medical and generally accepted procedures;**
- **the cost of hospitalization in a deluxe or VIP room or other suites;**
- **experimental treatments or drugs, namely all forms of treatment or medication which, in the opinion of the Medical advisors, are not conventional or whose effectiveness has not been proven;**

- **in respect of pharmacy items, products which are not recognized as drugs such as sunscreen, makeup, over-the-counter products, etc.,**

- **the cost of cosmetic, esthetic or reconstruction treatments performed by a plastic surgeon to improve or transform the appearance - even for psychological reasons - unless this treatment is linked to the restoration of a physical feature or function following a disfiguring Accident or surgery related to the Treatment of cancer occurring during the Period of insurance coverage;**

**- treatments and stays in health resorts, fitness centers, convalescent homes or nursing homes, spas and thermal treatment centers, ... and other similar establishments which are not recognized as Hospitals;**
**- all tests and treatments for obesity/anorexia, or which are required as a result of obesity or anorexia, including, in particular, programs and fees for weight loss/weight gain and medicinal support and drugs prescribed for obesity/anorexia. In some clinical cases, with the approval of the Medical advisor, surgical procedures for morbid obesity (BMI = Body Mass Index> 40) may be covered;**
**- products classified as vitamins or minerals and dietary supplements (except in the treatment of a serious vitamin deficiency), over-the-counter products and cosmetics;**
**- all types of care, treatment and consultations for Mental illnesses or disorders (excluding stays in a psychiatric hospital and excluding consultations with Psychiatrists, if covered under the plan and limited to the number of days/sessions specified in the plan) or behavioral disorders (chapter V of the WHO International Classification of Diseases, version 10). These treatments can be medicinal, based on consultations or dialogues or administered using equipment;**
**- the care, treatment and all consequences of attempted suicide or self-inflicted injuries or Illnesses, or the use of narcotics without a medical prescription;**
**- consultations in psychology, psychotherapy and/or psychoanalysis with a therapist or family counselor (even if such consultations are conducted by a Psychiatrist);**
**- cognitive developmental delay, except for a child under 20 who has not attained the level of cognitive development expected for a child of their age. Treatments are not covered if the development of the child is only slightly or temporarily delayed. The cognitive developmental delay must have been quantitatively measured by qualified personnel;**
**- speech therapy will only be covered in the native language of the person receiving the treatment, unless the Medical advisor rules otherwise;**
**- expenditure arising when receiving an organ donation or purchasing an organ, namely:**

- **mechanical or animal organs, except in cases where a mechanical device is used temporarily for the sole purpose of maintaining vital functions while awaiting a transplant;**
- **any purchase of an organ from a donor regardless of origin;**
- **the cultivation and storage of stem cells, for prevention purposes, for hypothetical future use in the event of a possible Illness;**

**- costs generated by complications caused directly by an injury or Illness which is not covered or only partially covered under the plan;**
**- pre-existing conditions: any Illness, condition or injury, or related symptoms, which developed before the date of enrollment in the plan of which the Member or their Dependents were aware, or of which they could reasonably have been aware and which we have not expressly agreed to cover;**
**- the cost of transportation and evacuation. Some of these costs will be covered under the terms and conditions of 'Medical Evacuation and Medical Transportation' benefits and under the 'Repatriation' option if selected;**
    **- all costs of Medical evacuation from a ship to a medical center on land;**

- **the cost of medical hospitalization or stays in sanatoriums or preventoriums if the establishments where the Insured member was treated are not approved by the competent public authority;**
- **foot care from a podiatrist or chiropodist, such as treatments for corns/calluses, thickened and/or deformed nails, except in cases of Medical necessity approved by the Medical advisor;**
- **fetal surgery, i.e. treatment or surgery carried out in the womb before birth, unless it is the result of complications reported during Pregnancy;**
- **the cost of voluntary termination of Pregnancy;**
- **the cost of gestational surrogacy, namely all treatments directly related to the use of a surrogate mother (gestational surrogacy) whether the Insured member is the surrogate mother or the intended parent;**
- **all devices, operations and treatments for the purpose of preventing birth: contraception, sterilization, vasectomy, termination of Pregnancy (unless there is a threat to the health of the mother), family planning consultations, etc.;**
- **all devices, operations and treatments for sexual dysfunction (sexual deficiencies such as impotence, regardless of cause) or disorders related to gender (disorders related to sex changes or gender reassignment);**
- **the cost of Infertility treatments (and, in particular, Medically assisted reproduction) unless the optional benefit Health+Child (Maternity) was purchased by the Member and/or their Dependents;**
- **Infertility treatment costs other than those specified in chapter '4) Healthcare Benefits in detail: Healthcare Benefits Schedule' if the optional benefit Health+Child (Maternity) has been selected;**
- **sleep disorders, including insomnia, unless the Insured member is diagnosed as suffering from severe sleep apnea;**
  - **Pre and postnatal care costs if the 'Maternity' benefit has not been purchased;**
  - **the consequences of breaking the laws of the country where the Insured member is staying;**
  - **the cost of psychomotor therapy;**
- **disorders of the temporomandibular joint (TMJ), except in cases of Medical necessity approved by the Medical advisor;**
- **costs for which a Request for prior approval was not submitted or where it was denied by the Insurer;**
- **life-sustaining treatments, unless the Medical advisor rules otherwise;**
- **treatments administered for more than 90 consecutive days to an Insured member who has permanent neurological damage and/or is in a persistent vegetative state (PVS) unless the Medical advisor rules otherwise;**
- **administrative costs;**
- **Doctors' fees for purely administrative purposes (for example, to obtain a visa, complete a claim form, etc.);**
- **care provided in a nursing facility or retirement home and the costs resulting from personal assistance with daily activities, even if that person has been declared as being in a state of**

**temporary or permanent disability. Such services are classed as home care even if they are prescribed by a Doctor and delivered by providers with medical or paramedical status;**

- **non-medical admissions or hospital stays which include:**
  - **treatment which could be administered in day care or on an outpatient basis,**
  - **treatment which is not medically justified in the opinion of the Medical advisor,**
  - **convalescence.**
- **treatment of a condition which is subject to a specific exclusion. Specific exclusions are listed on your Certificate of enrollment;**
- **costs which were paid by another insurance provider, person, organization or state program;**
- **any loss, damage, Illness and/or injury which may occur as a result of Medical treatment administered in a Hospital or performed by a Doctor, even if the treatment was approved as being covered;**
- **all care, treatment and consultations outside the selected geographical Coverage zone, if in a Coverage zone higher than one selected, other than in an Emergency following an Accident or sudden, unexpected and unforeseen Illness requiring surgery or Medical treatment which cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness which poses an immediate and serious threat to the health of the Insured member or if we have authorized its treatment by way of an exception with the approval of the Medical advisor;**
- **all care, treatment and consultations provided under HEALTH+ (Dental/Vision) and/or HEALTH+CHILD (Maternity) benefits if the Member and any Dependents did not purchase these options;**
- **all care, treatment and consultations received within a Coverage zone which is higher than the selected Coverage zone, particularly in the United States, in the following cases:**
  - **If the Member (and any Dependents) did not opt for the higher Coverage zone where the care was received, we will not cover the care, treatment and consultations received in this zone, except in cases of medical Emergency as defined in the plan (Emergencies following an Accident or sudden, unexpected and unforeseen Illness requiring surgery or Medical treatment which cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness which poses an immediate and serious threat to the health of the Insured member).**

  - **If the Member (and any Dependents) opted for the 'United States' Coverage Zone, we will not cover care, treatment and consultations received in the United States if it is established that the Member (and any Dependents) enrolled in the plan for the sole purpose of traveling to the United States to receive care, treatment and consultations, and if the symptoms of the condition were known to them prior to their enrollment in the plan.**

**as well as the consequences of:**

- **intentional acts committed by the Member or the Dependent;**

- **civil or foreign war, insurrection, rebellion (with or without declaration of war), riots, military coups or any usurping of power, martial law or acts committed by any illegally constituted authority, regardless of the location and the protagonists of the events, except in cases of legitimate self-defense;**

- **the direct or indirect effects of changes in the structure of the atomic nucleus, chemical contamination, radioactivity or any nuclear material, explosions or Illnesses which have been declared an epidemic and placed under the control of the public health authorities and any other conflict or disaster, if the Insured member has endangered themselves by entering a conflict zone recognized by the Government of their home country, has actively taken part in the conflict or has shown a blatant disregard for their own safety;**
- **harmful, dangerous or addictive use of alcohol, narcotics and/or drugs and any treatment arising from the harmful, dangerous or addictive use of these substances;**
  - **alcoholism or drunkenness on the part of the Member or Dependent;**
- **participation in any sporting competitions and training for these competitions as well as the practice of any sports in a club or federation;**
- **the practice of sports for professional purposes;**
  - **the practice of the sports listed below:**
- **extreme sports: bungee jumping, caving, extreme canoeing and kayaking (in rapids greater than Class V, rivers greater than Class II, on seas and oceans more than two nautical miles from land), sailing (transoceanic and single-handed navigation more than 20 nautical miles from shelter) and base jumping,**
- **mountain sports: mountaineering, climbing (excluding artificial holds without a safety rope), rock climbing, hiking above 3,000 meters, ski jumping, bobsleigh, Skeleton, skiing (alpine, cross-country and snowboarding) off marked trails which are open to the public and canyoning,**
- **air sports: aerobatics, gliding, parachuting, microlighting, hang gliding, paragliding and skysurfing,**
- **water sports: scuba diving as part of a sporting competition or for leisure purposes, riverboarding and kite surfing,**
- **competitive self-defense and combat sports,**
- **motor sports: motor racing, motorcycle racing or kart racing.**

**However, the practice of these sports, including introductions to the sport, for leisure purposes or by way of “initiation”, if it is supervised by a professional with the qualifications and skills required by the State, is covered with the exception of ‘extreme’ sports.**

**MEDICAL EXPENSES DEEMED TO BE EXCESSIVE, UNREASONABLE OR UNUSUAL CONSIDERING THE COUNTRY IN WHICH THEY WERE INCURRED ARE ALSO EXCLUDED FROM THE INSURANCE. COVERAGE OF THESE EXPENSES MAY BE DENIED OR, ON THE ADVICE OF THE INSURER’S MEDICAL ADVISOR, LIMITED, AS RECOMMENDED BY THIS MEDICAL ADVISOR.**

# 6) General operating procedures

## 6.1) YOUR PLAN

### . Coverage options

The plan provides:

- a range of BASIC BENEFITS (commercialized as '**HEALTH'**) covering costs related to hospitalization, **Routine healthcare** on an outpatient basis, **Preventive** and alternative **medicine**, pharmacy items, equipment and medical **Prostheses**,

- two OPTIONAL BENEFITS available in addition to the BASIC BENEFITS (HEALTH), chosen by each **Member**, covering the following costs:

  . LEVEL 1 OPTIONAL BENEFITS (commercialized as '**HEALTH+')**:
  Vision and Dental.

  . LEVEL 2 OPTIONAL BENEFITS (commercialized as '**HEALTH+CHILD'**):
  Maternity. Level 2 optional benefits can only be selected if level 1 optional benefits have themselves been selected.

Within each of these benefits, four packages are offered to each **Member** on enrollment: Quartz, Pearl, Sapphire and Diamond, providing increasing levels of benefits and services.

The plan also offers, in respect of Basic benefits and Level 1 Optional benefits (excluding Level 2 optional Maternity benefits), the possibility for the **Member** to choose a **Deductible** as defined in chapter '**3) Definitions of Healthcare benefits'**. Four levels of **Deductible** are available as well as the option of having no **Deductible**.

For Zone 5 (USA), the plan also offers various levels of co-payment.

The plan is therefore a highly flexible offering suited to the needs of each of the **Members**.

It is specified that:

- the optional benefits, if they are selected by the **Member**, also apply to all of their **Dependents** listed on the **Certificate of enrollment**,

**- a Member who has purchased optional benefits will only be able to withdraw from these optional benefits once for the entire duration of the plan in order to retain only the basic benefits.**

### . Eligibility for the insurance

**Primary Member**

Each member of the **Contracting association** may be enrolled in the insurance, for a specific **Coverage zone** corresponding at least to their **Country of expatriation**, on condition that:

- they are of a different nationality from that of their **Main country of residence** for the duration of their membership of the plan,

- they have duly completed and signed the **Application for coverage** and the **Medical questionnaire**,

- they are under the age of 66 at the time of enrollment or under the age of 71 if they are still in paid employment.

However, certain professional activities (those in force on the **Effective date** of the plan are listed below) are either subject to prior approval from the **Insurer**, or will be denied coverage.

The occupations subject to prior approval from the **Insurer** are:

- occupations including **activities involving personal protection, security and rescue,**
- occupations including **activities involving the security and protection of goods,**
- occupations including **activities involving the transportation or purchase of valuable goods, precious metals and stones, art objects and/or currencies,**
- occupations the purpose of which is the **teaching and practice of sports,**
- any **occupation requiring the carrying, use or transportation of weapons** of any kind whatsoever,
- occupations which require the **handling of radioactive, corrosive or toxic substances,**
- occupations the purpose of which is to **conduct public or private police investigations, gather confidential information and negotiate the release of hostages,**
- occupations involving **oil, mining, off-shore or maritime activities,**
- occupations involving **activities at heights of more than 20 meters.**

**The occupations which will not be covered by the Insurer are:**

- **bodyguards and firefighters,**
- **cash escorts,**
- **occupations including activities involving the security of banks, embassies or consulates,**
- **occupations involving the teaching and/or practice of motor, air, sea, underground or combat sports,**
- **occupations which require underground or underwater activity,**
- **occupations which require the handling of explosives (including demining),**
- **occupations which lead to the taking part in a conflict (war, civil war, insurrection, riots or hostage release), regardless of who is involved,**
- **occupations including activities on oil platforms.**

## . Specific country of residence and Coverage zone under the plan

The **Member's Main country of residence** or expatriation determines the minimum **Coverage zone** to be selected, in which the benefits will apply.

It is specified that:

- the **Selected coverage zone** must be the same for both the **Member** and the **Dependents**.

- a higher **Coverage zone** than the one including the **Main country of residence** or expatriation may be selected, particularly if the **Home country** is located in a higher **Coverage zone**.

There are 5 different **Coverage zones** under the plan, defined as follows:

- Zone 5: USA and Zones 1, 2, 3, 4
- Zone 4: Bahamas, Brazil, China, Hong Kong, United Kingdom, Switzerland and Singapore and Zones 1, 2, 3
- Zone 3: Australia, Austria, Canada, Greece, Ireland, Israel, Italy, Japan, Monaco, New Zealand, Portugal, Qatar, Russia Spain, Taiwan, Turkey, UAE and Vanuatu and Zones 1, 2,
- Zone 2: Angola, Argentina, Azerbaijan, Bahrain, Barbados, Belarus, Belgium, Bolivia, Bosnia and Herzegovina, Bulgaria, Chile, Colombia, Costa Rica, Croatia, Cyprus, Czech Republic, Denmark, Djibouti, Dominican Republic, Ecuador, Finland, France, Georgia, Germany, Guatemala, Hungary, Iceland, Kazakhstan, Kuwait, Latvia, Lebanon, Liechtenstein, Luxembourg, Malaysia, Mexico, Mozambique, Netherlands, Nigeria, Norway, Oman, Panama, Peru, Polynesia, Saint Barthelemy, Saint Martin, Saint Pierre and Miquelon, Saudi Arabia, Slovakia, South Africa, Sweden, Thailand, Ukraine, Uruguay, Venezuela, Vietnam and Wallis and Futuna and Zone 1
- Zone 1: worldwide excluding the countries in Zones 2 – 5

**It is specified that, based on events (war or civil war, insurrection, etc.) which may occur there and, in any event, in accordance with the designation of countries at risk issued by the ministry of foreign affairs of the Member's country of nationality, enrollment in the plan may be excluded for certain countries to which travel is strongly discouraged by the ministry (red zone) or subject to prior acceptance by the Insurer if travel to that country is discouraged by the ministry unless for compelling reasons (orange zone).**

The benefits apply in the **Selected coverage zone** and in lower **Coverage zones** (for example, if the **Selected coverage zone** is zone 3, the benefits will apply in zones 3, 2 and 1).

The benefits also apply, **in respect of Emergency care only**, worldwide outside the **Selected coverage zone if in a Coverage zone higher than one selected**, during temporary stays (for professional or leisure purposes) for less than 60 consecutive days, (**only if it is required following an Accident or sudden, unexpected and unforeseen Illness requiring surgery or Medical treatment which cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness which poses an immediate and serious threat to the health of the Insured member).**

## 6.2) LIFE OF YOUR PLAN

### . Effective date and renewal of the plan

The **Open group insurance plan** arranged between the **Insurer** and the **Contracting association** takes effect on July 1, 2015.

It is purchased for an initial period ending December 31, 2015 and is **automatically renewed on January 1st of each year for successive periods of one year unless terminated by either party by registered mail sent two months before each renewal date.**

The plan may be amended by mutual agreement between the **Insurer** and the **Contracting association**. In this case the **Member** will receive prior notification, under the conditions of the paragraph entitled 'Information to Members', of the changes made to their rights and obligations under the plan.

## . Enrollment in the plan and persons insured

The **Member** can choose enrollment in the plan for themselves only (Individual **Premium**) or for themselves and all or some of their **Dependents** as defined in the chapter '3) Definitions of Healthcare benefits' (with as many individual **Premiums** as **Dependents** in addition to the individual **Premium** for the primary **Member**).

The **Member** can also choose to enroll one or several dependent children under the age of 18, subject to these children being expatriated outside their **Country of nationality** and outside their parents' **Country of residence** and subject to the **Application for coverage** being duly completed and signed by the **Member**.

On enrollment, the **Member** selects a healthcare package or packages, decides whether or not to purchase optional benefits and chooses the level of benefits and the amount of the **Deductible** and **Co-payment**.

It is specified that the packages and levels of benefits for all of the **Member's Dependents**, as well as the **Deductibles** and **Co-payments,** must be the same as those selected for the **Member** themselves.

Therefore:
- if an optional benefit is selected by the **Member**, it also applies to all of their **Dependents** who are registered on enrollment,
- all of the **Member's Dependent** children must be covered by the same benefits.

These choices are made by the **Member** at the time of their enrollment in the plan. They can be amended on each anniversary of enrollment in the plan.

To be eligible for benefits, or if the selected benefits are amended, the **Member** and each **Dependent** must complete and sign a **Medical questionnaire** as enrollment in the plan or amendments to the benefits is subject to the medical approval of the **Insurer**.

Having reviewed the **Medical questionnaire**(s), the **Administrator** (MSH INTERNATIONAL) may request further medical examinations.

**If a Member or a Dependent presents an Increased health risk, the Insurer may either accept them under special conditions or deny them coverage.**

The special conditions of acceptance of enrollment in the plan or the conditions declared in the **Medical questionnaire** which gave rise to denial of coverage will be notified by registered mail.

**The minimum period of membership is 12 months.**

**If the Administrator (MSH INTERNATIONAL) denies a request to amend the benefits during the period of membership, it is specified that the Member and any of their Dependents registered on enrollment remain covered under the conditions which were in place before the requested amendment(s).**

Membership is formalized by the issuing of a **Certificate of enrollment** showing the name and address of the **Member**, those of the insured **Dependents** and the **Effective date of enrollment**, the benefits selected, the **Selected coverage zone**(s), the **Deductible**, the **Co-payment** where applicable, the corresponding **Premium** and, if applicable, the fixed term of membership.

**FREQUENTLY ASKED QUESTIONS ABOUT YOUR MEMBERSHIP OF THE PLAN AND THE PERSONS INSURED**

- **Do my Dependents have access to the same services?**

  Yes, your **Dependents** who are enrolled in the plan are entitled to the same services as you, for all benefits selected, excluding death & disability.

- **What should I do if my child no longer wants to be covered by the ASFE healthcare benefits provided under my plan?**

  In this case your child will need to take out their own insurance. Please feel free to contact one of our advisors for details of a suitable solution: contact@asfe-expat.com.

## . Adding one or more Dependents to the plan

You can request the addition of a **Dependent** family member during the life of the plan by filling out the **Application for coverage** provided for this purpose.

Newborns can be covered from birth without a **Medical health questionnaire** (except in cases of multiple births or the adoption of a child from a care home or foster family), provided we are notified within 30 days of the child's birth.

To inform us of your intention to add a newborn to your plan, please make the request in writing within 30 days of the child's birth.

If we are informed of the addition of a newborn more than 30 days after birth, the child will be required to undergo full medical screening and will only be covered from the date of our acceptance (subject to Medical approval of the **Application for coverage**).

Please note that all children from multiple births and children adopted from a care home or foster family will be subject to full medical screening.

