FIRST'EXPAT+//RELAIS'EXPAT+

// INFORMATION BOOKLET SERVING AS THE GENERAL TERMS & CONDITIONS

// INFORMATION BOOKLET SERVING AS THE GENERAL TERMS & CONDITIONS

CONTENTS

1. / PRESENTATION OF ASFE, ITS ADMINISTRATOR MSH AND PURPOSE OF THE INSURANCE 2
   1.1. / PRESENTATION OF ASFE AND ITS ADMINISTRATOR (MSH) 2
   1.2. / PURPOSE OF THE INSURANCE 2
   1.3. / COVERAGE OPTIONS 3
   1.4. / DETAILS OF DEDUCTIBLES 4
   1.5. / COVERAGE ZONES UNDER THE PLAN 4
2. / DEFINITIONS OF HEALTHCARE BENEFITS 5
3. / HEALTHCARE BENEFITS: / YOUR HEALTHCARE BENEFITS IN DETAIL 12
   3.1. / BENEFITS SCHEDULE FOR MEMBERS WHO SELECTED THE COVERAGE ZONE 1, 2, 3 OR 4 12
   3.2. / OPTIONAL BENEFITS FOR MEMBERS (COVERAGE ZONE 1, 2, 3 OR 4) 22
   3.3. / HEALTHCARE BENEFITS FOR MEMBERS WHO SELECTED THE USA COVERAGE ZONE 24
   3.4. / OPTIONAL BENEFITS FOR MEMBERS WHO SELECTED THE USA COVERAGE ZONE 30
4. / EXCLUSIONS FROM HEALTHCARE BENEFITS (WHAT IS NOT COVERED) 32
5. / GENERAL OPERATING PROCEDURES 35
   5.1. / YOUR PLAN 35
   5.2. / LIFE OF YOUR PLAN 36
   5.3. / REIMBURSEMENTS 40
   5.4. / YOUR PREMIUM 41
   5.5. / LEGAL INFORMATION 42
6. / GENERAL PROVISIONS OF MEDICAL EVACUATION BENEFITS INCLUDED AS STANDARD WITH YOUR HEALTHCARE PLAN 47
   6.1. / GENERAL 47
   6.2. / DESCRIPTION OF OUR SERVICES AND BENEFITS 50
   6.3. / FRAMEWORK OF THE PLAN 51
7. / GENERAL PROVISIONS - PERSONAL THIRD-PARTY LIABILITY BENEFITS 56
   7.1. / DEFINITIONS 56
   7.2. / COVERAGE 56
   7.3. / UPPER LIMITS OF COVERAGE 57
   7.4. / GEOGRAPHICAL SCOPE 57
   7.5. / EMBARGO CLAUSE 57
   7.6. / ACQUISITION AND DURATION OF COVERAGE 57
   7.7. / APPLICATION OF COVERAGE 57
   7.8. / MANAGEMENT AND PAYMENT OF CLAIMS 57
   7.9. / MISCELLANEOUS PROVISIONS 58
   7.10. / APPENDIX: CRIMINAL DEFENSE AND REMEDY 58
   7.11. / THE INSURANCE CONTRACT 59
   7.12. / OBLIGATIONS OF THE INSURED MEMBER 60
8. / GENERAL PROVISIONS OF LEGAL ASSISTANCE BENEFITS 62
   8.1. / LEGAL EXPENSES INSURANCE FOR EXPATRIATES AND IMPATRIATES 62
   8.2. / SERVICES AND ASSISTANCE FOR EXPATRIATES AND IMPATRIATES 65
   8.3. / COMPLAINTS PROCEDURE 66
9. /MEDICAL ASSISTANCE AND REPATRIATION OPTION – GENERAL PROVISIONS OF BENEFITS 67
   9.1. / SOME HELPFUL TIPS… 67
   9.2. / GENERAL 68
   9.3. / SCHEDULE OF ASSISTANCE BENEFITS AVAILABLE AS AN OPTION 71
   9.4. / ASSISTANCE SERVICES 72
   9.5. / INSURANCE SERVICES 76
   9.6. / FRAMEWORK OF THE PLAN 78
   9.7. / PRIOR APPROVAL PROCEDURE FOR THE “ADVANCE OF HOSPITAL CHARGES” SERVICE WITH ASSISTANCE 80
10. / CONTACT MSH 100
11. APPENDIX 1: LIST OF CHRONIC CONDITIONS 100
12. APPENDIX 2: DATA SHARING AGREEMENT BETWEEN MSH AND EUROP ASSISTANCE ON THE PROTECTION OF PERSONAL DATA 101