## . The various components of your plan

Your membership of the ASFE plan is formalized by all of the following documents which make up your plan:

- **Certificate of enrollment:** this is a single document, issued only at the time of enrollment, which confirms the **Member's** enrollment in the plan and specifies, in addition to the name and address of the **Member**, those of any insured **Dependents**, the **Effective date of enrollment**, the selected benefits and packages, the **Selected coverage zone**, the **Deductible(s)** and **Co-payment(s)** if applicable and the corresponding **Premium**. The **Certificate of enrollment** corresponds to the special conditions of your plan.

- **Certificate of insurance:** this is a document which can be reissued, the purpose of which is to serve as proof of insurance coverage for the person presenting it. It contains the following information: name of the **Member** and any of their **Dependents**, **Effective date of enrollment**, number and type of plan purchased, the **Insurer** of the plan, the benefits and packages selected and the **Selected coverage zone.**

- **Premium notice**: this is a document which shows the amount of your insurance **Premiums** and the **Period of coverage**. The insurance **Premiums** are paid on the date shown on the **Premium notice.**

- **Members' Guide (information booklet and general terms & conditions):** this refers to this document which defines the benefits, exclusions and conditions of use of the insurance plan (including all information relating to claims procedures), and which should be read in conjunction with the **Certificate of enrollment** and the **Benefits schedule**. For ease of use, we will refer to it here as the **Members' Guide**.

**IMPORTANT: When you enrolled in the plan, you received a welcome letter containing your MSH INTERNATIONAL card. Keep it safe; it will help facilitate your dealings with healthcare professionals.**

## . Obtaining a Certificate of enrollment for a new Dependent

On acceptance of a new **Dependent** following the medical screening process carried out by our **Medical advisor**, we will send you a new **Certificate of enrollment** to reflect the addition of the new **Dependent**. This certificate replaces any other versions in your possession.

## . Canceling your membership before it takes effect: the Cancelation period

**In accordance with article L.112-9 of the French Insurance Code, the Member may reverse their decision to enroll in the plan by registered mail with proof of delivery during a period of 14 calendar days from the date on which their Certificate of enrollment is sent out, without having to provide reasons or pay penalties.**

This cancelation should be worded as follows:
*'I, the undersigned .......................................... (last name - first names) declare my express wish to cancel my membership of plan no. 210 / XXXX and request the reimbursement of the* ***Premium*** *paid under the terms and conditions defined by article L112-9 of the French Insurance Code.'*

Exercising the right to cancel within the period specified in the first paragraph results in the termination of membership of the plan from the date of receipt of the registered mail referred to in the same paragraph by the **Administrator MSH INTERNATIONAL**.

Once the **Member** becomes aware of an event that may result in a claim under the plan, they can no longer exercise their right to cancel.

In case of cancelation, the **Member** is only required to pay the portion of the **Premium** corresponding to the period during which the risk was covered, that period being calculated until the **Date of termination.**

The Administrator MSH INTERNATIONAL is required to reimburse the balance no later than 30 days following the **Date of termination**. However, the entire **Premium** remains due to the **Insurer** if the right to cancel is exercised when an event that may result in a claim under the plan, and of which the **Member** was not aware, occurred during the cancelation period.

## . Start of membership and effective date of benefits

For the **Member**:

The effective date of membership is subject to acceptance by the **Administrator (MSH INTERNATIONAL)** once they have received:

- the **Application for coverage** and the **Medical questionnaire(s)** duly completed and signed,

- and full payment of the first monthly, quarterly, bi-annual or annual installment of the **Premium**.

Membership takes effect on the date shown on the **Certificate of enrollment** and at the earliest on the 1st day or 15th day of the month following notification of acceptance of membership specified on the **Certificate of enrollment**.

Membership of the plan is purchased for a fixed period shown on the **Certificate of enrollment whose duration cannot be less than 12 months** or for a period ending after 365 days of coverage with automatic annual renewal on the anniversary of enrollment for successive periods of one year, subject to payment of the **Premiums** specified by the **Insurer**.

When membership of the plan is purchased by the **Member** solely on behalf of one or more **Dependent children under the age of 18**, who are expatriated outside their country of nationality and outside their parents' **Main country of residence**, membership takes effect under the conditions specified above.

When the **Member** applies for optional benefits after enrollment in the plan and, at the earliest, on the anniversary of the effective date of their enrollment under the basic version of the plan, the optional benefit(s) will take effect, subject to the outcome of the medical formalities, on expiration of the **Waiting periods** specified in the paragraph below. The waiting periods will be counted from the date of acceptance of the amendment by the **Insurer**. Until these waiting periods have passed, the **Member** will only be covered by the basic benefits.

<u>For the **Member's Dependents**</u>:

Subject to the outcome of the requested medical formalities, the enrollment of **Dependents** in the plan takes effect:

- on the same date as the **Members** themselves if they are registered at the time of the original enrollment,
- if there is a change in family status as a result of marriage, civil partnership, **Common-law marriage**, birth or adoption of a child, from the 1st day or 15th day of the month following the signing of the application to enroll these new **Dependents** in the plan, **subject to this change being declared to the Administrator (MSH INTERNATIONAL) within 90 days of the change. Otherwise, the Dependent's enrollment will be postponed until the anniversary date in the year following the application**.

**Coverage takes effect for each Member and their Dependents, subject to application of the following Waiting periods:**

- **immediately on the date of enrollment as specified above** for medical expenses in respect of the following benefits: 'Medical or surgical hospitalization – Surgical procedures and fees', 'General Medicine - Specialties – **Laboratory tests**', 'Pharmacy items', 'Preventive Medicine' (excluding **Health Check-ups**) and '**Alternative Medicine**' and 'Dental/vision consultations and care' if they are the result of an **Accident** or **Unforeseen illness** requiring surgery or **Medical treatment** that cannot wait until expiration of the **Waiting period**,

Or after application of the following **Waiting periods** (depending on the benefits selected):

- **Waiting period of 3 months** in respect of the following benefits: routine 'Dental/Vision consultations and care' (excluding **Emergencies**)' and '**Periodontics**',
- **Waiting period of 6 months** in respect of the following benefits: 'Vision', 'Dental (excluding dental consultations and care): **Dentures**, dental implants, bone grafts and dental surgery' and 'Equipment and medical, orthopedic and hearing **Prostheses**',
- **Waiting period of 10 months** in respect of the following benefits: '**Maternity**' (including **Pre and postnatal care**),
- **Waiting period of 12 months** in respect of the following benefits: '**Orthodontics**', '**Fertility treatment** (including **Medically assisted reproduction**)' and '**Psychiatric treatments and care**'.

If the member was previously enrolled in a plan which provided equivalent benefits both in terms of the benefits purchased and the levels of reimbursement, no **Waiting period** will be applied **(other than the 10 months in respect of 'Maternity' benefits (including Pre and postnatal care) and the 12 months in respect of 'Fertility treatment'.**

**It is specified that the Insurer will only cover expenses incurred in respect of treatments and procedures prescribed from the Effective date of benefits.**

## . Renewing your membership of the plan

Membership takes effect on the date shown on the **Certificate of enrollment** and at the earliest on the 1st day or 15th day of the month following notification of the acceptance of membership shown on the **Certificate of enrollment.**

**Membership is for an initial period of one year. It is renewed automatically on each anniversary for successive periods of one year unless terminated by either party by registered mail two months prior to each anniversary.**

## . Cessation of membership and end of coverage (right of Withdrawal and termination)

Membership and benefits cease for each **Member** and their **Dependents**:

- on the **Date of termination** of the plan. In this case, the **Insurer** will offer the **Member** a plan which provides continued coverage on an individual basis subject to payment of the **Premium** specified by the **Insurer**.
- if the **Member** no longer has membership of the **Contracting association**, the association must inform the **Administrator (MSH INTERNATIONAL)** of this within a period of one month.
- in accordance with the conditions specified in the section 'Procedure if I fail to pay my Premium' if the **Premiums** corresponding to the membership are no longer being paid.
- at the end of the calendar quarter during which the **Member** returns permanently to **their Country of nationality (**or **Home country)**.
- in the event of the **Member's** death. On this date, their surviving **Spouse**, **Partner or Common-law spouse** who is enrolled in the plan can take out membership of the plan for themselves and, if applicable, for their **Dependents**:
    - in accordance with the conditions specified in the section 'Your enrollment in the plan and persons insured' if they are under the age of 60 on the date of the member's death,
    - in accordance with the conditions specified in the section 'Your enrollment in the plan and persons insured' other than those relative to maximum age on enrollment if they are over the age of 60 on this date. However, no medical formalities will be required by the **Insurer**.

Membership and coverage cease in any event:

- at the end of the fixed term shown on the **Certificate of enrollment** or at the end of the period covered by the last **Premium** paid, if the **Member** requests to be removed from the plan, by mail sent to the **Administrator (MSH INTERNATIONAL) subject to a notice period of 2 months.** This request can be submitted at any time **but at the earliest after 12 months of membership of the plan.**
- when membership and coverage are renewed automatically on each anniversary for successive periods of one year: on the last day of the calendar quarter following the date of receipt by the **Administrator (MSH INTERNATIONAL)** of the Member's request to be removed from the plan by mail sent to the **Administrator (MSH INTERNATIONAL)** at least two months before the desired date of termination.

**It is specified that any removal from the plan is final. Termination of the Member's membership gives rise, in any event and on the same date, to termination of coverage and the removal of all of their Dependents from the plan.**

If membership of the plan is purchased by the **Member** solely on behalf of one or more dependent children **under the age of 18**, who are expatriated outside their country of nationality and outside their

parents' **Main country of residence**, membership and coverage cease, for each of the relevant children, when they reach their 18th birthday. On this date, this membership may be extended, with no new medical formalities, with the child acquiring **Member** status.

Coverage under the plan ceases in any event, for **Dependents**:

- for the **Spouse**: on the date of final judgment in a divorce or legal separation,

  or for the **Partner**: on the date on which the civil partnership is terminated,

  or for the **Common-law spouse**: on the date on which the **Common-law marriage** ends,

- for children: when they cease to be dependent on the **Member** and, at the latest, at the end of the school year in which they reach their 20th birthday or 26th birthday if they are in full-time education and are covered under the plan from the 1st euro.

**It is specified that the Insurer will only cover expenses incurred in respect of treatments and procedures prescribed before the date of termination of coverage.**

**The plan is null and void if its implementation, the settlement of a claim or the provision of any Benefits or services exposes the Insurer to any sanctions, restrictions or prohibition under trade or economic resolutions or sanctions imposed by the United Nations or the laws and regulations of the European Union, the United Kingdom or the United States of America.**

## . Making changes to the plan

We will send all important communications and information about your plan to the address you provided in the Enrollment form (private mailing address and email address). If you want to change this, you can do it directly in the **Members'** Area, in the section 'Your Enrollment/Your Details'. You must inform us if you/your **Dependents** change address, **Main country of residence** or nationality.

**- changing your place of residence, mailing address or email address:**

changing your private mailing address, email address or **Main country of residence**:
please notify us in writing as soon as possible of any changes in:
. your private mailing address, even if you are staying in the same **Main country of residence**
. your email address,
. your **Main country of residence**.

**IMPORTANT:**

**If you move to another country, it is your responsibility to notify us of this immediately. This is because the levels of healthcare costs in your new Main country of residence may be different from those in your current Main Country of residence and your coverage zone and the corresponding Premium may need to be increased or decreased as a result.**

**You should also keep us informed of any change of address for the Member and/or their Dependents.**

**- changing the Primary member:**

If, when renewing the plan, you want to change the primary **Member**, the new primary member will need to complete a new **Application for coverage** and will be subject to full medical screening.

**- death of the Primary member or a Dependent:**
f the primary **Member** dies, we should be informed within a period of one month following the death.

The plan will then come to an end and the **Premium** for the current year, calculated on a pro rata basis, will be refunded.

If they so wish, the first **Dependent** shown on the **Certificate of enrollment** would then have the option of sending us an application to become the primary **Member** of the plan (if they have reached the required minimum age) and including the other **Dependents** in their plan.

Following the death of a **Dependent**, their membership will come to an end and the **Premium** for the current year for this **Dependent**, calculated on a pro rata basis, will be refunded.

- **changing the package (Quartz, Pearl, Sapphire or Diamond):**

The package can only be changed on the anniversary of enrollment in the plan. **There can be only one change of package during the entire duration of membership of the plan.**

- **changing the Deductible**

Changes to the **Deductible** (or the introduction of a **Deductible** if the **Member** did not opt for one in the **Application for coverage**) are only possible on the anniversary of enrollment in the plan. **There can be only one change of deductible during the entire duration of membership of the plan.**

- **changing the level of coverage (from the 1st euro/dollar or in addition to CFE benefits (Caisse des Français de l'Etranger))**

Changes to the level of coverage are only possible on the anniversary of enrollment in the plan. **There can be only one change of level of coverage during the entire duration of membership of the plan.**

- **changing the option(s) (HEALTH, HEALTH+ or HEALTH+CHILD)**

Any change of option is only possible on the anniversary of enrollment in the plan. **There can be only one change of option during the entire duration of membership of the plan.**

- **changing the currency (euro or dollar)**

Any change of currency is only possible on the anniversary of enrollment in the plan. **There can be only one change of currency during the entire duration of membership of the plan.**

- **changing the Coverage zones (Zone 1, 2, 3, 4 or 5) and adding a Dependent to the plan**

Contact your claims department to make any changes to the **Coverage zone** or to add a **Dependent** to the plan.

## 6.3) YOUR PREMIUM

### . Calculating your Premium

The annual **Premium** is set, per insured person, depending on:

- the age of the insured person at the time of enrollment,
- the **Selected coverage zone,**
- the benefits selected (Basic benefits only (HEALTH) or Basic benefits + Optional benefits: Vision/Dental (HEALTH+) or Vision/Dental + **Maternity** (HEALTH+CHILD),
- the package selected (Quartz, Pearl, Sapphire or Diamond),
- the **Deductibles** and/or **Co-payments** selected,
- and the coverage (from the 1st euro/dollar or in addition to CFE benefits).

It is specified that, as long as at least 3 children are covered in respect of the membership of an **Insured member**, **Premiums** will only be payable for the 2 children, the highest of the amounts, with the other children being covered without payment of a **Premium**.

The amount of the **Premium** is reviewed on each anniversary of enrollment in the plan taking into account the age of each person covered under the plan and the pricing in place on that date (taking into account the application of the Adjustment clause specified below).

Any taxes applicable to the plan, the recovery of which is not prohibited, are charged to the **Member** and payable at the same time as the **Premium**.

### . Changes in the level of your Premium

**Adjustment of the Premium for the Open group insurance plan:** Premium rates may be reviewed on January 1st each year based on the results of the **Open group insurance plan** provided by the ASFE association **from Groupama Gan Vie, the Insurer**, during the previous calendar year and changes in the level of healthcare costs throughout the world.

In order to do this, the amounts of the **Premiums** in euros/dollars are assigned a coefficient (K) which is calculated using the following formula:

$$K = \frac{C}{P.\ net}$$

where:
C is the number of claims made in the period under review,
P. net is the amount of premiums, net of loading charges, collected during the same period.

**Adjustment of your membership premium:** the amount of your membership **Premium** is reviewed on each anniversary of enrollment in the plan taking into account the age of the **Member** and each of their dependents covered under the plan (determined by difference in years) and the pricing in place on that date, taking into account the application of the Adjustment clause specified above. This adjustment of the **Premiums** is applied to your membership of the plan on each anniversary of enrollment.

### . Ways of paying your Premium and additional charges

**Premiums** are payable to ASFE monthly (in case of direct debit from a bank account in France), quarterly, bi-annually or annually in advance, in euros or US dollars.

ASFE **Premium notices** are sent out, depending on the type of payment installment you chose on enrollment: monthly (in case of direct debit from a bank account in France), quarterly, bi-annually or annually. To make your payment, you can choose between several different payment methods:

⇨ online, by bank card (Visa - MasterCard - American Express):
at www.asfe-expat.com, **Members'** Area, Online payment.

⇨ by direct debit (only from a bank account in France): complete and sign the direct debit authorization form provided with your **Premium notice** (also available on request).

⇨ by check:
Make your check payable to ASFE and include your ASFE **membership** number on the reverse of the check (this is very important for ensuring the check is correctly allocated). Please make your payment by the due date to avoid receiving a final demand.

⇨ by wire transfer:
. from France: use MSH INTERNATIONAL's bank details
. or from abroad: by Swift, use MSH INTERNATIONAL's IBAN and BIC.

**Please contact us for details of our bank account.**

Be sure to include your ASFE **membership** number (this is very important for ensuring the transfer is correctly allocated).

You will pay the bank charges associated with this type of payment method.

### . <u>Online information on paying your Premium</u>

To keep you informed about your **Premium** payments, and in line with the type of payment installment you selected, you will receive an ASFE **Premium notice** by email one month before each due date. It is therefore important to keep your email address up to date to ensure you receive these reminders and help you keep track of your **Premiums**.

### . <u>Procedure if you fail to pay your Premium</u>

In accordance with the provisions of article L113-3 of the French Insurance Code, all **Premiums** due remain payable and may be recovered by any legal means.

In case of non-payment of a **Premium by the Member**, in accordance with the provisions of article L141-3 of the French Insurance Code, the **Contracting association** must, at the earliest, 10 days after the due date of the unpaid **Premium**, send the **Member** a registered letter of formal notice. By mutual agreement between the **Insurer** and the **Contracting association**, it is agreed that the Contracting association authorizes the **Insurer** to prepare and send out this letter.

The letter will state that, at the end of a period of 40 days of dispatch of this letter, the **Member** is barred from the insurance plan due to non-payment of the **Premium**. The **Member** remains liable for the full **Premium** until the date of their removal from the plan.

### . <u>Bank charges</u>

You must pay any administrative fees which your bank may charge you in relation to the payment of your **Premium**.

### . Reimbursement of the Premium

In case of **Termination** of membership of the plan (at the earliest 12 months after the date of enrollment), membership and benefits are maintained until the end of the period covered by the last **Premium** paid.

## 6.4) LEGAL INFORMATION

### . Applicable legislation and jurisdiction

The **Open group insurance plans** are governed by French law and the French Insurance Code and in particular by articles L.141-1 and following. They fall under section 2 (Healthcare) of article R. 321-1 of the Insurance Code.

Coverage under the plan is based on the declarations made by the **Contracting association**, the **Members** and the **Insured members**.

**The Contracting association, the Insurer, the Member and the Insured member declare that they submit to the jurisdiction of the French courts and waive their right to take legal action in any other country.**

### . Information to Members

This **Members' Guide**, which has been prepared by the **Insurer** and serves as the general terms and conditions, is provided to each **Member** by the **Contracting association**, along with the **Certificate of enrollment** containing the special conditions.

It is the duty of the **Contracting association**:

- to inform **Members** in writing of any proposed amendments to their rights and obligations, in accordance with article L141-4 of the French Insurance Code, at least three months before the date of their entry into force,
- to alert **Members** to the termination of the plan and inform them of the conditions under which they can enroll in the individual plan made available by the **Insurer**.

**It is the duty of the Contracting association to provide proof that the Members' Guide and information relating to amendments to and termination of the plan have been issued to the Member.**

By mutual agreement between the **Insurer** and the **Contracting association**, it is agreed that the association authorizes the **Insurer** to prepare and send out this information.

### . Applicable language

The language of the group insurance plan is French. In case of disagreement on the interpretation of the benefits provided under this plan, only the French version of this plan will be taken into consideration. Translations of the contractual documents which make up the plan are made available to **Members** purely for information purposes and only the French language is binding.

## . Regulatory information

**LIMITATION PERIOD**

**In accordance with article L114-1 of the French Insurance Code, all legal actions arising from an insurance contract are barred two years from the event that gave rise to them. However, this time limit runs:**

- **in the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only from the date on which the insurer is aware of it,**

- **in the event of a claim, only from the date the relevant parties are aware of it, if they can prove they were unaware of such facts until then.**

**In accordance with article L114-2 of the French Insurance Code, the limitation period is interrupted by one of the ordinary causes that interrupts it. These are listed under articles 2240 and following of the French Civil Code which specify, in particular:**

- **when the debtor acknowledges the right of the person against whom they were prescribing (article 2240 of the French Civil Code),**

- **a legal claim, even in summary proceedings, until the end of the hearing. This also applies when the legal claim is brought before a court which has no jurisdiction or where the act of referral to the court is cancelled by the effect of a procedural irregularity (Articles 2241 and 2242 of the French Civil Code). The interruption is void if the claimant withdraws his application or allows the suit to lapse, or if he is defeated in his claim (Article 2243 of the French Civil Code),**

- **an act of enforcement or precautionary measures taken in implementation of the code of civil enforcement procedures (Article 2244 of the Civil Code).**

**The limitation period is also interrupted by:**

- **the appointment of experts in response to a claim for benefits,**

- **the dispatch of a registered letter with proof of delivery sent by the insurer to the contracting party regarding action for payment of the Premium and by the contracting party or the member to the insurer regarding provision of the benefit.**

**It is specified that membership of the plan is null and void if the implementation of the plan, the settlement of a claim or the provision of any benefits or services exposes the insurer to any sanctions, prohibition or restrictions whatsoever under trade or economic resolutions or sanctions imposed by the United Nations or the laws and regulations of the European Union, the United Kingdom or the United States of America.**

## . Privacy and data protection

**Protection of personal data:** The personal data of **Members** and **Dependents** is processed in accordance with the French law on Data Protection and Freedom of Information of January 6, 1978 amended. The processing of this data is necessary for the management of their membership and benefits. With the exception of health-related data, it is intended for the **Insurer** and/or the **Administrator** (**MSH INTERNATIONAL**) and their distributors, agents, service providers and subcontractors and for the reinsurers as well as professional and administrative bodies with respect to

legal obligations.

This data can also be used for the purposes of the evaluation and acceptance of risks, internal control (portfolio monitoring) and in the context of legal provisions, notably with respect to combating money laundering and the financing of terrorism. As part of the campaign against insurance fraud, the **Member's** personal data may be passed on to professional bodies involved in combatting fraud as well as to licensed investigators.

The **Member,** having provided proof of identity, has the right to access, rectify, remove and object to this data free of charge by mailing a letter to the **Insurer**:

Groupama Gan Vie - Direction des Affaires Générales - Correspondant Informatique et Libertés 4-8 Cours Michelet - 92082 La Défense Cedex - France.

**Collection and processing of health-related data:** The **Member** or **Dependent** expressly accepts the collection and processing of health-related data. This data is required for the management of the benefits and is processed in compliance with medical confidentiality. It is intended for the exclusive use of the **Insurer's Medical advisor** and their medical department, or for internal or external authorized persons (including medical experts).

The **Member** and the **Dependent** have the right to access, rectify, remove and object to data relating to them by mailing a letter, together with a photocopy of ID, to the **Insurer's Medical advisor** whose contact details will be provided on request at the above address.

**Recording of telephone calls:** The **Member** and/or **Dependents** may be required to contact the **Insurer** and/or the **Administrator (MSH INTERNATIONAL)** by telephone for all types of inquiries.

The **Insurer** and/or the **Administrator (MSH INTERNATIONAL)** will inform them that their calls may be recorded to ensure the proper implementation of their benefits and, more generally, to improve quality of service. These recordings are intended only for the departments of the **Insurer** and/or the **Administrator (MSH INTERNATIONAL)** who handled that particular call.

If the **Member** or a **Dependent** has been recorded and wants to listen to the recording of a conversation, they can make the request by mailing a letter to the **Insurer and/or the Administrator (MSH INTERNATIONAL)** at the above address. They will be provided with copies of the recording or a transcript of the content of the conversation free of charge, within the time limits set for storage of these recordings.

**Transfer of information outside the European Union:** With respect to the implementation of the plan and benefits and in compliance with the stated purposes, personal data relating to **Members** and/or **Dependents** may be transferred to countries within the European Union or outside the European Union. **Members** and **Dependents** are informed of this by these provisions and expressly authorize it.

## . Force majeure

The **Insurer** cannot be held responsible for failures in the execution of their obligations resulting from cases of force majeure or the following events: civil or foreign wars, acknowledged political instability, civil unrest, riots, acts of terrorism, reprisals, restrictions on the free movement of goods and persons, strikes, explosions, natural disasters, nuclear disintegration or delays in the implementation of **Benefits** or services arising from the same causes.

## . Fraud and concealment of the facts – Misrepresentation

**Irrespective of the ordinary causes of nullity and subject to the provisions of article L132-26 of the French Insurance Code, the insurance plan is null and void in the event of concealment or intentional misrepresentation on the part of the Member and their Dependents, when such concealment or misrepresentation changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the Member or the Dependent concealed or distorted has no impact on the claim. The Insurer is then entitled to retain the Premiums paid and to payment of all due Premiums by way of damages.**

**In the event that a claim for reimbursement proves to be false, fraudulent or intentionally overstated or if the Member or one of their Dependents had resorted to fraudulent methods or means to take advantage of the insurance plan, the claim will not be paid.** As a result, the **Member** or their **Dependents** would then be immediately liable for any amount paid in respect of this claim before the discovery of the fraudulent act or omission. If fraudulent methods or means have been employed, the **Premium** will not be refunded, either in whole or part, and any pending claims for reimbursement will not be honored.

## . Penalties for misrepresentation

**Any intentional concealment or misrepresentation will render the membership null and void in accordance with article L113-8 of the French Insurance Code.**

## . Complaints procedures and mediation service

To make a complaint (disagreement or dissatisfaction) regarding the plan, the **Member** or **Dependent** can contact:

- the **Administrator MSH INTERNATIONAL** by writing to the following address:

MSH INTERNATIONAL - Service réclamation, 82 rue de Villeneuve 92 587 CLICHY Cedex - France.

If a potential dispute is not resolved following this initial contact, you have the option of contacting the Ombudsman of the Union of Insurance Brokers (*Chambre Syndicale des Courtiers d'Assurances*), who is the competent authority for handling complaints from individuals, 91 rue Saint Lazare, 75009 PARIS, or the Prudential Control Authority (*Autorité de Contrôle Prudentiel*), 61 rue Taitbout 75009 PARIS; Or

- the **Insurer's** customer relationship department at the following address:

. by mail:
Service des relations avec les consommateurs Groupama Gan Vie
Immeuble Michelet - 4-8 Cours Michelet - 92082 LA DEFENSE CEDEX - France
Tel: +33 (0)1 70 96 62 68

. by email: src-collectives@ggvie.fr

If the response is not satisfactory, the complaint may be submitted to the **Insurer's** Complaints department at the following address:

. by mail:
Groupama Gan Vie – Service Réclamations
160 avenue Charles de Gaulle - TSA 41269 - 91246 Morangis Cedex – France

. by email: service.reclamations@ggvie.fr

In both cases, the **Insurer** agrees to acknowledge receipt of the complaint within a period of no more than 10 working days. It will be processed within 2 months at the most. If this is not the case, the complainant will be informed.

Finally, and without prejudice to their right to take legal action if necessary, the **Member** or the **Dependent** may apply to the **Insurer's** ombudsman by writing to the following address:
Médiateur de Groupama Gan Vie - 5-7 rue du Centre - 93199 Noisy-le-Grand Cedex – France.

Details of complaints processing procedures are available from the usual advisor and in the 'Legal notices' section of the website www.gan-eurocourtage.fr.

### . Liability

The **Insurer's** liability in respect of insured persons is limited to the amounts shown in the **Benefits schedule** and in any endorsements to the plan. Under no circumstances can the amount of the reimbursement under the terms and conditions of the plan, public medical coverage or any other insurance exceed the amount of expenses specified on the invoice.

### . Communicating with Dependents

With respect to the management of the insurance plan, the **Administrator** may request additional information from the **Member** or their **Dependents**. If the **Administrator** needs to discuss a **Dependent** (for example, if additional information is required in order to process a claim for reimbursement), the plan **Administrator** may contact the primary **Member**, acting in the name and on behalf of their **Dependents,** to provide the required information. Similarly, in order to manage claims for reimbursement, any information related to a person covered by the plan may be sent directly to the primary **Member**.

## 7) General provisions of Medical Evacuation benefits included as standard with your Healthcare plan

### I. GENERAL

#### I.A. PURPOSE OF THE INSURANCE

These General Provisions relating to emergency medical assistance and emergency transportation/evacuation services agreed between EUROP ASSISTANCE, a company governed by the French Insurance Code and the Policyholder, are intended to provide Insured members who meet the conditions of coverage with the assistance services purchased on their behalf by the association, ASFE, the Policyholder of this plan.

## I.B. DEFINITIONS

For the purposes of this plan, these terms are defined as follows:

- **Abroad**

The term Abroad means any country outside your Home country.

- **Accident (personal)**

A sudden and fortuitous event affecting the Insured, not intended by them and resulting from sudden action with an external cause.

- **Assistance provider**

In this plan, the company Europ Assistance is referred to as "we" or "us". The assistance services are implemented by Europ Assistance, a company regulated by the French Insurance Code, a French limited company ("société anonyme") with a capital of 35,402,786 euros, registered with the French "Registre du Commerce et des Sociétés de Paris" in Nanterre under number 451 366 405. Its registered office is located at 1 Promenade de la Bonnette - 92230 GENNEVILLIERS, France.

- **Country of expatriation**

The Country of expatriation is deemed to be the country in which you live for more than 180 days per year. It must be different from the Home country.

- **Deductible**

The portion of costs payable by you.

- **Event**

Any situation provided for under these General Provisions which triggers a request for assistance from the Assistance provider.

- **Family member**

Family member means the Insured member's spouse, civil partner or de facto spouse living under the same roof, his or her legitimate, natural or adopted children and his or her father and mother.

- **France**

The term France means mainland France and the Principality of Monaco.

- **Home**

Home is deemed to be your main and usual place of residence specified as your home on your income tax assessment notice before your date of departure on an expatriate assignment. It can be located anywhere in the world. Insured members are required to reside outside their Home country during the period of validity of the plan.

- **Hospitalization**

The admission of an Insured member, supported by a patient status report, to a hospital facility (hospital or clinic) prescribed by a doctor, following an Illness or Accident and including at least one overnight stay.

- **Illness**

Pathological condition duly confirmed by a medical doctor, of a sudden and unpredictable nature and requiring medical care.

- **Insured member (You)**

Members of the association, ASFE, before their expatriation, according to the coverage zone selected on enrollment. This term refers to the Primary member and their dependents listed on the application for coverage. In this plan Insured members are also referred to as "you".

- **Natural disaster**

A natural phenomenon, such as an earthquake, volcanic eruption, tidal wave, flood, or natural cataclysm caused by the abnormal intensity of a natural agent and acknowledged as such by the public authorities in the country where the disaster occurred.

- **Place of residence**

Your main and usual place of residence in your Country of expatriation is deemed to be your Place of residence.

- **Policyholder**

Policyholder means the association, ASFE, which has arranged this group plan for the benefit of its Insured members.

- **Trip**

All of your private and business trips both in and outside your Country of expatriation which do not exceed 180 consecutive days.

## I.C. WHAT TYPES OF TRIP ARE COVERED UNDER THE PLAN?

The assistance services provided under the plan and described in chapter II apply:

- in your Country of expatriation, to trips for leisure purposes as well as business trips,
- outside your Country of expatriation, during any trips for leisure or business purposes of not more than 180 consecutive days, provided the Insured member has taken out coverage for the corresponding geographical zones.

It is the Policyholder's responsibility to check that Insured members meet the conditions of enrollment set out in these General Provisions.

Business trips begin from the moment the Insured member leaves their Place of residence, or the place in which they normally conduct their business in the Country of expatriation, and end on their return to the first of these two locations.

## I.D. WHAT IS THE GEOGRAPHICAL COVERAGE OF THE PLAN?

The assistance services apply worldwide.

## I.E. CONDITIONS OF COVERAGE

We will use every possible means required to assist you wherever you are in the world and in accordance with the terms of these General Provisions.

However, we will be able to intervene only under the following conditions:

- if there are no restrictions on the free movement of persons and goods, whether by land, sea, or air, and for any reason whatsoever, including following a decision or recommendation by local, national or international authorities or the occurrence of a Natural disaster or a situation of war,

- if, as a minimum, the international airport nearest to your location is open,

- if the safety of the persons who will carry out the assistance services is guaranteed, it being understood that it is not within our remit to conduct military-style operations.

## I.F. USING OUR SERVICES

### I.F.1. IF YOU REQUIRE ASSISTANCE

**In an emergency, it is essential to contact the local first response services for problems falling within their remit.**

**Under no circumstances can our intervention replace local public services or those of any service provider which we would be obliged to use under local and/or international regulations.**

**To enable us to provide a response:**

**We recommend you prepare your call.**

**We will ask you for the following information:**

- **your surname(s) and first name(s),**
- **your precise location and the address and telephone number where you can be reached,**
- **your plan number.**

**You must:**

- **call us without delay on: 01 41 85 84 46 (from abroad call 33 1 41 85 84 46), fax: 01 41 85 85 71 (33 1 41 85 85 71 from abroad),**
- **obtain our prior approval before taking any initiative or incurring any expense,**
- **comply with the solutions we recommend,**
- **provide us with details of your plan,**
- **provide us with all original supporting documentation for the expenses you are claiming.**

**IMPORTANT:**

**It should be noted that the Insured member must request their health insurance provider, GROUPAMA GAN VIE, via the Administrator MSH INTERNATIONAL, to issue precertification to the hospital to which they have been admitted.**

#### I.F.2. WHAT ARE THE CONDITIONS OF IMPLEMENTATION OF THE ASSISTANCE SERVICES?

We reserve the right to request any documentation required in support of requests for assistance, proof of Home address or Place of residence, proof of expenses, tax assessment notice on which all details have been obscured other than your name, address and the persons declared as members of your household for tax purposes.

We operate on the express condition that the Event which prompts us to provide the service was uncertain at the time of enrollment in the plan and at the time of departure.

It follows therefore that the plan cannot cover an event whose origins lie in an illness and/or injury which was pre-existing, diagnosed and/or treated or which required continuous hospitalization or day hospitalization or outpatient hospitalization in the 6 months preceding the request for assistance. This applies equally to the manifestation or the deterioration of the condition.

In the event that EUROP ASSISTANCE provides a response without proper checks having been made or on the basis of insufficient or inaccurate data with respect to the information which must be provided to EUROP ASSISTANCE, the cost of the intervention by EUROP ASSISTANCE will be billed to the Insured member and will be payable on receipt of invoice.

#### I.F.3. CUMULATIVE INSURANCE

If the risks insured under this plan are covered by another insurance policy, you must provide us with the name of the insurer from whom the other insurance was purchased (French Insurance Code L121-4) as soon as you become aware of this information and at the latest when making the claim.

#### I.F.4. MISREPRESENTATION

When they change the subject of the risk or decrease our assessment of that risk:

- any concealment or intentional misrepresentation with respect to the composition of the risk renders the plan null and void. We are then entitled to retain the premiums paid and to payment of all due premiums in accordance with the French Insurance code, Article L113-8,
- any omission or inaccurate declaration by you, the bad faith of which has not been established, will result in termination of the policy 10 days after you have been notified by registered mail with proof of delivery and/or application of the reduction in compensation specified in the French Insurance Code, Article L113-9.

#### I.F.5. FORFEITURE OF COVERAGE DUE TO FRAUDULENT DECLARATIONS

**In the event of a loss or a request for the provision of assistance services (as provided for in these General Provisions) if you have used supporting documentation which you know to be inaccurate, or used fraudulent means, or if you have made inaccurate or incomplete declarations, you will forfeit any right to the assistance services provided for in these General Provisions, for which these declarations are required.**

### I.G. WHAT TO DO WITH YOUR TICKETS

When transportation is organized and covered under the terms of the plan, you agree either to allow us to use the tickets in your possession or to refund us the amount reimbursed by the organization which issued your tickets.

## II. DESCRIPTION OF OUR SERVICES AND BENEFITS

### II.A. ASSISTANCE SERVICES

Scope of assistance services during your expatriation.

#### II.A.1. DESCRIPTION OF OUR SERVICES

##### II.A.1.1. PERSONAL ASSISTANCE IN THE EVENT OF ILLNESS OR INJURY

###### II.A.1.1.1. REPATRIATION TRANSPORTATION

If you are sick or injured, our doctors will contact the local doctor you consulted following the Illness or Accident.

The information we obtain from the local doctor, and your usual doctor where required, enables us to activate and organize the following, subject to our doctors' decision and based on medical requirements:

- either your return to your Place of residence,

- or your transportation, under medical supervision where required, to a suitable nearby hospital in your Country of expatriation or in a neighboring country, by light medical vehicle, ambulance, train (first-class seat, first-class berth or sleeper) or by airline or air ambulance.

In some cases, your medical condition may require preliminary transportation to a nearby care center before a return to a facility close to your Place of residence can be considered.

Only your medical condition and compliance with the health regulations in force are taken into consideration when making the decision to transfer you, the choice of means used for this transfer and the place of hospitalization where required.

**IMPORTANT**

In this respect, it is expressly agreed that the final decision to be implemented will be taken by our doctors to avoid any conflict between medical authorities.

Furthermore, should you refuse to follow the decision deemed the most appropriate by our doctors, you release us of all liability, in particular in the event of you returning by your own means or if your medical condition deteriorates.

If precertification has not been issued by the healthcare insurer to the hospital to which the Insured member has been admitted, the Assistance provider will be unable to deliver the repatriation assistance services unless the incurred medical expenses are settled by the Insured member themselves or by one of their relatives.

It should also be noted that the Assistance provider cannot be held responsible for delays in the fulfilment of services resulting from delays in the precertification procedure by the healthcare insurer or any third party involved in the payment of medical expenses prior to the implementation of the "Repatriation transportation" benefit.

The Assistance provider cannot be held responsible if the costs incurred following the Insured member's admission to hospital have not been paid to the hospital or if the Insured member's medical insurance is inadequate or non-existent, as payment of these costs is a precondition of repatriation transportation.

### II.A.2. WHAT WE EXCLUDE

**We cannot under any circumstances replace local emergency services.**

**In addition to the general exclusions specified in chapter III, the following are excluded from coverage:**

- **the consequences of infectious risk situations in an epidemic context, exposure to infectious biological agents, whether dispersed intentionally or accidentally, exposure to chemical agents such as combat gas, exposure to incapacitating agents, exposure to neurotoxic agents or those with latent neurotoxic effects,**
- **the consequences of intentional acts by you or the consequences of fraudulent acts, suicide attempts or suicide,**
- **illnesses and/or injuries which were pre-existing, diagnosed and/or treated or which required continuous hospitalization or day hospitalization or outpatient hospitalization in the 6 months preceding the request for assistance. This applies equally to the manifestation or the deterioration of the condition,**
- **expenses incurred without our approval or not expressly specified in these General Provisions of the plan,**
- **expenses not supported by original documents,**
- **losses occurring in countries excluded from coverage or outside the validity dates of the plan, and in particular beyond the duration of the trip Abroad,**
- **the consequences of incidents occurring during motor trials, races or competitions (or their test runs) subject, in accordance with current regulations, to prior authorization from the local authorities when you are taking part as a competitor or during test runs on a track which is subject to prior authorization from the local authorities even if you are using your own vehicle,**
- **trips undertaken for the purpose of medical diagnosis and/or treatment or for cosmetic surgery procedures, their consequences and the resulting costs,**
- **the organization and coverage of transportation specified in the chapter entitled "REPATRIATION TRANSPORTATION" for benign conditions which can be treated locally and do not prevent you from continuing with your journey or your stay,**

- **requests for assistance relating to medically assisted reproduction or voluntary termination of pregnancy, their consequences and the resulting costs,**
- **requests for assistance relating to reproduction or gestational surrogacy, its consequences and the resulting costs,**
- **medical equipment and prostheses (dentures, hearing aids and medical prostheses),**
- **spa cures, their consequences and the resulting costs,**
- **hospitalization costs, medical costs (consultations, pharmacy items and other treatments and procedures) and dental treatment,**
- **scheduled hospitalization, its consequences and the resulting costs,**
- **the cost of vision care (glasses and contact lenses for example),**
- **vaccines and vaccination costs,**
- **medical checks, their consequences and related costs,**
- **esthetic procedures, their consequences and the resulting costs,**
- **stays in rest homes, their consequences and the resulting costs,**
- **rehabilitation, physical therapy, chiropractic, their consequences and the resulting costs,**
- **medical or paramedical services and the purchase of products whose therapeutic value is not recognized under French legislation, and related costs,**
- **health checks for preventive screening, regular treatments or laboratory tests, their consequences and the resulting costs,**
- **search and rescue missions, particularly in the mountains and at sea,**
- **search and rescue missions in the desert and the resulting costs,**
- **costs related to excess baggage when traveling by air and the cost of forwarding the bags if they cannot travel with you,**
- **trip cancelation costs,**
- **restaurant costs,**
- **customs duties.**

## III. FRAMEWORK OF THE PLAN

This plan is subject to French law.

### III.A OBLIGATIONS OF THE POLICYHOLDER

**Information to Insured members**

The Policyholder is responsible for providing Insured members with a copy of the General Provisions which include a definition of the benefits provided under this plan and how they are implemented. The Policyholder must also provide them with the Benefits Schedule and details of the options and geographical zones selected.

Insured members must also be informed in advance and in writing of any amendments made to the coverage during the life of the plan.