1. / PRESENTATION OF ASFE, ITS ADMINISTRATOR MSH AND PURPOSE OF THE INSURANCE

1.1. / PRESENTATION OF ASFE AND ITS ADMINISTRATOR (MSH)

You have chosen an ASFE (Association of Services for Expatriates) international health 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 ASFE 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 500,000 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 to administer the plan will be referred to throughout this document as "MSH International", "the Administrator", "the Administrating Organization" 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) - registered with the Paris Trade and Companies Register under number 340 427 616 - APE 6511 Z Head office: 8-10 rue d'Astorg - 75383 PARIS Cedex 08, France - Company governed by the French Insurance Code and subject to the French Prudential Supervision and Resolution Authority (ACPR) – 4 place de Budapest - CS 92459 - 75436 Paris Cedex 09, France, hereinafter referred to as "the Insurer".

1.2. / PURPOSE OF THE INSURANCE

The ASFE Insurance plans in which you are enrolled are a type of plan known as "open group". They provide coverage from the 1st euro/1st dollar or 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 or as a top-up to benefits paid by the CFE, as a reimbursement of medical expenses incurred by ASFE Members living outside their Home country, 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". You and any dependents enrolled in the plan will be referred to as "Insured member".
Each plan provides basic healthcare coverage which can be supplemented by optional benefits and 4 levels of coverage within these options, Quartz, Pearl, Sapphire, and Diamond (see section 1.3 / Coverage options p.3). Each plan also includes 5 coverage zones (see section 1.5/ Coverage zones under the plan p.4).
These plans are numbered as follows:
FIRST' EXPAT (1st euro/1st dollar):

- No. 0210/863689/00010, No. 0210/863689/00020, No. 0210/863689/00030, No. 0210/863689/00040 and No. 0210/863689/55555; No. 0210/644144/00000 (1st euro hospitalization)
- No. 0210/863691/00020, No. 0210/863691/00030, No. 0210/863691/00040 and No. 0210/863691/55555; No. 0210/644144/55555 (1st US dollar hospitalization);

RELAIS' EXPAT (as a top-up to the CFE):

- No. 0210/863690/00010, No.0210/863690/00020, No. 0210/863690/00030, No. 0210/863690/00040 and No.0210/863690/55555; No. 0210/644145/00000 (hospitalization).
- No. 0210/863692/00020, No. 0210/863692/00030, No. 0210/863692/00040 and No. 0210/863692/55555.

As part of your membership, your healthcare benefits are supplemented as standard by medical assistance benefits. Europ Assistance, a company governed 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 purchase life & disability benefits to protect you in the event of death or sick leave from work.

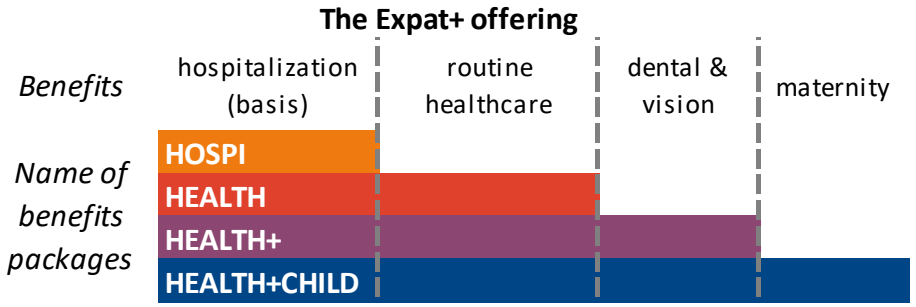
1.3. / COVERAGE OPTIONS

The plan provides:

- a BASIC BENEFIT (commercialized as 'HOSPI') covering costs related to hospitalization.
- three OPTIONAL BENEFITS available in addition to the BASIC BENEFIT ('HOSPI'), chosen by each Member, covering the following costs:
  - LEVEL 1 OPTIONAL BENEFITS (commercialized as 'HEALTH'): Routine healthcare, Routine healthcare on an outpatient basis, Preventive and alternative medicine, pharmacy items, equipment and Medical prostheses,
  - LEVEL 2 OPTIONAL BENEFITS (commercialized as 'HEALTH+'): Vision and Dental
  - LEVEL 3 OPTIONAL BENEFITS (commercialized as 'HEALTH+CHILD'): Maternity.