### III.B LIABILITY - COMPLAINTS

**Each party will bear the consequences of errors and breaches of their obligations in respect of the plan.**

Europ Assistance will therefore have sole liability for the provision of Assistance services to Insured members, as described in this plan.

Europ Assistance will respond to any complaints which may be made by Insured members in respect of their Assistance Services.

In the event that the Policyholder receives a complaint from an Insured member in respect of the Assistance services, it should be promptly forwarded to the Europ Assistance Quality Department: Service Qualité d'Europ Assistance, 1 Promenade de la Bonnette, 92633 Gennevilliers Cedex, France.

With respect to third parties, each party is solely responsible for their own procedures and services under this plan.

**III.C LIMITATION PERIOD**

In accordance with Article L114-1 of the French Insurance Code:

"All legal actions arising from an insurance contract are barred two years from the event that gave rise to them".

However, this time limit runs:

1. In the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only from the date on which the insurer became aware of it;

2. In the event of a loss, only from the date on which the relevant parties became aware of it, if they can prove they were unaware of such facts until then.

If the action taken by the insured against the insurer arises from a claim made by a third party, the limitation period shall run only from the date on which this third party brings a legal action against the insured or has received compensation from him or her."

In accordance with Article L114-2 of the French Insurance Code:

"The limitation period is interrupted by one of the ordinary causes of interruption and by the appointment of experts following an insured loss. The interruption of the limitation period may also be initiated by the dispatch of a registered letter with proof of delivery from the insurer to the insured regarding action for payment of the premium and by the insured to the insurer regarding payment of the indemnity."

The ordinary causes of interruption of the limitation period are described under Articles 2240 to 2246 of the French Civil Code: the acknowledgement by the debtor of the right of the person against whom they were seeking interruption of the period of limitation (Article 2240 of the French Civil Code), a legal claim (Articles 2241 to 2243 of the French Civil Code) or an act of enforcement (Article 2244 of the French Civil Code).

Under Article L114-3 of the French Insurance Code:

"Notwithstanding Article 2254 of the French Civil Code, the parties to the insurance contract cannot, even by mutual agreement, modify the duration of the limitation period, nor add to the motives for its suspension or interruption."

**III.D SUBROGATION**

In the event that the Policyholder is subrogated to the rights and actions of the Insured member against any third party which is in debt to this Insured member, the Policyholder agrees to assign them to Europ Assistance, up to the level of the costs incurred by them in fulfilment of the plan.

**III.E APPLICABLE LAW AND LANGUAGES**

The plan is governed by the French Insurance Code.

Pre-contractual communications and the plan itself are governed by French law. Any dispute arising from the fulfilment, non-fulfilment or interpretation of the plan will be under the jurisdiction of the French courts. The language used for the duration of the plan is French.

In the event of any difference in interpretation between the French version and the foreign language version of the documents issued to the insured member, the French language version will prevail.

**III.F EFFECTIVE DATE AND DURATION OF THE PLAN AND THE BENEFITS**

**Effective date of the plan:**

**The plan arranged between the Policyholder and Europ Assistance takes effect on July 1, 2015. It is acquired for an initial period of one year from the effective date and may be terminated each year by registered mail sent 2 months before each annual renewal date. On expiration, it is automatically renewed from year to year unless terminated by the Insurer or the Policyholder.**

The option of terminating the plan each year is available to both the Policyholder and the Insurer. The termination notice period runs from the date on the postmark.

Effective date of benefits:

For Insured members, and subject to payment of the corresponding premium, the period of validity of the benefits corresponds to the dates of the stay Abroad, declared by the Insured to the Policyholder and specified in the application for coverage, with a maximum duration of 365 consecutive days.

The effective date of benefits cannot be earlier than the date on which the Policyholder took out the insurance.

The duration of the validity of benefits for each Insured member cannot exceed 365 consecutive days.

**III.J TERMINATION OF THE PLAN AND CESSATION OF BENEFITS**

**Cancelation of the group plan between the Insurer and the Policyholder**

In addition to the option of annual termination specified above (in the paragraph entitled “DURATION OF THE PLAN”), the plan may be terminated:

- by the Insurer:
- in the event of non-payment of the premium, under the conditions of Article L113-3 of the French Insurance Code,
- if omissions or inaccuracies appear in the declarations made by the Policyholder on application or during the life of the plan (Article L113-9 of the French Insurance Code),
- in case of aggravation of the risk under the conditions of Article L113-4 of the French Insurance Code.

- by the Policyholder:
- if, following a Claim, the Insurer terminates another plan taken out by the Policyholder (Article R113-10 of the French Insurance Code)

- in the other cases stipulated in the French Insurance Code.

- automatically:
- in the event of withdrawal of the Insurer’s official authorization (Article L326-12 of the French Insurance Code).

Termination must be carried out by registered mail or by a declaration, for which a receipt should be obtained, made at the registered office of Europ Assistance.

**For our part, we must terminate the policy by registered mail sent to your last known home address.**

## III. K. CESSATION OF BENEFITS

**Your benefits come to an end:**

- for each individual Insured member

  - **on the day on which you no longer belong to the insurable group insofar as you no longer meet the conditions of enrollment (see definition of Insured member)**
  - **on the date on which you are no longer a member of the association, ASFE,**
  - **in the event of non-payment of the premiums by the Insured member,**
  - **on the date of termination of the contract between the Policyholder and us,**
  - **at the end of the year during which you reach the age of 70.**

- For all Insured members

- in the event of termination of the contract between the Policyholder and the Insurer, the Policyholder will inform their Insured members.

**Once the plan has been terminated or suspended, it will cease to apply to Insured members.**

## III.L. WHAT ARE THE RESTRICTIONS IN CASES OF FORCE MAJEURE OR OTHER SIMILAR EVENTS?

**Under no circumstances can we replace local organizations in an emergency.**

**We cannot be held responsible for failures or delays in the fulfilment of services resulting from cases of force majeure or events such as:**

- **civil or foreign war, manifest political instability, civil unrest, riots, acts of terrorism and reprisals,**
- **recommendations from WHO or national or international authorities or restrictions on the free movement of persons and goods, irrespective of the cause but in particular for reasons of health, safety, weather or restrictions or bans on air traffic,**
- **strikes, explosions, natural disasters, nuclear disintegration or radiation from a source of radioactive energy,**
- **delays in and/or impossibility of obtaining administrative documents such as exit and entry visas, passports, etc. required for travel within or outside the country where you are located or on arrival in the country, as recommended by our doctors for hospitalization there,**
- **the use of local public services or those of any service provider which we are obliged to use under local and/or international regulations,**
- **lack or unavailability of the appropriate technical and human means to enable travel (including denial of service).**

## III.M. EXCEPTIONAL CIRCUMSTANCES

**Passenger transportation operators (including airlines) may place restrictions on persons suffering from certain medical conditions or women who are pregnant. These restrictions apply until the journey begins and are subject to change without notice (for airlines: medical examination, medical certificate, etc.).**

**Consequently, the repatriation of these persons can only be carried out if the operator does not refuse them travel, and of course, in the absence of an unfavorable medical opinion (as specified in and in accordance with the terms set out in Chapter II.A.1.1.1. "REPATRIATION TRANSPORTATION") with respect to the health of the Insured member or an unborn child.**

## III.N. WHAT ARE THE GENERAL EXCLUSIONS APPLICABLE TO THE PLAN?

**The general exclusions under the plan are the exclusions common to all the assistance services described in these General Provisions.**

**The following are excluded:**

1. **civil or foreign war, riots and civil unrest,**
2. **the voluntary participation of an Insured member in riots or strikes, brawls or assaults,**
3. **the consequences of nuclear disintegration or radiation from a source of radioactive energy,**
4. **unless otherwise stated in the plan, earthquakes, volcanic eruptions, tidal waves, floods or natural disasters except under the provisions resulting from Act N 82-600 of July 13, 1982 with respect to compensation of victims of natural disasters,**
5. **the consequences of the use of medication, drugs, narcotics and similar products which are not medically prescribed, and alcohol abuse,**
6. **any intentional act on your part which may give rise to a claim under the plan.**

## III.O. SUBROGATION

Having incurred costs in respect of our assistance services, we are subrogated to the rights and actions which you may have or take against the third parties liable for the Loss as specified in Article L122-12 of the French Insurance Code.

Our subrogation is limited to the amount of the costs we incurred in fulfillment of this plan.

## III.P. WHAT IS THE LIMITATION PERIOD?

In accordance with Article L114-1 of the French Insurance Code:

“All legal actions arising from an insurance contract are barred two years from the event that gave rise to them. However, this time limit runs:

1. In the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only from the date on which the insurer became aware of it;

2. In the event of a loss, only from the date on which the relevant parties became aware of it, if they can prove they were unaware of such facts until then.

If the action taken by the insured against the insurer arises from a claim made by a third party, the limitation period shall run only from the date on which this third party brings a legal action against the insured or has received compensation from him or her.”

In accordance with Article L114-2 of the French Insurance Code:

“The limitation period is interrupted by one of the ordinary causes of interruption and by the appointment of experts following an insured loss. The interruption of the limitation period may also be initiated by the dispatch of a registered letter with proof of delivery from the insurer to the insured regarding action for payment of the premium and by the insured to the insurer regarding payment of the indemnity.”

The ordinary causes of interruption of the limitation period are described under Articles 2240 to 2246 of the French Civil Code: the acknowledgement by the debtor of the right of the person against whom they were seeking interruption of the period of limitation (Article 2240 of the French Civil Code), a legal claim (Articles 2241 to 2243 of the French Civil Code) or an act of enforcement (Article 2244 to 2246 of the French Civil Code).

In accordance with Article L114-3 of the French Insurance Code:

"Notwithstanding Article 2254 of the French Civil Code, the parties to the insurance contract cannot, even by mutual agreement, modify the duration of the limitation period, nor add to the motives for its suspension or interruption."

**III.Q. COMPLAINTS**

EUROP ASSISTANCE's address for service is the address of its registered office.

In the event of a complaint or dispute, You can write to their Customer Feedback department at: Service "Remontée Clients", Europ Assistance, 1 Promenade de la Bonnette, 92633 Gennevilliers Cedex, France.

If the time required to handle the complaint or dispute is to exceed ten working days, you will be sent an acknowledgement within that period. A written response to the complaint will be sent within a maximum period of two months from the date of receipt of the initial complaint.

**III.R. SUPERVISORY AUTHORITY**

The supervisory authority is the "Autorité de Contrôle Prudentiel et de Résolution – A.C.P.R." (French Prudential Supervisory Authority) – 61, rue Taitbout – 75436 Paris Cedex 09 – France.

**III.S. DATA PROTECTION AND FREEDOM OF INFORMATION**

All the information collected by EUROP ASSISTANCE FRANCE, 1 Promenade de la Bonnette, 92633 Gennevilliers Cedex, France during the process of application for one of its services and/or during the provision of the services is required for the fulfilment of our obligations to you. If you do not respond to the request for information, EUROP ASSISTANCE FRANCE will be unable to provide you with the service you wish to purchase.

This information is reserved solely for the EUROP ASSISTANCE FRANCE departments in charge of your plan and may be passed on, for the sole purpose of fulfilment of service, to service providers or partners of EUROP ASSISTANCE FRANCE.

EUROP ASSISTANCE FRANCE also has the option of using your personal data for the purposes of quality control or statistical analysis.

EUROP ASSISTANCE FRANCE may pass on some of your data to the partners providing these assistance services.

You have the right to access, amend, rectify and remove information concerning you by writing to the Customer Feedback department: EUROP ASSISTANCE FRANCE, Service "Remontée Clients", 1, Promenade de la Bonnette, 92633 Gennevilliers Cedex, France.

If, for the purposes of fulfilling the requested service, information about you is transferred outside the European Union, EUROP ASSISTANCE FRANCE will take contractual measures with the recipients to ensure this transfer is secure.

Moreover, Insured members are informed that telephone conversations with EUROP ASSISTANCE FRANCE may be recorded for the purposes of quality control and staff training. These recordings will be kept for a period of two months. Insured members may object to this by informing the agent handling the call.

## 8) General provisions of Personal Third-Party Liability benefits included as standard with your Healthcare plan (page 95)

**Policy no. 160125359 contracted by ASFE with AXA COURTAGE**

**If you need to use your Civil Liability coverage, contact ASFE:**

- **By telephone: +33 (0) 1 44 20 48 07**
- **By fax: +33 (0) 1 44 20 48 79**
- **By e-mail: admineurope@asfe-expat.com**

**And provide:**

- **Your first & last names.**
- **Your ASFE ID number.**
- **The number of your civil liability policy: No. 160125359**

**Upon request, we will send you the form needed to submit your Civil Liability claims.**

### POLICYHOLDER

A.S.F.E. (Association de Services des Français de l'Etranger - Association of Services for French Abroad).

### INSURED CATEGORY

The insured members of A.S.F.E who are enrolled in a MAPS plan or benefit from Assistance coverage.

### PURPOSE OF THE POLICY

The present policy is intended to cover the insured member for the financial consequences of any civil liability that he/she may incur for personal injury, material damage and consequential immaterial losses caused to third parties and resulting from an action while he/she is residing overseas, whether or not as a complementary cover to another policy, the amounts of which shall constitute a deductible applicable to this policy.

### DEFINITIONS

- Personal injury: any physical harm suffered by someone.
- Material damage: any alteration, deterioration, loss or destruction of an object or substance, any physical harm to animals, the loss or death of animals.
- Consequential immaterial loss: any prejudice resulting from the deprivation of enjoyment of a right which is caused by material damage covered by the present policy.
- Claim: any out-of-court or court claim initiated by a third-party against the insured member for damage likely to result in the application of the present coverage.

  All claims relating to the same event or resulting from the same original technical cause, including cases where several third-parties are involved, are considered to be one and the same. The date of claim shall be determined according to the date of the first claim.

### EXCLUSIONS

**Coverage excludes:**

- **Hunting or the destruction of harmful animals and the organization thereof, practice of any aerial sport, participation in any sporting competition as a professional or in any sporting event (or trial) which is subject to administrative authorization and/or to the purchase of an insurance policy,**
- **Any loss or damage caused to property owned, rented or maintained by the insured member,**
- **Any material damage and immaterial loss resulting from fires, explosions or floods if they have occurred on premises owned, co-owned, rented or occupied in any other way by the insured member,**
- **All consequences of contractual obligations made by the insured member,**

- **All consequences of the insured member's liability as a vendor for damage caused to any goods or items sold,**
- **All consequences of the insured member's liability as an owner or co-owner of real estate,**
- **All expenses incurred to prevent any damage or to repair, modify or improve any property that caused damage,**
- **Robbery,**
- **Any damage caused by flying, sea, river or lake crafts or vehicles, land vehicles with an engine and a trailer or semi trailer, cable cars that the insured member or any other dependent person owns, drives or maintains, even if said damage is caused whilst said crafts, vehicles or cable cars are not in use, including when they are used as a tool,**
- **All financial consequences resulting from the insured member's liability due to damage caused by intentional fault or deceit.**
- **Any immaterial loss:**
  - **Which does not result from personal injury or material damage,**
  - **Which results from personal injury or material damage not covered under the present policy.**

## AMOUNT OF BENEFITS

| NATURE OF BENEFITS | CEILINGS OF BENEFITS | DEDUCTIBLES |
|---|---|---|
| Aggregate of all benefits: | €1,524,490 | |
| • Including personal injury and immaterial losses consequential to personal injury | €1,524,490 per claim | Nil |
| • Including other damage:<br>- material damage<br>- consequential immaterial losses | €762,245/claim (aggregate limit)<br><br>€762,245/claim included, up to<br><br>€304,898 | **€152.45/claim** |
| • Including legal defense fees | Included in the coverage | **Nil** |

* onsequential immaterial loss shall mean any prejudice resulting from the deprivation of enjoyment of a right which is caused by material damage covered by the present policy.

## TERM AND EFFECTIVE DATE

The policy shall be effective from its start date (which cannot be later than January 1, 1996) until the date of the first annual renewal.
It shall then be automatically renewed each year, unless prior terminated by either party at least two months before the expiry of the current policy year.
Termination shall be effective at the end of the calendar quarter following the request for termination, and in all cases, simultaneously with the termination of the principal healthcare or assistance insurance plan.

*The original version of this document is in French. In the event of a dispute, the French version shall prevail over any languages*

# 9) General provisions of Legal Assistance benefits included as standard with your Healthcare plan

## 1 – LEGAL EXPENSES INSURANCE FOR EXPATRIATES AND IMPATRIATES

**HOTLINE: from France: 0 825 800 146**
**N° INDIGO, €0.15 inc. tax/mn, rate as at 01/01/2015**

**From abroad: international country code + 33 1 40 05 52 15**
**http://www.civis.fr**

### 1 - 1 LEGAL AND TAX INFORMATION

**In order to provide you with information on French law, you have access to our "ASFE INFORMATION JURIDIQUE" service.**

Our legal experts answer your questions on legal matters among the fields listed below, whether with regard to documentation or daily life:

- **Consumer law:** the purchase, hiring, financing, ownership or sale of personal estates or services intended for your private use.
- **Real estate law, concerning your home in France:** leasing during your expatriation, condominium, relations with your landlord/lady in your capacity as a tenant, neighbors, maintenance or repair work, insurance, etc.
- **Transportation law:** moving, luggage transportation, liability of the carrier, etc.
- **Tax law:** information about income declaration, income tax for individuals, VAT on goods and services intended for your private use, tax procedures, etc.
- **Customs law:** customs clearance, etc.
- **This service is available 24/7:**
- **By telephone:**
  - From France: 0 825 800 146 (N°INDIGO, €0.15 inc. tax/min, rate as at 01/01/2015)
  - From abroad: international country code + 33 1 40 05 52 15
- **Via internet** : http://www.civis.fr. You can contact a legal expert by chat through a Web Call Center.

### 1 – 2 LEGAL EXPENSES INSURANCE

#### *PURPOSE OF YOUR COVER*

We provide you with the legal and financial resources you require in order to inform, assist and defend you in the event of a covered case of litigation and to assert and exercise your rights.

### *COVERED EVENTS*

- **In the event of litigation against a third party in the following fields, whether under the jurisdiction of a court of the French Republic or of another State:**

  **Consumer law:** in the event of litigation following the purchase, hiring, financing, ownership or sale of personal estates or services intended for your private use.

- **Transportation law:** in the event of litigation resulting from the transportation of your personal estates intended for your private use and your personal effects (moving, luggage transportation, etc.).

- **Real estate law:** in the event of litigation against your landlord/lady in your capacity as a tenant, concerning your home in your State of expatriation: concerning expatriates from France to another State, in the event of litigation concerning your home in France: leasing during your expatriation, condominimum, neighbors, maintenance or repair work, insurance, etc.

- **Employment law:** in the event of litigation against your employer in your capacity as an employee, concerning the signature, implementation and termination of your employment contract.

- **Criminal law: defense in the event of criminal proceedings** (hearings, police custody, indictments or legal action brought before a criminal court), when the services of an attorney are required by the procedure in the country in question, and the provision of advances for bail bonds if necessary.

- **Administrative law: in the event of litigation against your State of expatriation concerning administrative matters** (regulations, disputes with a public body, customs disputes, etc.), **excluding disputes regarding tax matters.**

- **In the event of litigation involving the tax department of the French Republic concerning tax law matters:** income tax for individuals, VAT on goods and services intended for private use, etc.

### *EVENTS THAT ARE NOT COVERED*

- **If the prejudicial event or reprehensible action causing the litigation is brought to your attention before your enrollment to the policy underwritten by ASFE, or after the termination of your membership.**
- **If your request is legally inadmissible, lapsed or if the amount at stake is less than the minimum coverage limit, set at €200/$250.**
- **If the litigation results from your third-party liability when it is covered by an insurance policy.**
- **If the litigation results from:**
  - **your expression of political, trade-union or religious opinions,**
  - **the protection of your patents, intellectual property or copyright,**
  - **your capacity as endorser, guarantor or assignee of rights,**
  - **criminal proceedings, investigation measures or claims filed against you within the European Economic Area for a crime or offense involving deliberate actions to do harm, or for a brawl or insult,**
  - **the practice of a non-salaried professional activity, as regards your relations with the French tax department or the department in the State of expatriation,**
  - **the application of book I of the French civil code (*Code Civil*) (divorce, filiation, citizenship, etc.) and marriage settlements, inheritance and inter vivos gifts,**
  - **civil or foreign war,**
  - **the application of this policy.**

### *IN THE EVENT OF LITIGATION*

This cover provides you with the services of legal experts who will assist you under the following conditions:

***Declaration of your litigation:***

As soon as you are made aware of a lit gation procedure, you must request our assistance by

contacting us **by telephone or via our website**. You must then send us, if necessary, all details and papers for the litigation investigation and to find an out-of-court solution.
**This declaration must reach us before the launch of legal action and before any referral of the litigation to an attorney, judicial officer or expert, with the exception of urgent and appropriate proceedings to preserve rights. In the event of an inaccurate or dishonest declaration concerning the facts, events or situation at the source of the litigation, or more generally concerning any factor that may contribute to a settlement, cover is forfeited.**

***Management of your litigation:***

We undertake to seek an amicable arrangement for your litigation as quickly as possible.

To do this, legal experts will first of all inform you of your rights and then will launch, with your consent, any interventions, proceedings and negotiations that may lead to an out-of-court settlement of your litigation:

- **For litigation that does not require legal proceedings and for which your specific expatriate situation prevents us from providing you with the information requested**, we arrange a consultation with an attorney.

You may therefore meet with an attorney of your choice, and upon your written request, we can put you into contact with a local attorney (*avocat correspondant*) or an attorney recommended by the Consulate.

**You may consult an attorney no more than two times per year of insurance, up to a ceiling of €450/$560 incl. tax per consultation corresponding to legal fees and the attorney's own fees.**

- **For other litigation, within the European Union only, if you are notified that the third party is assisted by an attorney by private agreement, or if we are directly notified,** you must also be assisted by an attorney. You may choose an attorney, and upon your written request, we can put you into contact with one of our usual attorneys. **We will pay the attorney's own fees and legal fees directly, up to a ceiling of €450/$560 incl. tax per litigation for this out-of-court phase.**

- **If your litigation is brought before a French or foreign court, or in the event of a conflict of interest**, you may choose an attorney, and upon your written request, we can put you into contact with a local attorney (*avocat correspondant*) or an attorney recommended by the Consulate.

You have, with our assistance should you so wish, control of the directives and measures that may prove necessary during the proceedings. Under all circumstances, it is necessary to obtain our prior approval on the coverage of legal and attorney's fees related to the action or legal remedies that you intend to pursue in order to enable us to examine the cogency and appropriateness of said action, by providing us with all useful documents. The same procedure applies to the acceptance of a transaction.
It is your responsibility to pay all amounts, retainers and deposits that may be required and that are not covered by this plan.

**We will pay the legal fees and fees of representatives, up to the amounts shown in the following table relating to the lawyer acting on your behalf, as well as all other fees required to resolve the litigation.**

**You are covered for up to two cases of litigation per year of insurance. Our total payments per litigation may not exceed €5,000/$6,250 incl. tax, the fees for any consultations previously conducted and related to the same litigation process are included in this amount.**

**The amounts allocated to fees and costs and unrecoverable fees are allocated as a priority to any fees that you have personally paid out. In excess of your own fees, we will be subrogated to your rights and actions for the recovery of these amounts, up to the amounts we have paid.**

| EXPENSES THAT WE WILL PAY TO THE ATTORNEY ACTING ON YOUR BEHALF | | EXPENSES THAT WE WILL NOT COVER |
|---|---|---|
| - Consultation **€450/$550**<br><br>- Assistance during the out-of-court phase (if the third party is assisted by an attorney): **€450/$550**<br><br>- Administrative commission, District judge (*Juge de proximité*) (for criminal matters), Police Court (1st to 4th category)<br>Criminal mediation, Police Court (5th category), Correctional Court, Summary Proceedings **€450/$550**<br><br>- Institution of civil action proceedings **€380/$475**<br>- Liquidation of civil interests **€460/$575**<br>- Other procedures: **€450/$550**<br><br>- Assistance for appraisal, investigation measures **€245/$305**<br>- District Court (*Tribunal d'Instance*), District judge (*Juge de proximité*) (for civil matters), Court for Social Matters (*Tribunal des Affaires Sociales*), Regional Court (*Tribunal de Grande Instance*), Commercial Court, Administrative Court **€800/$1,000** | - Board in Industrial Disputes (*Conseil de Prud'hommes*)<br>Conciliation **€305/$380**<br>Judgment Board **€580/$725**<br>Deciding judge **€380/$475**<br>- Appeal Court (*Cour d'Appel*)<br>- Defense (criminal matters) **€580/$725**<br>- Other **€800/$1,000**<br><br>- Highest Court of Appeal (*Cour de Cassation*), Council of State (*Conseil d'Etat*)<br>- appeal for defense **€1,500/$1,900**<br>- appeal for a petition **€2,000/$2,500**<br>- Criminal Court (*Cour d'Assises*) **€1,525/$1,900**<br><br>- Settlement in the judicial phase:<br>- without drafting of minutes **50%** of the maximum amount set for the jurisdiction in question<br>- with drafting of minutes **100%** of the maximum amount set for the jurisdiction in question | **Any fines and amounts that you have to pay or reimburse to a third party (or third parties)**<br><br>**Expenses and costs incurred by the third party (or third parties) and to be borne by you**<br><br>**Attorney fees based on performance**<br><br>**Expenses and actions made necessary or more serious due to an action on your part** |
| **In addition to attorney fees, these amounts include VAT as well as any expenses, rights, disbursements or other fees (e.g. for cases submitted to the Regional Court (*Tribunal de Grande Instance*)) .**<br>**However, they do not include judicial officers' fees or, where applicable, fees incurred for representatives before the Commercial Court.**<br><br>**These amounts are applicable in pursuance of an order, judgment or a ruling or if there are several attorneys involved, i.e. when an attorney replaces another attorney upon your request to defend your interests, or if you decide to be assisted by several attorneys.**<br><br>**If the litigation falls under a foreign jurisdiction, the amount applicable is that of the equivalent French jurisdiction or, failing this, that of the level of the jurisdiction in question.** | | **Investigations to identify or locate the third party (or third parties)**<br><br>**Expenses incurred without our approval** |

## *ARBITRATION IN THE EVENT OF DISAGREEMENT*

- **If our disagreement concerns our refusal to cover a litigation procedure that you wish to launch and that we consider unjustified within the framework of the provisions contained in the chapter IN THE EVENT OF LITIGATION, you can either:**
  - launch the litigation procedure thate refuse to cover at your own expense, after informing us in writing of such action.
  - If you obtain a final judgment that is favorable to your interests, we will compensate you for the expenses and attorney fees incurred for this action, the amount of which has not been supported by the third party (or third parties). The reimbursement will be made upon submission of supporting documents and in accordance with the terms and conditions of the cover.

  Or

  - request that an arbitration procedure be launched in accordance with the conditions detailed below.

- **If our disagreement concerns the measures to be taken to settle the litigation:**
  - this difficulty may be submitted to a third-party for consideration, an arbitrator appointed of a common accord among professionals entitled to provide legal advice (notary public, attorney, professor of faculty, etc.) or, failing this, by the presiding judge of the Tribunal de Grande Instance (regional court) ruling in summary proceedings. We will cover the fees

incurred to exercise this up to €800/$1,000 incl. tax.

- However, the presiding judge of the Tribunal de Grande Instance, ruling in summary proceedings, may decide otherwise if you have exercised this right in wrongful conditions.

**If you have launched a litigation at your own expense and you obtain a settlement that is more favorable than that proposed by ourselves or the third-party arbitrator, we will compensate you for the expenses incurred for this action, up to the covered amount.**

## 1 – 3 BAIL BOND

In the event of proceedings involving you and requiring the settlement of a bail bond, we will provide **an advance** of the bail bond, **up to the ceiling of €16,000/$20,000.**

In the event of proceedings abroad, we will send the bail bond to an intermediary designated by the French Consulate and expressly appointed by yourself. This written appointment must be sent to us by fax or e-mail together with the amount of the bond (in figures and written in full) via a French diplomatic office located in the country in which you are staying.

Our payment of **this advance** is subject to the following terms:

- In the event of an emergency, within 24 hours of the date of the request, we will pay the amount of €8,000/$10,000 by transfer of funds in cash form, and the remainder, i.e. €8,000/$10,000, by international bank transfer within 5 working days of the request, to the intermediary designated above.

- Or the amount of €16,000/$20,000, by international bank transfer to this intermediary within 5 working days of the request.

These services are executed subject to the foreign exchange control legislation of the country in which you are staying.

## 1 – 4 DEFINITIONS

- ***CONFLICTS OF INTEREST:*** when we must defend your interests and those of the third party(ies) simultaneously.

- ***FORFEIT:*** loss of the right to coverage.

- ***COSTS:*** legal fees incurred by the trial, not including attorney fees.

- ***EXPATRIATE:*** *any person residing outside their country of origin and who is an insured member of ASFE, the policyholder.*

- ***UNRECOVERABLE FEES:*** amounts paid by a party during legal proceedings, not included in costs and compensated by an indemnity under article 700 of the Revised Code of Civil Proceedings (*Nouveau Code de Procédure Civile*) or article 475-1 of the Code of Criminal Proceedings (*Code de Procédure Pénale*) or article L 8.1 of the Code of Administrative Courts and Administrative Appeal Courts (*Code des Tribunaux Administratifs et des Cours Administratives d'Appel*).

- ***LEGALLY INADMISSIBLE:*** indefensible character of your position or of your litigation with regard to legislation and case law currently in force.

- ***IMPATRIATE:*** any person who is not a French citizen, residing in France and not covered by the French Social Security plan or any similar plan, who is an insured member of ASFE, the policyholder.

- ***LITIGATION:*** situation of conflict caused by a prejudicial event or reprehensible action between yourself and a third party (or third parties), leading you to assert a contested right, oppose a claim or defend yourself before a court of law.

***US:*** GIE CIVIS economic interest group acting on behalf of the insurer
*GIE CIVIS 90 avenue de Flandre 75019 PARIS Tel.: 01.53.26.25.25 - Fax: 01.53.26.36.34*

***MINIMUM COVERAGE LIMIT:*** amount of the litigation in principal under which we do not provide coverage; the minimum amount is set at €200/$250

- ***THIRD PARTY:*** a natural or legal person who is not covered by the policy and against whom you have launched an action.
- ***YOU:*** the insured member, i.e. the member of the ASFE association, the policyholder, as an expatriate or impatriate, his/her spouse or equivalent not legally or physically separated and dependent children for tax purposes.

## 2 – SERVICES AND ASSISTANCE FOR EXPATRIATES AND IMPATRIATES

***IN THE EVENT OF THE LOSS OR THEFT OF, OR TECHNICAL DAMAGE TO MEANS OF PAYMENT:***

***1. Cash advance***

**This cash advance** will be payable within 3 hours, 7 days a week, from 10am to 5pm, French time. **The maximum amount is €800/$1,000, and is limited to two advances per year.**

***2. The booking and/or payment in the form of an advance of nights in a hotel across the world.***

This booking or **advance payment** of hotel stays is made through the ACCOR network, our partner for these hotel services. For other hotels, we pay the bill for the hotel after you notify us of its contact details. **The maximum amount is €800/$1,000, and is limited to two advances per year.**

***3. The booking or payment in the form of an advance of air fares to enable the journey to continue.***

**This booking or advance payment of air fares is made through the AIR France network. This advance is based on one ticket in economy class and is for a maximum amount of €800/$1,000. You are entitled to two advances per year.**

**Under all circumstances:**

***4. The delivery by international courier according to urgency of the following: (Chronopost/UPS/Federal Express/Jet Service/official courier of the GIE CIVIS)***

- administrative documents,
- air fares,
- traveler's checks,
- prescription drugs,
- corrective lenses.

As part of this cover, we undertake to send you those via all means available if these are essential and cannot be delivered through the cover subscribed as part of your assistance policies.

***5. Escort service for children under six and dependent persons traveling alone***

For air travel between the country of expatriation and France (expatriates), or between France and your country of origin (impatriates), we undertake to contact a network of escorts for your children under six years of age and dependent persons for tax purposes, subject to the request being made at least 72 hours before travel v a the hotline, seat availability for the selected dates and delivery times.

As part of this service, **we cover the cost of an air ticket for an escort once a year.**
In excess of this annual coverage, a return air ticket in economy class will be invoiced for each escort assignment.

***6. As regards air travel and in the event of overbooking, we undertake to find alternative***

***solutions with other airlines and advance the amount of expenses incurred due to overbooking (hotel, related secondary transportation, etc.) up to a ceiling of €800.***

**The cash advance service will be executed subject to the foreign exchange control legislation of the country in which you are staying. You must reimburse these services within two months of their execution.**

***7. If maintenance and/or repair work is needed for your private home in Metropolitan France: access to a service to contact one (or several) building contractor(s) and to check the estimate(s) provided by the contractor(s):***

***Purpose of the service***

We provide you with the service detailed below via telephone, in the event of maintenance and/or repair work in your private home in Metropolitan France involving the following trade(s): plastering – painting – floor coating – joinery (PVC, wood, aluminium) – locksmith – mirror – electricity – plumbing – heating:

- discuss with you the work that you intend to perform and the trade(s) required for said work,
- put you in contact with an appropriate building company according to the work needed by the client (or companies, if several companies are required),
- check the estimate(s) provided by the company for each trade to inform you about our comments, if any.

This service is exclusively provided by telephone from a distance, without us visiting the premises or monitoring the work. You are responsible for the order, follow-up and payment of the work. The completion of the work, the work and their consequences, including conformity of installations, are to be exclusively performed by the company (or companies) in charge of these; we are not liable for these services.

***Processing turaround time***

You will be provided with the contact details of the building company and will be put in contact with such company in real time or via a phone meeting, within 24 hours at the latest after calling (business days).

Estimate checks and the phone call are made within five business days as from the receipt of the estimate by our teams.

## 3 – CLAIMS PROCEDURE:

In the event of a claim concerning the implementation of your policy or quality of service, you may contact our Quality Department, which will ensure that you receive a reply as quickly as possible:

**GIE CIVIS QUALITY DEPARTMENT 90 AVENUE DE FLANDRE 75019 PARIS.**

If your claim still stands following the reply from our Quality Department, you will be given the contact details of the mediator upon request, should you wish to obtain a second opinion.
The original version of this document is in French. In the event of a dispute, the French version shall prevail over any languages.

# 10) General provisions of Medical Assistance/Repatriation benefits available as an option

**If you need medical assistance services,**
**contact immediately Europ Assistance, 24/24, to obtain prior approval:**

**By telephone: + 33 1 41 85 84 46**
**By fax: +33 1 41 85 85 71**
**By e-mail: service-medical@europ-assistance.fr**

**And provide:**

- **Your first & last names.**
- **The name of your policy: ASFE**
- **The telephone number you are calling from or on which you can be reached.**
- **The name, location and telephone number of the healthcare facility where you are receiving care where applicable and the name of the local physician.**

## I- GENERAL PROVISIONS

### I.1. Introduction

These General Provisions of the ASFE Assistance policy between EUROP ASSISTANCE, company governed by the French Insurance Code, and the policyholder will govern the reciprocal duties between EUROP ASSISTANCE, the policyholder and the members as defined hereafter.

### I.2. Definitions

***Members***
Are considered to be members, the insured members of the ASFE who are enrolled in the “Medical assistance and repatriation” coverage.
In this policy, the term “member” will be replaced by “you”.

***Accident***
A sudden and fortuitous event affecting any natural person, occurring independently of the victim’s intent, resulting from the sudden action of an external cause and preventing him/her from traveling by his/her own means.

***Assistance company***
“Assistance company” shall mean EUROP ASSISTANCE. In this policy, the company name EUROP ASSISTANCE is replaced by the term “we”. The services as defined in the chapter “Assistance” are provided and implemented by EUROP ASSISTANCE.

***Abroad***
“Abroad” shall mean the entire world except your country of origin and the countries listed under I.4 “Geographical scope of cover”.

***France***
“France” shall mean Metropolitan France and the Principality of Monaco.

***Illness***
A deterioration of a member’s health, as certified by a competent medical authority strictly interdicting from leaving home, requiring medical treatment and the cessation of all professional or other activities.

***Family member***
Legal or common-law spouse domiciled at the same address, dependent children, brothers or sisters, father, mother, parents-
in-law, grandchildren or grandparents.

***Country of origin***
Is considered to be the country of origin, your country of citizenship.

***Country of residence***
Is considered to be the country of residence, the country of expatriation to which you are assigned.

***Policyholder***
"Policyholder" shall mean the ASFE that takes out this policy on behalf of its insured members.

### I.3 Covered travel

Coverage is provided during all business and personal trips.

### I.4 Geographical scope of cover

Assistance coverage is provided worldwide. However, countries in a state of civil or international war, notorious political instability, subjected to reprisals, restrictions on free movement of persons and goods are excluded.

Furthermore, the "Worldwide" zone may be changed according to the internal or international evolution of the countries where we are operating. In order to obtain information before you leave, please contact our sales department on:
+33 (0)1.41.85.85.84.

### I.5 Travel tickets

When transportation is organized and covered as per the guarantees of the policy, you commit yourself either to allowing us to use your travel ticket(s) or to refunding the amounts that are reimbursed by the organization that issued your travel ticket(s).

### I.6 Conditions for subscription

Membership may be obtained in favor of natural persons whose country of origin is located anywhere in the world.

### I.7 Subrogation

After payment of benefits we are subrogated to your rights and actions in connection with claims against all third parties liable for the event that caused the loss or damage. Our subrogation is limited to the amount of the benefits we paid or the services we provided.

### I.8 Period of limitation

No action arising from this policy may be entered more than two years after the event that gave rise to such action.

### I.9 Exemption from liability in the event of force majeure and similar events

We may not be held liable for impediments in the performance of our services in the case of force majeure or events as civil or international wars, notorious political instability, popular uprisings, riots, acts of terrorism, reprisals, restrictions on freedom of movement of persons and goods, air traffic restriction or interdiction, explosions, natural disasters, disintegration of the atomic nucleus, nor for delays resulting from these events.
We may not be held liable for impediments in the performance of our services in case of waiting periods and/or impossibility to
obtain administrative documents as entry and exit visa,
passport, etc. that are necessary to transport you within or outside of the country where you are, or to enter the country where our physicians recommended you to be hospitalized, nor for delays resulting from these events.

### I.10 General exclusions

- **Consequences of civil or international wars, riots, popular uprisings;**
- **The voluntary participation of a member in riots or strikes;**
- **Disintegration of the atomic nucleus or any release of radiation from a radioactive energy source;**
- **Alcohol abuse, drunkenness, consumption of medication, drugs or non-prescribed narcotics;**
- **Consequences of intentional acts or consequences of fraudulent acts or attempted suicide;**
- **Any event caused by a pre-existing illness and/or injury diagnosed and/or treated, that required a hospitalization within the 6 months prior to this event, whether it concerns a recurrence or the deterioration of this condition.**

### I.11 How to use our services

**In case you need assistance:**
To enable Europ Assistance France to provide assistance services, you need to:

| Telephone numbers: | From FRANCE: 01.41.85.84.46<br>From abroad: +33.1.41.85.84.46 |
|---|---|
| Telex: | 616710 EURA PARIS |
| Fax: | From FRANCE: 01.41.85.85.71<br>From abroad: +33.1.41.85.85.71 |
| E-mail: | service-medical@europ-assistance.fr |

1) contact immediately Europ Assistance France via:
2) obtain prior approval from Europ Assistance France before taking any action or making any payment,
3) conform to the solutions recommended by Europ Assistance France.

## II. ASSISTANCE POLICY

### ARTICLE 1. Assistance services (available 24/24)

### 1.1. In case of illness or injury

#### 1.1.1 Medical contact

You are ill or injured: our physicians contact the local physician treating you following the illness or accident.
Our physicians obtain from the local physician, and possibly from your usual physician, all necessary information to make a
decision in your medical interest.

#### 1.1.2 Transportation/Repatriation

The information that is gathered allows us, after the decision made by our physicians, to start and arrange, based on the medical need, your transportation. If needed you will be relocated, under medical supervision, to a better equipped or specialized hospital in your country of residence or in a neighboring country; or to a hospital in your country of origin by medical vehicle or car, ground ambulance, sleeper train, $1^{st}$ class train (couchette or seat), airliner or air ambulance.
In some cases, your safety may require preliminary transportation to a nearby healthcare facility before considering a return to a facility near your residence.
Only your medical condition and compliance with applicable health regulations will be taken into consideration when deciding on transportation, the means of transportation to be used and the place of hospitalization where required.

Information from local physicians or your usual physician may be vital and will enable us to make the decision best suited to your situation.
Accordingly, it is expressly agreed that our physicians shall have the exclusive responsibility for making the final decision in
order to avoid any conflict between medical authorities.

Furthermore, should you refuse to comply with the decision deemed the most appropriate by our physicians, you will expressly release us from any liability regarding return travel at your own expense or travel resulting in the deterioration of your medical condition.

#### 1.1.3 Return of an accompanying party

If you are transported under the conditions stipulated in chapter 1.1.2 "Transportation/Repatriation", we will arrange and cover the cost of transportation of a member (as defined under this policy) from the country of residence to the place of hospitalization or to your residence in the country of origin, by train in the $1^{st}$ class section or by airliner in economy class.