Important:

- Level 2 optional benefits can only be selected if Level 1 optional benefits have themselves been selected.
- Level 3 optional benefits can only be selected if Level 2 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 the Basic benefit ('HOSPI'), and Level 1 (HEALTH) and Level 2 (HEALTH+) Optional benefits (excluding Level 3 optional Maternity benefits), the possibility for the Member to choose a Deductible as defined in chapter 3 / HEALTHCARE BENEFITS: / YOUR HEALTHCARE BENEFITS IN DETAIL p.12. Four levels of Deductible are available as well as the option of having no Deductible:

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

See specific conditions depending on the zones and packages chosen in section 1.4/ DETAILS OF DEDUCTIBLES p.4.

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

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.
- For Zone 5 (USA), it is not possible to purchase only the HOSPI basic benefit: insured members must at least purchase the HEALTH package.

1.4. / DETAILS OF DEDUCTIBLES

Depending on the zones and packages chosen, the plan provides for 4 Deductible amounts defined as follows:

	Deductibles			
QUARTZ	€ 350 / $ 500	€ 750 / $ 1,000	€ 2,000 / $ 2,500	€ 4,000 /$ 5,000
Zone 4	**YES**	**YES**	**NO**	**NO**
Zone 3	**YES**	**YES**	**NO**	**NO**
Zone 2	**YES**	**YES**	**NO**	**NO**
Zone 1	**YES**	**YES**	**NO**	**NO**

PEARL	€ 350 / $ 500	€ 750 / $ 1,000	€ 2,000 / $ 2,500	€ 4,000 /$ 5,000
Zone 5 (USA)	**YES**	**YES**	**YES**	**YES**
Zone 4	**YES**	**YES**	**YES**	**NO**
Zone 3	**YES**	**YES**	**YES**	**NO**
Zone 2	**YES**	**YES**	**NO**	**NO**
Zone 1	**YES**	**YES**	**NO**	**NO**

SAPPHIRE	€ 350 / $ 500	€ 750 / $ 1,000	€ 2,000 / $ 2,500	€ 4,000 /$ 5,000
Zone 5 (USA)	**YES**	**YES**	**YES**	**YES**
Zone 4	**YES**	**YES**	**YES**	**YES**
Zone 3	**YES**	**YES**	**YES**	**NO**
Zone 2	**YES**	**YES**	**NO**	**NO**
Zone 1	**YES**	**YES**	**NO**	**NO**

DIAMOND	€ 350 / $ 500	€ 750 / $ 1,000	€ 2,000 / $ 2,500	€ 4,000 /$ 5,000
Zone 5 (USA)	**YES**	**YES**	**YES**	**YES**
Zone 4	**YES**	**YES**	**YES**	**YES**
Zone 3	**YES**	**YES**	**YES**	**NO**
Zone 2	**YES**	**YES**	**YES**	**NO**
Zone 1	**YES**	**YES**	**YES**	**NO**

1.5. / COVERAGE ZONES UNDER THE PLAN

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

- Zone 5: USA and territories under US jurisdiction (Porto Rico, United States Virgin Islands, Northern Mariana Islands, United States Minor Outlying Islands, American Samoa) as well as countries in Zones 1, 2, 3 and 4,
- Zone 4: Bahamas, Brazil, China, Hong Kong, Jersey, Mexico, St. Barthelemy, St. Martin, Singapore, Switzerland, United Kingdom and countries in Zones 1, 2 and 3,
- Zone 3: Australia, Austria, Canada, French Polynesia, Greece, Ireland, Israel, Italy, Japan, New Zealand, Portugal, Qatar, Russia, Saint Pierre and Miquelon, Spain, Taiwan, Turkey, United Arab Emirates, Vanuatu and countries in Zones 1 and 2,
- Zone 2: Andorra, 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, Georgia, Germany, Guatemala, Hungary, Iceland, Kazakhstan, Kuwait, Latvia, Lebanon, Liechtenstein, Luxembourg, Malaysia, Monaco, Mozambique, Netherlands, Nigeria, Norway, Oman, Panama, Peru, Saudi Arabia, Slovakia, South Africa, Sweden, Thailand, Ukraine, Uruguay, Venezuela, Vietnam, Wallis and Futuna and countries in Zone 1,
- Zone 1: Worldwide (including France) excluding countries in Zones 2 to 5.

2. / DEFINITIONS OF HEALTHCARE BENEFITS

You will find below the definitions of the terms used in this document (Information Booklet serving as the General Terms & Conditions).

Accident: Any bodily injury not intended by the person who suffered it, resulting from sudden, unpredictable action with 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:

- the Aggregate limit on healthcare benefits refers to the maximum amount the Insurer 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;
- 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. 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 out-of-pocket maximum: The annual out-of-pocket maximum is the maximum amount of cost-sharing that you will have to pay during the Insurance year.