The return journey for the accompanying party will be taken either with the ill or injured member or individually depending on the recommendation of our medical team.
This service cannot be combined with the "Hospital Visit" service.

#### 1.1.4 Hospital Visit

If you are hospitalized during your stay abroad following an illness or accident and our physicians consider that you cannot be transported for another 10 days, we will arrange and cover the expenses of a return journey by train in the $1^{st}$ class section or by airliner in economy class for a person you choose from your country of origin or your country of residence to come to your bedside.
This service cannot be combined with the "Return of an accompanying party" service.

#### 1.1.5 Return to the country of residence

If you have been transported under the conditions stipulated in chapter 1.1.2 "Transportation/Repatriation" and your medical condition enables you to be transported alone, under normal transportation conditions and subject to the

prior approval of your usual physician and our medical team, we will arrange and cover the cost of your return by train in the 1st class section
or by airliner in economy class to your country of residence before your transportation.

The return must be arranged within 2 months following the date of transportation.

#### 1.1.6 Early return in the event of hospitalization of a family member

Should you learn during your stay of the serious and unforeseen hospitalization of a family member, to enable you to go to the bedside of the hospitalized person in your country of origin, we will arrange and cover the expenses of a return journey by train in the 1st class section or by airliner in economy class. Should no supporting document be submitted (hospitalization form, document substantiating your relationship with the family member) within 30 days, we reserve the right to charge you the entire cost of the arranged travel.
This coverage is provided within the following limits: one return ticket for a "single" plan and two return tickets for a "family" plan.

### 1.2 Assistance in the event of death

#### 1.2.1Transportation in the event of a member's death

In the event of the death of a member, we arrange and cover the costs of repatriation of the body from the place of death to the place of interment in the country of origin.
We also cover the entire costs of post mortem care and making the necessary transportation arrangements.
Furthermore, we also contribute to coffin costs up to €765, all taxes included.
Other expenses (such as the ceremony, local transportation and burial) are the responsibility of the member's family.

#### 1.2.2 Early return in the event of a family member's death

Should you learn during your stay of the death of a family member, to enable you to attend the funeral in your country of origin, we will arrange and cover the expenses of a return journey by train in the 1st class section or by airliner in economy class. Should no supporting document be submitted (death certificate, document substantiating your relationship with the family member) within 30 days, we reserve the right to charge you the entire cost of the arranged travel.
This coverage is provided within the following limits: one return ticket for a "single" plan and two return tickets for a "family" plan.

### 1.3 Travel assistance

#### 1.3.1 Advance of bail bonds and legal fees

In the event that you are the subject of criminal proceedings abroad following a road accident (excluding all other causes) which you caused, we will advance the bail bond up to €3,050 all taxes included as well as legal fees up to €15,245 all taxes included.
You undertake to reimburse us the said advance within 30 days upon receipt of our invoice or, in the case of advance of bail bond, upon restitution of the bail by the authorities should the return occur before expiry of said time limit.
This service does not cover the legal consequences of proceedings instigated in your country of origin following a road accident occurring abroad.

#### 1.3.2 Transmission of urgent messages

If you are materially incapable of transmitting an urgent message to someone, we will arrange for transmitting at a time and day of your choice said message, communicated to us via telephone or to the following dedicated number: +33 1 41 85 81 13.

You may also use this telephone number to leave a message to the person of your choice, who will only need to call said number.

**NOTE:** Your messages may only be recorded through this special number (excluding collect call); we may not be held liable for the content of said messages which are subject to French criminal and administrative legislation. Failure to comply with said legislation may result in the refusal from us to communicate the message.

#### 1.3.3 Delivery of medication

In the event that you are in your country of residence and that medication vital to continuing treatment which, if interrupted, would incur a risk to health in our physicians' opinion:
- we will search for equivalent medication on site and accordingly organize a medical check-up with a local physician who will prescribe them. You will need to pay for medical expenses and medication.
- if there is no equivalent medication available locally, we will arrange the delivery of medication prescribed by your usual physician, provided that the latter sends our physicians a copy of the prescription and that such medication is available in pharmacies.

We will cover the cost of shipment and will charge customs clearance duties and the purchase of said

medication. You undertake to reimburse us upon receipt of our invoice.

Said shipments are subject to the standard terms and conditions of the carrier companies we operate with. In all cases, they are subject to the regulations and conditions provided by the domestic laws of each country with regard to the import and export of medication.
We shall not be held liable for any delay, loss or theft of medication in the course of shipment transportation and for any consequence resulting therefrom.

In all cases, the following are excluded from delivery: blood products and derivatives, products restricted to hospital use or products requiring specific storage conditions, including cold storage.
In addition, cessation of manufacture, withdrawal from market or unavailability in France of medication shall be deemed cases of force majeure which may delay or prevent the service from being carried out.

## ARTICLE 2. Scope of exclusions

### 2.1. Exclusions applicable to the policy

**We cannot under any circumstances replace local emergency services. In addition to the general exclusions listed under section I.10, coverage excludes:**

- **Expenses incurred without our prior approval or which are not covered under this policy,**
- **Expenses for which original supporting documents have not been submitted,**
- **Claims occurring in countries excluded from coverage or outside the policy term,**
- **The consequences of incidents occurring during motorized trials, races or competitions (or their trials) in which you participate as a competitor,**
- **Pre-existing illnesses or injuries diagnosed and/or treated that required a period of hospitalization within the 6 months prior to the request for assistance coverage,**
- **Travels undertaken with a view to obtaining medical diagnosis and/or treatment,**
- **Organization and coverage of transport as indicated under "Transportation/Repatriation" for benign afflictions which may be treated on site and do not prevent you from pursuing your assignment,**
- **Requests for assistance relating to medically assisted procreation or induced termination of pregnancy,**
- **Incidents related to a pregnancy, the risk of which was known prior to departure and the related consequences (including delivery) and in all cases, incidents due to pregnancy after the $36^{th}$ week of amenorrhea and their consequences (including delivery),**
- **Medical expenses incurred in your country of origin,**
- **Expenses incurred for vision care (e.g. eyeglasses lenses or contact lenses),**
- **Expenses incurred for medical appliances and prostheses,**
- **Expenses incurred for thermal spa therapy,**
- **Cosmetic interventions,**
- **Room and board fees incurred during a stay in a convalescent home,**
- **Expenses incurred for re-education, physical therapy, chiropractic sessions,**
- **Vaccines and vaccination expenses,**
- **Expenses incurred for medical check-ups,**
- **Expenses incurred for medical or paramedical services and the purchase of products whose therapeutic effects are not acknowledged by French legislation,**
- **Mountain, sea and desert search expenses,**
- **Any damage supported by the member whilst he/she is under military supervision,**
- **Expenses relating to excess luggage weight when traveling by airplane and to luggage forwarding costs when they are not transported with you,**
- **Catering costs,**
- **Customs clearance duties.**

V-01/01/2015

*The original version of this document is in French. In the event of a dispute, the French version shall prevail over any languages*

# Summary of the General Provisions of the Life & Disability benefits

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# Title 1 – General

## Article 1 – *Purpose of the insurance*

The purpose of this group insurance plan with optional membership is:
- the payment of a lump sum to the designated beneficiaries in the event of the member's death (Article 4),
- the payment of a lump sum to the member him/herself in the event of permanent total disability (Article 5),

and, if optional benefits have been purchased by the member:
- the payment of an additional lump sum to the designated beneficiaries in the event of the accidental death of the member (Article 6),
- the payment to the member of a lump sum proportional to the degree of infirmity, in the event of his or her total or partial infirmity (Article 7),
- the provision to the member of benefits in the event of sick leave from work following an illness or accident (Article 8),

In respect of this Sick Leave benefit, three options are available to the member: "Standard Sick Leave benefit", "Short-Term Disability benefit" and "Long-Term Disability benefit". Reference numbers specific to each particular plan, as described in Article 3 below, are assigned to these different options.
The benefits and options purchased by the member are shown on the Certificate of enrollment.

## Article 2 – Definitions and Geographical limits

### A) Definition

**Accident**
Any physical injury, not intended by the member or the dependent, resulting from sudden action with an external cause. In accordance with Article 1315 of the French Civil Code, it is the responsibility of the beneficiaries to provide evidence of the accident and the direct relationship of cause and effect between the accident and the death.

**Basic social security scheme**
Any social security scheme in force in the country of expatriation or the Caisse des Français à l'étranger – CFE.

**Certificate of enrollment**
Document issued to each member confirming their enrollment in the plan and specifying, in particular, the benefits and level of coverage selected, the effective date and the premiums.

**Contracting association**
**ASFE:** Legal entity which provides the plan to its members and agrees to fulfill the corresponding obligations.

**FOC**

French Overseas Communities (Saint Pierre and Miquelon, Wallis and Futuna, Saint-Barthélemy and Saint-Martin).

**FODR**
French Overseas Departments and Regions (Guadeloupe, Guyana, Martinique, Reunion and Mayotte).

**Hospitalization**
A stay in a hospital (public or private) for medical or surgical treatment of an illness, accident or maternity. Home hospitalization is an alternative to conventional hospitalization and allows the patient to be cared for in their own home.

**Illness**
Any deterioration in the state of health certified by a competent medical authority.

**Member**
Member of the contracting organization requesting enrollment in this plan and meeting the conditions set out in Article 12.

### B) Geographical limits

Coverage applies in the country of destination located anywhere in the world as well as in France and in the FODRs and FOCs.

However, coverage also applies for periods of not more than 60 consecutive days between two stays in the country of destination during international trips out of the country of destination (in a private capacity).
**It is specified that, based on events (war or civil war, insurrection, etc.) which may occur there and, in any event, in accordance with the designation of countries at risk issued by the French Ministry of Foreign Affairs, enrollment in the plan may be excluded for certain countries to which travel is strongly discouraged by the ministry (red zone) or subject to prior acceptance by the insurer if travel to that country is discouraged by the ministry unless for compelling reasons (orange zone).**

## Article 3 – *Language and Currency of the plan – Reference numbers used in the plan*

MSH INTERNATIONAL is the organization mandated by the **Insurer** and the **Contracting association**, particularly for the purpose of managing membership of the plan.

### A) Language of the plan

The language of the group insurance plan is French.

However, MSH INTERNATIONAL provides members with English versions of the plan and the documents required for management of plan membership such as individual enrollment forms, medical questionnaires, confidential medical certificates, etc.
However, in case of disagreement on the interpretation of the benefits provided under the plan or the terms of their implementation, only the French version of the relevant document will be taken into consideration. Translations of documents are made available to members purely for information purposes and only the French language version is binding.

### C) Currency of the plan

The currency of the plan is the euro. However, MSH INTERNATIONAL gives members the option of using the US dollar for their membership, both for the premiums and the benefits.

The currency selected by the member is shown on the certificate of enrollment.
For the insurer, the premiums and benefits are in all cases payable in euros.
A particular reference number, as described in paragraph D) below, is assigned to the plan according to whether the membership operates in euros or dollars.
**IMPORTANT: Payments cannot be made, either directly or indirectly, to a country which is subject to sanctions such as those imposed, for example, by the United Nations, the Office of Foreign Assets Control of the US Treasury (OFAC) or the European Union.**

## D) Reference numbers used in the plan

The plan uses the following reference numbers:

- **Membership in euros:**
  - n° 509/863693 in all cases, other than those where Short-Term Disability benefit and/or Long-Term Disability benefit have been purchased by the member,
  - n° 509/863694 where Short-Term Disability benefit and/or Long-Term Disability benefit have been purchased by the member.

- **Membership in dollars:**
  - n° 509/863693/10 in all cases, other than those where Short-Term Disability benefit and/or Long-Term Disability benefit have been purchased by the member,
  - n° 509/863694/10 where Short-Term Disability benefit and/or Long-Term Disability benefit have been purchased by the member.

# Title 2 – Benefits

## Preamble – Instructions to members for claiming benefits

The purpose of this section is to provide the member with an overview of how the life & disability benefits operate should they need to make a claim:

➔ **Contact**: the AD&D AND SUPPORT department at MSH INTERNATIONAL:
- by telephone: + 33 (0)1 44 20 48 07,
- by email: add_support@msh-intl.com,
- by fax: + 33 (0)1 44 20 48 79.

➔ To make the payment of benefits easier and faster, all the documents to be provided (listed in the relevant article describing each type of benefit) should be sent to the AD&D AND SUPPORT department at MSH INTERNATIONAL.

## Article 4 – Death of the member

**A) DEFINITION AND AMOUNT OF THE BENEFIT**

The purpose of this benefit is to pay a lump sum in the event of the death of the member to the designated beneficiaries listed in paragraph C) below. This payment is subject to the provisions of paragraph B) with the amount being equal to 100% of the selected lump sum.
The member is free to choose the amount of the lump sum.
The amount of the insured lump sum to be selected can be between:
- in euros: €25,000 and €1,000,000, in multiples of €25,000,
- in dollars: $30,000 and $1,200,000, in multiples of $30,000.
The amount selected by the member is shown on the certificate of enrollment.

**B) EXCLUSIONS FROM COVERAGE**

**The benefit is not payable in the following cases:**
- **Death resulting from a war involving France is excluded.**
- **Death caused by civil or foreign war, insurrection, riots, brawls, regardless of where the events take place and who the protagonists are (unless the member does not take an active part or is called upon to carry out a servicing or surveillance assignment for the purpose of ensuring personal security) is excluded.**
- **Suicide, however it is classified, is excluded during the first year of membership of the plan.**

**C) DISTRIBUTION OF DEATH BENEFIT**

Subject to any stipulation to the contrary which is valid on the day of the member's death, the insured lump sum is paid:
- to his or her surviving spouse from whom he or she is neither divorced nor legally separated or, failing that, to his or her surviving civil partner *[A civil partnership is a contract concluded between two adult persons of the opposite sex or same sex to organize their common life together* (Article 515-1 of the French Civil Code)]
- failing that, to his or her children born and unborn, living or represented for the purposes of inheritance,

- failing that, equally between them, to his or her father and mother or the entire amount to the surviving parent,
- failing that, to his or her other heirs.

If the member does not want the insured lump sum to be allocated according to the above clause, or if, during the life of the plan, he or she wants to designate one or more other beneficiaries, he/she should designate the beneficiary or beneficiaries of his/her choice and inform the insurer.

This designation may be carried out by private deed or certified document.

To avoid any risk of duplication of names and to make it easier to locate the designated beneficiaries, the member should provide, for each beneficiary, details which will allow them to be accurately identified, including their surname, first names and date and place of birth.

**Any designation or change in designation which is not brought to the attention of the insurer is non-binding.**

**The insurer draws the member's attention to the need for regular updates of their special beneficiary designation(s).**

With the member's agreement, any designation of beneficiary may be subject to acceptance, after a period of at least 30 days following the effective date of membership of the plan, if the designation is made free of charge.

While the member is alive, this acceptance must be formalized either by an endorsement signed by the insurer, the member and the beneficiary or by a private deed or certified document signed by the member and the beneficiary.

Acceptance is only binding on the insurer if they have been notified in writing.

Proof of such notification falls upon the person claiming the benefit.

**It is specified that the designation in favor of a specific beneficiary becomes irrevocable if it is accepted by them under the above conditions.**

A private deed is a document, which can be freely drafted, drawn up by one of the parties and signed by all participants. There must be as many originals as there are participants. The private deed may or may not be registered with the tax department. A certified document is a document drawn up by a public official and signed before them by all parties.

The entitlement of beneficiaries to the insured lump sum is subject to them surviving for two days following the death of the member.

**D) FORMALITIES TO BE COMPLETED IN THE EVENT OF A CLAIM AND PAYMENT OF BENEFITS**

Except in cases of force majeure, the death must be declared to the insurer within six months of its occurrence, by sending them the supporting documents required for settlement, including:
- an extract of the death certificate,
- a medical certificate, to be sent to the insurer's medical advisor under confidential cover, indicating the date of death and specifying if it was a natural or accidental death or a death resulting from an event excluded under the plan,
- any document proving identity and/or marital status,
- where appropriate, any documents specifying the cause and circumstances of the accident resulting in the death.

The insurer reserves the right to request any additional supporting documents they consider necessary for settlement of the claim.

Payment of the lump sum is made to the designated beneficiary or beneficiaries within fifteen days of the date of receipt of the supporting documents by the insurer.

If there is more than one beneficiary:
- the lump sum is allocated as specified by the member or, in the absence of any specific instructions, shared equally between beneficiaries of the same class,
- the lump sum will not be distributed by the insurer but a single payment will be made subject to a receipt being signed jointly by the parties or their legal representative.

## Article 5 – Permanent total disability of the member

***This benefit is payable in addition to the death benefit provided for under Article 4.***

**A) DEFINITION AND AMOUNT OF THE BENEFIT**

If, before claiming their old-age pension from Social Security and no later than the date of their 70th birthday, a member, following an illness or accident and subject to the provisions of paragraph B) below, is affected by a disability which renders them totally unable to perform any professional activity whatsoever and, moreover, if they require the assistance of a third party to perform everyday tasks, the insurer will recognize them as having a permanent and total disability.

**Permanent and total disability status is assessed by the insurer's medical advisor independently of decisions made by the Social Security scheme to which the member may belong.**

The insurer then pays the member **a lump sum of the same amount as that paid under Article 4.**

The payment of the lump sum due in the event of permanent and total disability ends any entitlement to the benefit specified under Article 4 in the event of the member's death.

**B) EXCLUDED RISKS**

- **accidents or illnesses caused intentionally by the member or resulting from either a suicide attempt or intentional self-inflicted injuries or the use of narcotics or psychotropic drugs without a medical prescription,**
- **accidents or illnesses caused by civil or foreign war, insurrection, riots or brawls regardless of where the events take place and who the protagonists are unless the member does not take an active part or is called upon to carry out a servicing or surveillance assignment for the purpose of ensuring the security of persons and goods,**
- **accidents or illnesses caused by a war involving France.**

**Furthermore, other than in application of Article L113-8 of the French Insurance Code, and subject to the exclusions listed above, the benefit applies to the consequences of medical conditions or disabilities which occurred before the date of signature of the application for coverage under the plan if they were declared on the application form and were not subject to a specific exclusion of which the member was notified by registered mail.**

**C) FORMALITIES TO BE COMPLETED IN THE EVENT OF A CLAIM AND PAYMENT OF BENEFITS**

**C.1) Formalities to be completed**

**Responsibility for declaring the state of permanent and total disability rests with the member who is required to provide proof of the condition to the insurer by means of the supporting documents required for settlement.** These include:
- a detailed certificate from the treating doctor indicating the nature of the illness or accident, to be sent to the insurer's medical advisor under confidential cover,
- any evidence establishing the need for third party assistance such as the notification of the award, if any, by Social Security of a disability allowance requiring third party assistance,
- any document proving identity and/or marital status,
- where appropriate, any documents specifying the cause and circumstances of the accident which caused the permanent and total disability.
The insurer reserves the right to request any additional supporting documents they consider necessary for settlement of the claim.

**C.2) Recognition and monitoring by the insurer of the state of permanent and total disability**
Until the date on which the benefit becomes payable, the insurer has the right to carry out any checks and submit the claimant to any medical examinations deemed useful to assess, recognize or monitor the state of permanent and total disability. For this purpose, the insurer's doctors, agents or representatives must be able to visit the member, who agrees to meet with them and provide them with an honest account of his or her condition. **If the member does not agree to the visits and/or medical examinations, the insurer is automatically authorized by law to suspend payment of the benefit.**
In the event of a disagreement between the member's doctor and that of the insurer regarding the state of permanent and total disability, the member and the insurer may together choose a third doctor in order to reach a majority decision and, if they cannot agree on the choice of doctor, the appointment will made by the *Tribunal de Grande Instance* of Paris. Arbitration fees are shared equally between the member and the insurer. **Members agree to submit to the jurisdiction of the Paris courts and waive the right to any proceedings in any other country.**

**C.3) Payment of the lump sum**
The insured lump sum, payable to the member him/herself, is paid six months after the date of recognition by the insurer of the permanent and total disability and subject to the continuation of this state.
In the event of the member's death before the lump sum is paid, a lump sum will be paid to the designated beneficiaries as defined under Article 4.C).

## Article 6 – Optional benefit in case of accidental death of the member

***This benefit, which is purchased in addition to the death benefit provided for under article 4, is payable if it is specified on the certificate of enrollment.***

### A) DEFINITION AND AMOUNT OF THE BENEFIT

The purpose of this benefit is to pay the beneficiary or beneficiaries specified under Article 4, if the member dies following an accident as defined under Article 2 and subject to the provisions of paragraph B) below, an **additional lump sum** the amount of which is equal to 100% of the death benefit provided for under Article 4.

**The benefit is payable on condition that the death occurs no later than twelve months after the accident. In accordance with Article 1315 of the French Civil Code, it is the responsibility of the beneficiaries to provide evidence of the accident and the direct relationship of cause and effect between the accident and the death.**

**B) EXCLUSIONS FROM COVERAGE**

**The benefit is not payable in the following cases:**

- **illness, even if it is the result of an accident,**
- **accidents caused intentionally by the member or resulting either from suicide or intentional self-inflicted injuries or the use of narcotics or psychotropic drugs without a medical prescription,**
- **accidents resulting from the member being under the influence of alcohol as defined by a blood alcohol concentration equal to or above that set by the French highway code to characterize the offense of drunk driving,**
- **air navigation accidents unless the member is aboard an aircraft with a valid certificate of airworthiness and flown by a pilot in possession of a non-expired permit and license. The pilot may be the member him/herself.**
- **accidents caused by:**
  **matches, races, bets and sporting competitions (unless the member is participating as an amateur),**
  **- motor racing**
  **- nuclear disintegration,**
  **- scuba diving,**
  **- bungee jumping,**
  **- air sports whether or not they require the use of a motorized vehicle (shows, conventions, adventure racing, aerobatics or flying competitions, records or record attempts, preparatory and acceptance trials, parachute jumps not carried out for safety reasons, hang gliding, paragliding, microlighting etc.)**
- **accidents caused by civil or foreign war, insurrection, riots or brawls regardless of where the events take place and who the protagonists are unless the member does not take an active part or is called upon to carry out a servicing or surveillance assignment for the purpose of ensuring the security of persons and goods,**
- **accidents caused by a war involving France.**

**C) PAYMENT OF THE BENEFIT**

**C.1) Formalities to be completed in the event of a claim**

The formalities are the same as those defined under Article 4 for benefits payable in the event of the member's death. In addition to the supporting documents listed for payment of the benefit, proof of the accident and the direct cause and effect between it and the death must be provided to the insurer by means of any suitable document.

**C.2) Distribution of the lump sum**

The lump sum is paid under the conditions defined under Article 4 for benefits payable in the event of the member's death.

## Article 7 – Optional benefit in case of infirmity of the member

***This benefit, which is purchased in addition to the death benefit provided for under Article 4, is payable if it is specified on the certificate of enrollment.***

**A) DEFINITION AND AMOUNT OF THE BENEFIT**

The purpose of the benefit is to provide, subject to the provisions of paragraph B. below, a lump sum to the member in the event of illness or accident causing bodily infirmity which affects them in their professional activity or their private life.

The member is free to choose the amount of the lump sum, **up to the level of the death lump sum selected by them.**

The amount of the insured lump sum to be selected can be between:
- in euros: €25,000 and €1,000,000, in multiples of €25,000,
- in dollars: $30,000 and $1,200,000, in multiples of $30,000.
The amount selected by the member is shown on the certificate of enrollment.

The amount of the lump sum due for cases of total infirmity (equal to 100%), as determined by the insurer's doctor, is set at 100% of the selected lump sum. If the infirmity is partial, the amount of the lump sum paid is proportional to the degree of infirmity.

**No lump sum is due for cases of infirmity of less than 33%.**
The age and profession of the member are never taken into account.
The degree of infirmity is determined by the insurer's doctor on the date of recovery from the accident or stabilization of the illness.

Determining the degree of infirmity: The degree of infirmity used in the application of the insurance contract is determined by medical expertise (joint opinion of the member's treating doctor and the insurer's medical examiner and, if necessary, by a third doctor acting as arbitrator as described below), depending on the degree of functional incapacity of the member. Functional, physical or mental incapacity is assessed independently of any consideration of resources or profession, with reference to the scale of incapacity in common law published in the French medical journal, *Concours Médical*.

***The degree of functional incapacity used for the calculation of this benefit may not be increased by illnesses or medical conditions which existed prior to the date of signature of the application for coverage under the plan and which were subject to a specific exclusion of which the member was notified by the insurer by registered mail.***

**B) EXCLUDED RISKS**

**The benefit is not payable in the following cases:**

- **accidents or illnesses caused intentionally by the member or resulting from either a suicide attempt or intentional self-inflicted injuries or the use of narcotics or psychotropic drugs without a medical prescription,**
- **accidents or illnesses caused by civil or foreign war, insurrection, riots or brawls regardless of where the events take place and who the protagonists are unless the member does not take an active part or is called upon to carry out a servicing or surveillance assignment for the purpose of ensuring the security of persons and goods,**
- **accidents or illnesses caused by a war involving France,**
- **the member driving a vehicle without a valid license or under the required age,**
- **accidents or illnesses resulting from the member being under the influence of alcohol as defined by a blood alcohol concentration equal to or above that set by the French highway code to characterize the offense of drunk driving,**
- **working underground or under water, handling explosives, the effects of atomic radiation,**
- **hernias and lumbago.**

**C) FORMALITIES TO BE COMPLETED IN THE EVENT OF A CLAIM AND PAYMENT OF BENEFITS**

**C.1)** <u>**Formalities to be completed**</u>

**The member must declare the illness or accident to the insurer as soon as possible with the declaration including details of the gravity, causes and circumstances of the illness or accident.** The member must also:

- send the insurer's medical advisor a certificate from the doctor who was called to provide first aid describing the precise nature of their current condition, injuries and their consequences. This declaration should be sent under confidential cover,
- where applicable, send any documents required to establish the fact and extent of the accident,
- agree to be examined by the insurer's doctor.

The insurer reserves the right to request any additional documents they deem necessary.

**Any fraud, concealment or false declaration on the part of the member with the purpose of misleading the insurer with respect to the circumstances or consequences of the illness or accident will lead to loss of entitlement to the benefit.**

**C.2)** <u>**Recognition by the insurer of the state of infirmity**</u>

The insurer has the express right to assess, recognize or monitor the state of infirmity of the member. For this purpose, the insurer's doctors, agents or representatives must be able to visit the member, who agrees to meet with them and provide them with an honest account of his or her condition. They may also invite the member to attend an appointment.

**If the member does not agree to the visits and/or medical examinations, the insurer is automatically authorized by law to suspend payment of the benefit.**

In the event of a disagreement between the member's doctor and that of the insurer regarding the state of infirmity, the member and the insurer may together choose a third doctor in order to reach a majority decision and, if they cannot agree on the choice of doctor, the appointment will made by the *Tribunal de Grande Instance* of Paris. Arbitration fees are shared equally between the member and the insurer. **Members agree to submit to the jurisdiction of the Paris courts and waive the right to any proceedings in any other country.**

**C.3)** <u>**Payment of the lump sum**</u>

Payment of the lump sum is made within a maximum period of one month following the agreement between the member's doctor and that of the insurer on the causes and consequences of the illness or accident and the degree of infirmity.

**D)** <u>**COMPENSATION FROM THE PERSON OR PERSONS WHO CAUSED THE ACCIDENT**</u>

The member retains the full amount of any compensation obtained from the persons responsible for the accident.

## Article 8 – Optional benefit in case of sick leave from work by the member

***This benefit which is purchased in addition to the death benefit provided for under Article 4, is payable if it is specified on the certificate of enrollment.***

**A)** <u>**DEFINITION AND PURPOSE OF THE INSURANCE**</u>

**A.1)** <u>**Definition of the benefit**</u>

Temporary total incapacity to work is a state of temporary incapacity **following an illness or accident** affecting the member in their professional activity or in their private life and which makes it totally physically or mentally impossible for them to perform any professional activity whatsoever. This state must be medically diagnosed and recognized by the insurer.

Permanent total or partial disability is a disability **following an illness or accident** making it totally or partially physically or mentally impossible for the member to carry out their normal professional activities or any professional activities providing the same level of income as before the period of sick leave following an illness or accident. This state must be medically diagnosed and recognized by the insurer.

**A.2) Purpose of the benefit**

The purpose of this benefit is to provide an allowance in the event of a period of sick leave by the member (a daily allowance in case of temporary total incapacity to work or an annual pension in case of permanent total or partial disability) following an illness or accident.

Three options hereafter referred to as Standard Disability Benefit, Short-Term Disability Benefit and Long-Term Disability Benefit, are available to the member in respect of this benefit. Options 2 and 3 may be purchased together (see definitions below).
The option or options selected by the member are shown on the certificate of enrollment.

**Sick leave benefits are paid to the member, provided he or she is recognized by the insurer as suffering from temporary total incapacity to work or permanent total or partial disability as defined in paragraph A.1) above and subject to the provisions set out in paragraph C.3) below**.
The state of temporary total incapacity to work or permanent total or partial disability is determined by the insurer's medical advisor independently of the rulings of any Social Security scheme to which the member may belong.

**A.3) Conditions governing the award of benefits**

Benefits are awarded with reference to current French Social Security regulations. If, at a later date, these regulations were to be changed, resulting in a change to the obligations of the member and the insurer, the insurer would adjust the premium payable in respect of sick leave benefits. If the member does not respond to the proposal made by the insurer, or if they expressly reject the new premium, the insurer may terminate the membership at the end of a period of 30 days. However, the insurer reserves the right, with respect to the payment of benefits, to refer to the legislation in force at the time of enrollment in the plan.

## B) AMOUNT OF BENEFITS

Depending on the option selected by the member, the insurer will pay the following benefits to a member recognized to be in a state of temporary total incapacity to work or permanent disability:

### B.1) Option 1: Standard Sick Leave benefit (daily allowance and pension)

**B.1.1. Amount of the benefit:**

The member is free to choose the amount of the daily allowance, **up to the limit of one thousandth of the selected death lump sum.**
The amount of the daily allowance to be selected can be between:
- in euros: €25 and €500 per day, in multiples of €25,
- in dollars: $30 and $600 per day, in multiples of $30,

**up to the limit of one thousandth of the selected death lump sum.**
However, if the amount of the selected death lump sum is less than or equal to €250,000 or $300,000, the amount of the daily allowance selected by the member may exceed one thousandth of the death lump sum and may be increased by €25 or $30 per day.
The amount of the daily allowance selected by the member is shown on the certificate of enrollment.

The monthly amount of the permanent total disability pension (for disabilities greater than or equal to 66%) is equal to that of the daily allowance multiplied by 30 to provide a monthly amount.

The amount of the daily allowance selected by the member is shown on the certificate of enrollment.

**Furthermore, it is specified that the daily allowance paid cannot, under any circumstances, exceed 70% of the average daily professional income earned by the member during the 12 calendar months preceding the period of sick leave taken into consideration.**

**B.1.2. Temporary total incapacity to work:**

When the insurer recognizes the member to be in a state of temporary total incapacity to work, the member is paid a daily allowance from the expiration of a period of total and continuous sick leave from work (known as the "waiting period") of **30 days, 60 days or 90 days** as chosen by the member and shown on the certificate of enrollment.

The amount of temporary total incapacity benefit paid by the insurer is set at 100% of the selected daily allowance, limited in all cases to **70% of the average daily professional income earned by the member during the 12 calendar months preceding the period of sick leave taken into consideration.**

- **Terms of payment of the benefit**: The daily allowance, which is acquired on a daily basis for as long as the member is in a state of temporary total incapacity to work, is payable to the member monthly in arrears until the date of recovery from the accident or stabilization of the illness and for a maximum period of no more than 24 months.

- **Cessation of payment of the daily allowance**: Payment of the daily allowance ends in all cases:
  - when the member returns to work or is found to be medically fit to return to work, even on a part-time basis,
  - from the day on which the member is recognized to be in a state of permanent disability with the provisions of paragraph B.1.2 below being applicable on that date,
  - on the date on which the member receives their retirement pension from Social Security, including for reasons of unfitness for work, and no later than the day on which the member reaches the age of 70,
  - and no later than the end of the maximum period of 24 months mentioned above.

**B.1.2. Permanent disability**

- **Determining the degree of disability "n":** The degree of disability "n" is determined by medical expertise (joint opinion of the member's treating doctor and the insurer's medical examiner and, if necessary, by a third doctor acting as arbitrator as described below), and with reference to the scales of functional and occupational incapacity shown below. The degree of disability is determined independently of the rulings of the member's Social Security scheme on the date of recovery from the accident or stabilization of the illness and at the latest on expiration of the maximum benefits period of 24 months specified in respect of Temporary total incapacity benefit.

  Functional, physical or mental incapacity is assessed independently of any professional considerations, with reference to the scale of incapacity in common law published in the French medical journal, *Concours Médical*. Occupational incapacity is assessed on the basis of the degree and nature of the incapacity in relation to the

insured's occupation, with consideration given to the manner in which the occupation was performed prior to the illness or accident, the normal conditions for performing the occupation and their remaining capacity to perform the occupation.

**The degree of functional and occupational disability used for the calculation of this benefit may not be increased by illnesses or medical conditions which existed prior to the date of signature of the application for coverage under the plan and which were subject to a specific exclusion of which the member was notified by the insurer by registered mail.**

The following table shows the rating obtained for various degrees of incapacity both functional and occupational. **To be eligible for a permanent disability pension the rating must be at least 40%.**

| DOI | DEGREE OF FUNCTIONAL INCAPACITY | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| 10 | --- | --- | --- | --- | --- | --- | 40.00 | 43.27 | 46.42 |
| 20 | --- | --- | --- | --- | 41.60 | 46.10 | 50.40 | 54.51 | 58.48 |
| 30 | --- | --- | --- | 42.17 | 47.62 | 52.78 | 57.69 | 62.40 | 66.94 |
| 40 | --- | --- | 40.00 | 46.42 | 52.42 | 58.09 | 63.50 | 68.68 | 73.68 |
| 50 | --- | --- | 43.09 | 50.00 | 56.46 | 62.57 | 68.40 | 73.99 | 79.37 |
| 60 | --- | --- | 45.79 | 53.13 | 60.00 | 66.49 | 72.69 | 78.62 | 84.34 |
| 70 | --- | --- | 48.20 | 55.93 | 63.16 | 70.00 | 76.52 | 82.79 | 88.79 |
| 80 | --- | 41.60 | 50.40 | 58.48 | 66.04 | 73.19 | 80.00 | 86.54 | 92.83 |
| 90 | --- | 43.27 | 52.42 | 60.82 | 68.68 | 76.12 | 83.20 | 90.00 | 96.55 |
| 100 | --- | 44.81 | 54.29 | 63.00 | 71.14 | 78.84 | 86.18 | 93.22 | 100.00 |

DOI = DEGREE OF OCCUPATIONAL INCAPACITY

In the event of a disagreement between the member's doctor and that of the insurer regarding the state of permanent disability, the member and the insurer may together choose a third doctor in order to reach a majority decision and, if they cannot agree on the choice of doctor, the appointment will made by the *Tribunal de Grande Instance* of Paris. Arbitration fees are shared equally between the member and the insurer. **Members agree to submit to the jurisdiction of the Paris courts and waive the right to any proceedings in any other country.**

**In any event, payment of the benefit may be terminated if there is an improvement in the health of the insured.**

- ***Amount of the permanent disability pension:*** If the degree of disability "n" determined by the insurer is greater than or equal to 66%, the disability is deemed to be total. A pension is then paid, the monthly amount of which is equal to 30 times the amount of the selected daily allowance. This amount is limited in all cases to **70% of the average daily professional income earned by the member during the 12 calendar months preceding the period of sick leave taken into consideration.**

If the degree of disability "n" determined by the insurer is between 40% and 66%, the disability is deemed to be partial. A reduced pension is then paid, the amount of which is based on the pension paid by the insurer in the event of total disability with the application of a coefficient of n/66.

**No benefits are due if the degree of disability "n" determined by the insurer does not reach 40%.**

- **Terms of payment of the benefit**: The pension is paid from the date on which the disability is recognized by the insurer but no earlier than the end of the maximum benefit period of 24 months in respect of the temporary total disability benefit specified above.
  The amount of the pension may be reviewed if there is a change in the disability status.
  The pension is payable to the member quarterly in arrears, for the entire duration of the disability.

- **Cessation of payment of the pension**: Payment of the pension ceases in all cases:
  - when the member returns to work or is found to be medically fit to return to work, even on a part-time basis,
  - and, at the latest, on the date on which the member receives their retirement pension from Social Security, including for reasons of unfitness for work and, at the latest, on the day on which the member reaches the age of 70.

**B.2) <u>Option 2: Short-Term Disability benefit</u>**

If the insurer recognizes the member to be in a state of temporary total incapacity to work, the member will be paid a daily allowance from:
- the 7th day of total and continuous absence from work due to illness,
- the 1st day of absence from work due to hospitalization,
- the 1st day of absence from work due to an accident.

The amount of the daily allowance is set at 70% of the average daily professional income earned by the member during the 12 calendar months preceding the period of sick leave taken into consideration.

- **Terms of payment of the benefit**: The daily allowance, which is acquired on a daily basis for as long as the member is in a state of temporary total incapacity to work, is payable to the member monthly in arrears until the date of recovery from the accident or stabilization of the illness and, at the latest, for a maximum duration which the member is free to choose and which is shown on the certificate of enrollment of **30, 60 or 180 days.**

- **Cessation of payment of the daily allowance**: Payment of the daily allowance ends in all cases:
  - when the member returns to work or is found to be medically fit to return to work, even on a part-time basis,
  - from the day on which the member is recognized to be in a state of permanent disability,
  - on the date on which the member receives their retirement pension from Social Security, including for reasons of unfitness for work, and at the latest on the day on which the member reaches the age of 70,
  - and, at the latest, at the end of the maximum period selected by the member and shown on the certificate of enrollment (unless the member has also taken out option 3 below).

**B.3) <u>Option 3: Long-Term Disability benefit</u>**

If the insurer recognizes the member to be in a state of temporary total incapacity to work, the member is paid a daily allowance from the expiration of a period of total and continuous sick leave from work (known as the “waiting period”) of **30 days, 60 days or 180 days** as chosen by the member and shown on the certificate of enrollment.
The amount of the daily allowance is set at 70% of the average daily professional income earned by the member during the 12 calendar months preceding the period of sick leave taken into consideration.

- **Terms of payment of the benefit**: The daily allowance, which is acquired on a daily basis for as long as the member is in a state of temporary total incapacity to work, is payable to the member monthly in arrears until the date of recovery from the accident or stabilization of the illness and, at the latest, until the 1,095th day of the period of sick leave.

- **Cessation of payment of the daily allowance**: Payment of the daily allowance ends in all cases:
  - when the member returns to work or is found to be medically fit to return to work, even on a part-time basis,
  - from the day on which the member is recognized to be in a state of permanent disability,
  - on the date on which the member receives their retirement pension from Social Security, including for reasons of unfitness for work and, at the latest, on the day on which the member reaches the age of 70,
  - and, at the latest, at the end of the period of 1,095 days specified above.

## C) PROVISIONS COMMON TO ALL SICK LEAVE BENEFITS

### C.1) Return to work on a part-time basis following a period of temporary total incapacity to work

If, after a period of temporary total incapacity to work, the member returns to work or is found to be medically fit to return to work on a full-time or part-time basis, **the daily allowance ceases to be paid by the insurer.**

### C.2) Provision specific to maternity or paternity

**A member who in a state of incapacity to work does not receive the daily allowance during periods of statutory maternity or paternity leave.**

### C.3) Return to work for less than 90 days

If a member who has been receiving the benefits specified above returns to work but, due to a relapse, requires another period of sick leave less than 90 days after resuming work, the benefits are restarted without the application of a waiting period, provided the plan is still in force on the date of the new period of sick leave.

### C.4) Cumulative benefits

The total amount of benefits paid by any Social Security scheme to which the member may belong (excluding the supplement for third party assistance) and those paid by the insurer may not exceed 70% of the professional income that the member would have earned had they continued to work.

### C.5) Exclusions from coverage

**Benefits are not payable in the following cases:**

- **accidents or illnesses caused intentionally by the member or resulting from either a suicide attempt or intentional self-inflicted injuries or the use of narcotics or psychotropic drugs without a medical prescription,**

- **accidents or illnesses caused by civil or foreign war, insurrection, riots or brawls regardless of where the events take place and who the protagonists are unless the member does not take an active part or is called upon to carry out a servicing or surveillance assignment for the purpose of ensuring the security of persons and goods,**
- **accidents or illnesses caused by a war involving France,**
- **accidents resulting from the member being under the influence of alcohol as defined by a blood alcohol concentration equal to or above that set by the French highway code to characterize the offense of drunk driving,**
- **air navigation accidents unless the member is aboard an aircraft with a valid certificate of airworthiness and flown by a pilot in possession of a non-expired permit and license. The pilot may be the member him/herself.**
- **accidents caused by:**
  **matches, races, bets and sporting competitions (unless the member is participating as an amateur),**
  **- motor racing**
  **- nuclear disintegration,**
  **- scuba diving,**
  **- bungee jumping,**
  **- air sports whether or not they require the use of a motorized vehicle (shows, conventions, adventure racing, aerobatics or flying competitions, records or record attempts, preparatory and acceptance trials, parachute jumps not carried out for safety reasons, hang gliding, paragliding, microlighting etc.)**

**Furthermore, unless Articles L113-8 and L113-9 of the French Insurance Code are enforced, and subject to the exclusions listed above, the benefits apply to the consequences of medical conditions or disabilities which occurred before the date of signature of the application for coverage under the plan if they were declared on the application and were not subject to a specific exclusion of which the member was notified by registered mail.**

**In addition, sick leave benefits are not paid during periods of statutory maternity or paternity leave.**

**C.6) <u>Formalities to be completed in the event of a claim</u>**

**The declaration of sick leave must be made by the member who is required to send it to the insurer within the following timescales:**
**- if the duration of the waiting period is less than 90 days: within three months of the start of the period of sick leave,**
**- if the duration of the waiting period is equal to or greater than 90 days: within 30 days of the expiration of the waiting period.**
**No payments will be made for the period prior to the declaration if the sick leave is not declared within these timescales.**

The declaration must be accompanied by:
- a medical certificate to be sent under confidential cover to the insurer's medical advisor stating the start date of the period of sick leave and the nature of the illness or accident, the date of the first medical diagnosis and the expected duration of absence from work,
- proof of professional income over the last 12 months prior to the period of sick leave,
- any document proving identity,
- and, where applicable:
  a confidential medical certificate using the form supplied by the insurer duly completed by the treating doctor,
  if the member is covered by a Social Security scheme: proof of payment of cash benefits from this scheme.

**The insurer reserves the right to request any additional supporting documents they consider necessary for the payment of benefits.**
**No benefits will be paid until the required supporting documents are sent to the insurer.**
**If the member returns to work, the insurer must be informed as soon as possible.**

**C.7)** **Recognition and monitoring by the insurer of the state of incapacity or disability**

The insurer has the express right to assess, recognize or monitor the state of incapacity or disability of the member. For this purpose, the insurer's doctors, agents or representatives must be able to visit the member, who agrees to meet with them and provide them with an honest account of his or her condition. They may also invite the member to attend an appointment.
**If the member does not agree to the visits and/or medical examinations, the insurer is automatically authorized by law to suspend payment of the benefits.**

In the event of a disagreement between the member's doctor and that of the insurer regarding the state of temporary total disability or the state of permanent total disability, the member and the insurer may together choose a third doctor in order to reach a majority decision and, if they cannot agree on the choice of doctor, the appointment will made by the *Tribunal de Grande Instance* of Paris. Arbitration fees are shared equally between the member and the insurer. **Members agree to submit to the jurisdiction of the Paris courts and waive the right to any proceedings in any other country.**

**C.8)** **Provisions applicable in the event of cancelation of the plan or membership of the plan**

Sick leave benefits (daily allowances paid under Options 1, 2 or 3 and disability pensions paid under option 1) continue to be paid, subject to the terms of the plan, at the level reached on the date on which the plan is canceled.

## Article 9 – Benefits schedule

| | TYPE AND AMOUNT OF BENEFITS | | |
|---|---|---|---|
| **BASIC COMPULSORY BENEFITS:** | | | |
| **Death or permanent total disability of the member (regardless of cause) – Articles 4 and 5**<br>▪ Lump sum selected by the member: | From €25,000 to €1,000,000 in multiples of €25,000 or from $30,000 to $1,200,000 in multiples of $30,000 | | |
| **OPTIONAL BENEFITS:** | | | |
| **Accidental death of the member– Article 6** | Double the amount of the death lump sum (all causes) | | |
| **Infirmity of the member (regardless of cause) – Article 7**<br>▪ Lump sum chosen by the member for total infirmity (equal to 100%), with reference to the scale of functional incapacity under common law published in the French medical journal, *Concours médical*:<br>If the infirmity is partial, the amount of the lump sum is proportional to the degree of infirmity (benefits are payable for infirmities equal to or greater than 33%) | From €25,000 to €1,000,000 in multiples of €25,000 or from $30,000 to $1,200,000 in multiples of $30,000 **up to the level of the selected death lump sum (all causes)** | | |
| **Total sick leave from work by the member – Article 8**<br>▪ 3 benefits options are available to the member: | **Standard Sick Leave benefit (Daily allowance and Disability pension)** | **Short-Term Disability benefit** | **Long-Term Disability benefit** |
| | | These 2 options can be purchased together. | |
| ▪ Waiting period dependent on the options selected by the member: | As selected by the member:<br>30, 60 or 90 days | 6 days (except in case of hospitalization or accident: benefit paid from the 1st day of sick leave) | As selected by the member:<br>30, 60 or 180 days |
| ▪ Amount of the Daily allowance (or pension) dependent on the option selected by the member: | As selected by the member:<br>- from €25 to €500 per day in multiples of €25,<br>- from $30 to $600 in multiples of $30,<br>**limited to one thousandth of the selected death lump sum** (with the option of increasing the amount of the allowance by €25/ $30 per day if the selected death lump sum is equal to or less than €250,000/$300,000)<br>Maximum amount of benefit: 70% of the member's professional income. | 70% of the member's professional income | 70% of the member's professional income |

| OPTIONAL BENEFITS: | | | |
|---|---|---|---|
| ▪ Maximum duration of benefit, dependent on the option selected by the member: | 24 months of daily allowance then payment of a disability pension until the date on which the retirement pension is paid and at the latest at age 70 | As selected by the member: 30, 60 or 180 days | Until the 1,095th day of the period of sick leave |

# Title 3 – Operation of the plan

## Article 10 – Legal framework

This group insurance plan with optional membership is governed by French law and the French Insurance Code, in particular by Articles L141-1 and following. The plan falls within the scope of branch 2 (Healthcare) and branch 20 (Life-Death) of Article R321-1 of the French Insurance Code.
The plan consists of these general conditions and the Certificate of enrollment.
Coverage under the plan is based on the declarations made by the member.
The group insurance plan is in French. MSH INTERNATIONAL may make an English version available to the member. In case of disagreement on the interpretation of the benefits provided under this plan, only the French version of this plan will be taken into consideration. Translations of the contractual documents which make up the plan are made available to Members purely for information purposes and only the French language version is binding.

Limitation period: **In accordance with Article L114-1 of the French Insurance Code, all legal actions arising from an insurance contract are barred two years from the event that gave rise to them. This limit is increased to ten years for Death benefits. However, this time limit runs:**

- **in the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only from the date on which the insurer became aware of it,**

- **in the event of a loss, only from the date on which the relevant parties became aware of it, if they can prove they were unaware of such facts until then.**

**In accordance with Article L114-2 of the French Insurance Code, the limitation period is interrupted by one of the ordinary causes of interruption. These are listed under Articles 2240 and following of the French Civil Code and include the following cases:**

- **when the debtor acknowledges the right of the person against whom they were prescribing (Article 2240 of the French Civil Code),**
- **a legal claim, even in summary proceedings, until the end of the hearing. This also applies when the legal claim is brought before a court which has no jurisdiction or where the act of referral to the court is cancelled by the effect of a procedural irregularity (Articles 2241 and 2242 of the French Civil Code). The interruption is void if the claimant withdraws his application or allows the suit to lapse, or if he is defeated in his claim (Article 2243 of the French Civil Code),**
- **an act of enforcement or interim measures taken in implementation of the code of civil enforcement procedures (Article 2244 of the French Civil Code).**

**The limitation period is also interrupted by:**

- **the appointment of experts in response to a claim for benefits,**
- **the dispatch of a registered letter with proof of delivery sent by the insurer to the member regarding action for payment of the premium and by the member or the beneficiary to the insurer regarding payment of the benefit.**

Cancelation: The member may reverse their decision to enroll in the plan by registered mail with proof of delivery within a period of 30 calendar days from the date on which their Certificate of enrollment is sent out.

This cancelation should be worded as follows:

*'I, the undersigned ......................................... declare my express wish to cancel my membership of the life & disability plan n° XXX/XXXXXX and request a refund of the premium paid under the terms and conditions defined under Article L132-5-1 of the French Insurance Code.'*

By canceling their membership, all amounts paid by the member are refunded within a maximum period of 30 calendar days from the date of receipt of the registered letter by the insurer.

## Article 11 – Effective date – duration and renewal of the plan

The contract concluded between the association and the insurer takes effect on July 1, 2015 for an initial period ending December 31st of the year during which it took effect.
**It is automatically renewed on January 1st of each year for successive periods of one year unless terminated by either party by registered mail sent two months before each renewal date.**

The plan may be amended, while it is in force, with effect from the 1st day of the calendar month, by mutual agreement between the insurer and the contracting association. If any amendments are agreed between the contracting association and the insurer, the insurer will issue an endorsement to the plan. In this case, the member will receive prior notification, under the conditions of Article 16, of the changes made to their rights and obligations under the plan.

## Article 12 – Enrollment of members of the contracting association

### 1) ENROLLMENT

Enrollment in the plan is open to any member of the contracting association who applies for membership of the plan, provided:
- they are aged 18 or over and under the age of 66,
- they are living abroad outside their country of nationality (the country in which they usually reside), in a private or professional capacity.

### 2) CONDITIONS OF ENROLLMENT

To enroll in the plan, the member of the above-mentioned contracting association must complete and sign the enrollment form provided by the insurer and a health questionnaire.
Depending on the age of the applicant and the level of coverage being taken out, a medical visit with a doctor approved by the insurer and/or additional information or medical examinations may be required further to a review of this questionnaire.
**If the medical information provided does not allow the applicant to be accepted under the standard conditions of the insurance, the insurer reserves the right to reject the application or grant coverage subject to the exclusion of certain risks or payment of an additional premium.**
**Any non-disclosure or intentional misrepresentation invalidates membership in accordance with Article L113-8 of the French Insurance Code.**
**If the applicant is accepted subject to special conditions, they will be notified of this by registered mail.**
The person who is accepted for membership of the plan is hereafter referred to as the "member".
Membership is formalized by the issuing of a Certificate of enrollment in the plan which includes:

- the reference number and effective date of membership,
- the currency used,
- the benefits and level of coverage selected,
- the premium rate.

## Article 13 – Effective date of membership and benefits

### 1) EFFECTIVE DATE, DURATION AND RENEWAL OF MEMBERSHIP

Membership takes effect on the date shown on the certificate of enrollment and at the earliest on the date of notification of acceptance by the insurer.
Subject to the provisions of Article 20:

- membership runs for a period of 12 months,
- **it is then renewed automatically on each anniversary for successive periods of one year unless terminated by registered mail at least two months prior to each renewal date.**

It ends if terminated in accordance with the provisions set out above and under Article 20.

### 2) EFFECTIVE DATE OF BENEFITS

The benefits take effect for each member, subject to the acceptance of the risk by the insurer, on the date of enrollment in the plan as set out above.

## Article 14 – Making changes to benefits

**At each annual renewal of membership, the member has the option of amending their benefits under the following conditions:**

### 1) DOWNGRADE OF SELECTED BENEFITS

If the member requests a downgrade of their benefits, the new benefits take effect on the 1st day of the calendar quarter following the request.

### 2) UPGRADE OF SELECTED BENEFITS

If the member wishes to upgrade their benefits, they should complete a new enrollment form and submit to the medical formalities specified in Article 12 above. The member must also make the request no later than two months before the annual renewal date of their membership of the plan.

**The insurer reserves the right to refuse an upgrade of benefits or to accept it subject to restrictions or the payment of an additional premium. However, the member remains covered under the conditions which were in place prior to their request.**

If accepted by the insurer, the new, upgraded benefits will take effect from the annual renewal date of membership of the plan, subject to notification of acceptance from the insurer. The member remains covered by the previous benefits until that date.

### 3) PURCHASING NEW OPTIONAL BENEFITS

A member wishing to purchase new optional benefits should complete a new enrollment form and submit to the medical formalities specified in Article 12 above.
**The insurer reserves the right to refuse the benefits or to accept them subject to restrictions or the payment of an additional premium.**
If accepted by the insurer, the new benefits will take effect from the date of notification of acceptance by the insurer and, at the latest, on expiration of a waiting period of 6 months in respect of sick leave benefits.

## Article 15 – Cessation of membership and benefits

### 1) CESSATION OF MEMBERSHIP

Membership of the plan and the benefits cease for each member:

- on the anniversary date of the year in which they request cessation of their membership of the plan, **provided the termination is notified to the insurer by registered mail at least two months before this date,**
- on the last day of the calendar quarter in which they cease to be members of the association, ASFE. ASFE must notify the insurer of this within a period of one month,
- on the last day of the calendar quarter during which the member returns permanently to their country of origin. The member must notify the insurer of this at least one month before their return date,
- on the last day of the calendar quarter in which their premiums are not paid subject to the provisions of Article 20 below,
- on the date on which they receive their Social Security old-age pension, including for reasons of unfitness for work and, at the latest, on the last day of the calendar quarter during which they reach the age of 71,
- on the date of termination of membership by the insurer. This is only possible in the first two years of membership,
- on the date of termination of the plan. However, a person who has been a member of the plan for two years or more at the date of its termination may apply for continuation of benefits until they receive their Social Security old-age pension, subject to the payment of the premium set by the insurer.

**2) CESSATION OF BENEFITS**

The benefits provided under the plan come to an end for each member on the date of cessation of their membership, under the conditions of paragraph 1) above and, at the latest, on the last day of the calendar quarter during which they reach the age of 70.

In addition:

- sick leave benefits cease to be paid in all cases on the date on which the member returns to work or is found to be medically fit to return to work, even on a part-time basis, regardless of the type of work involved,
- in the event of termination of the plan, sick leave benefits continue to be paid under the terms of the plan, at the level reached on the date of termination of the plan.

## Article 16 – Information to members

The general conditions and information booklet drawn up by the insurer are issued to the member together with the certificate of enrollment specified under Article 12.

It is the duty of the contracting association to inform members in writing of any proposed amendments to their rights and obligations, in accordance with Article L141-4 of the French Insurance Code, at least three months before the date of their entry into force.

## Article 17 – Complaints – Mediation – Data protection and freedom of information

**1) COMPLAINTS - MEDIATION**

To make a complaint (disagreement or dissatisfaction) regarding the plan, the member can contact their usual advisor or the customer relationship department at the following address:

- by mail: Service des relations avec les consommateurs Groupama Gan Vie - Immeuble Michelet 4-8 Cours Michelet - 92082 LA DEFENSE CEDEX – FRANCE - Tel. 01 70 96 62 68
- by email: src-collectives@ggvie.fr

If the response is not satisfactory, the complaint may be submitted to the insurer's complaints department at the following address:

- by mail: Groupama Gan Vie – Service Réclamations - 160 avenue Charles de Gaulle - TSA 41269 - 91246 Morangis Cedex, France
- by email: service.reclamations@ggvie.fr

In both cases, the insurer agrees to acknowledge receipt of the complaint within a period of no more than 10 working days. It will be processed within 2 months at the most. If this is not the case, the complainant will be informed.

Finally, and without prejudice to their right to take legal action if necessary, the member may apply to the insurer's ombudsman by writing to the following address:
Médiateur de Groupama Gan Vie - 5-7 rue du Centre - 93199 Noisy-le-Grand Cedex – France.

Details of complaint-handling procedures are available to the member from their usual advisor and in the 'Legal notices' section of the website www.gan-eurocourtage.fr.

## 2) DATA PROTECTION AND FREEDOM OF INFORMATION

**Protection of personal data:** The personal data of members is processed in accordance with the French law on Data Protection and Freedom of Information of January 6, 1978 amended. The processing of this data is necessary for the management of their membership and benefits. With the exception of health-related data, it is intended for their usual advisor, the insurer and their agents, service providers and subcontractors and for the reinsurers as well as professional and administrative bodies with respect to legal obligations. This data can also be used for the purposes of the assessment and acceptance of risks, internal control (portfolio monitoring) and in the context of legal provisions, notably with respect to combating money laundering and the financing of terrorism. As part of the campaign against insurance fraud, the member's personal data may be passed on to professional bodies involved in combatting fraud as well as to licensed investigators.

The member, having provided proof of identity, has the right to access, rectify, remove and object to this data free of charge by mailing a letter to the insurer:

Groupama Gan Vie - Direction des Affaires Générales - Correspondant Informatique et Libertés 4-8 Cours Michelet - 92082 La Défense Cedex, France

**Collection and processing of health-related data:** The member expressly accepts the collection and processing of health-related data. This data is required for the management of the benefits and is processed in compliance with medical confidentiality. It is intended for the exclusive use of the insurer's medical advisor and their medical department, or for internal or external authorized persons (including medical experts). The member has the right to access, rectify, remove and object to data relating to them by mailing a letter, together with a photocopy of ID, to the insurer's medical advisor.

**Recording of telephone calls:** The member may be required to contact the insurer by telephone for all types of inquiries. The insurer will inform them that their calls may be recorded to ensure the proper implementation of their benefits and, more generally, to improve quality of service. These recordings are intended only for the departments of the insurer who handled that particular call. If the member has been recorded and wants to listen to the recording of a conversation, they can make the request by mailing a letter to the insurer at the above address. They will be provided with copies of the recording or a transcript of the content of the conversation free of charge, within the time limits set for storage of these recordings.

**Transfer of information outside the European Union:** With respect to the implementation of the plan and benefits and in compliance with the stated purposes, personal data relating to members

may be transferred to countries within the European Union or outside the European Union. Members are informed of this by means of these provisions and expressly authorize it.

### Article 18 – Misrepresentation

Irrespective of the ordinary causes of nullity and subject to the provisions of Article L132-26 of the French Insurance Code, the insurance plan is null and void in the event of concealment or intentional misrepresentation on the part of the member, when such concealment or misrepresentation changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the member concealed or distorted has no impact on the claim. The insurer is then entitled to retain the premiums paid and to payment of all due premiums by way of damages.

## → Title 4 – Premiums

### Article 19 – Arbitration

All disputes regarding this plan will be resolved by arbitration. Each party appoints an arbitrator and the two arbitrators together appoint a third. If one of the parties fails to appoint their arbitrator within one month of notification by either party of the implementation of the arbitration clause, or if both arbitrators fail to agree on the appointment within the same timescale, the appointment will be made by the president of the *Tribunal de Grande Instance*, in summary proceedings, as instructed by the first party to act.
Arbitrators are not required to follow usual procedure and their decision will be final: the arbitration ruling is final and binding and must be delivered within a period of six months from the setting up of the arbitration tribunal. The parties also submit to the decision of the arbitrators with respect to arbitration costs.
This exclusion cannot impede, where applicable, the payment of benefits acquired in return for premiums or contributions previously paid by the insured.

### Article 20 – Premiums

1) **SETTING AND PAYING THE PREMIUM**
Benefits provided under the plan are subject to a premium expressed in euros or dollars, set according to the member's age (age is determined by the difference in years on January 1st of each year), the benefits selected and their amount.
The amount of the premium is shown on the certificate of enrollment.
Premiums for sick leave benefits are adjusted by the insurer on January 1st of each year, based on the claims experience recorded over the previous year.
Any taxes or charges which may become applicable to the plan, the recovery of which is not prohibited, are charged to the member and payable at the same time as the premium.

2) **PAYMENT**
Payment of the premium by the member: Premiums are payable to the contracting association monthly, quarterly, bi-annually or annually in advance, in euros and dollars.
If a member joins the plan during a payment period (month, quarter, half-year or year), the premium is calculated on a pro rata basis.
If membership is terminated, the membership and benefits are maintained until the end of the period covered by the last premium to be paid.

Non-payment of premium: In accordance with the provisions of Article L113-3 of the French Insurance Code, any premium due remains payable and may be recovered by any legal means.
In accordance with the provisions of Article L141-3 of the French Insurance Code, the contracting association must, at the earliest, ten days after the due date of the unpaid premium, send the member a registered letter of formal notice. By mutual agreement between the insurer and the contracting association, it is agreed that the contracting association authorizes the insurer to prepare and send out this letter.

The letter will state that, at the end of a period of 40 days of dispatch of this letter, the member is barred from the insurance plan due to non-payment of the premium. The member remains liable for the full premium until the date of their removal from the plan.

**Insurer's legal information: Groupama Gan Vie** – a French 'société anonyme' with a capital of 1,371,100,605 euros – RCS Paris 340 427 616 - APE 6511 Z Head office: 8-10 rue d'Astorg - 75383 PARIS Cedex 08 – France - Tel: 01.44.56.77.77. Company regulated by the French Insurance Code and subject to the Prudential Supervisory Authority (ACP) - 61 rue Taitbout - 75009 Paris
The insurance products distributed by brokers under the Gan Eurocourtage brand are Groupama Gan Vie products.

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