Annual renewal date: Each anniversary of the effective date of enrollment in the plan.

Application for coverage: Refers to the 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, Cost-sharing, Annual out-of-pocket maximum or Co-payments 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 5.2 / Life of your plan p.36 in the chapter 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: Caisse des Français de l'Etranger, 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 (option commercialized as 'HEALTH+CHILD').

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 manipulation.

Chronic conditions: These are conditions whose severity and/or long-term nature require prolonged treatment and costly therapy. The list of chronic conditions is defined under Article D. 322-1 of the French Social Security Code. This list is provided on page 80 as an appendix.

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 71 on the date of enrollment, who is living in a Common-law marriage with the Member, whether or not they are in paid employment, if and only if: 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).

If there are several common-law spouses, only the eldest will be recognized.

Contracting association: ASFE. Legal entity having purchased the plan for the benefit of its Members and which 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.

Cost-sharing: Cost-sharing is the percentage of each claim that is not covered by your insurance plan.

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 5.2/ Life of your plan p.36 in the chapter 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.

Dependent children: Children of the Member, their Spouse, Partner or Common-law spouse:

- Under a FIRST'EXPAT+ plan (1st Euro/Dollar): children under the age of 26 will be considered dependent if they are in full-time education and are covered under the plan
- Under a RELAIS'EXPAT+ plan (in addition to CFE benefits): children under the age of 20 will be considered dependent if they are in full-time education and are covered under the plan

In all cases, for children over the age of 18 who are in in full-time education and are covered under the plan as Dependents, a school certificate is required at the time of enrollment and subsequently at the beginning of each academic year.

Dietitian: A qualified health professional specializing in nutrition and food who is officially registered, qualified and recognized in the country in which they practice and who has the additional experience and qualifications required to deliver this service.

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.

Duration of membership: Period of coverage under the plan from the effective date of enrollment shown on the certificate of enrollment to the date of termination of membership as set out under section 5.2/ Life of your plan p.36 in the chapter CESSATION OF MEMBERSHIP AND END OF COVERAGE (right of withdrawal and termination).

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 hospitalization: Treatment administered following admission to a Hospital or medical center as a result of the onset of a sudden and unexpected health concern, following an Illness, Accident, infection, etc.

Emergency treatment outside the coverage zone: Refers to Emergency treatment received in a higher zone than the Selected coverage zone, during a trip for the purposes of either business or leisure.

Coverage is acquired for a maximum of 60 days per trip 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. Treatment dispensed by a General practitioner or a Specialist must begin within 24 hours of the event which triggered the claim.

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. Costs related to Pregnancy, Maternity, childbirth or any other Complication during Pregnancy or childbirth are also excluded from the benefit. 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.

Excluded countries: As a result of events (civil or foreign war, insurrection, etc.) which may be taking place there and, in all circumstances, in accordance with the classification of at-risk countries published by the French Ministry of Foreign Affairs, coverage may be excluded for certain countries or zones to which travel is classed by this Ministry as highly inadvisable (red zone) or inadvisable (orange 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: 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 which they would wish to be repatriated if necessary.

Home hospitalization: Care delivered in the patient's home as an alternative to conventional hospitalization with at least one visit per day from a nurse, subject to the agreement of the medical department/prior approval.

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. **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.

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.

Information booklet serving as the general terms & conditions: This 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.

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.

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. In this plan, insured members/ dependents are also referred to as “You”.

Insurer: For the purposes of the plan, Groupama Gan Vie, a company governed by the French Insurance code, is the Insurer of the benefits provided under the plan.

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.

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 and any Dependents reside 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, health insurance fund, 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 and/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. The Medical Questionnaire is valid for 4 months.

Medical imaging: 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 Optum RX 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.

To qualify, they must meet the following criteria:

- be necessary in order to diagnose or treat an Illness and/or injury suffered by a patient;
- 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);
- comply with medical and scientific standards and knowledge at the time of administration of the treatment;
- not be provided primarily for the patient's comfort and/or that of their Doctor;
- be clinically justified in terms of scale, duration, and demonstrated and proven medical effect, frequency, level and type;
- be dispensed in an appropriate healthcare facility and room and be of the appropriate quality to treat the patient's medical condition.

Member: Person, under the age of 71 on the date of enrollment regardless of their status, who is a member of ASFE and has submitted an Application for coverage under the plan which has been accepted in writing as defined in section 5.2 / Life of your plan p.36, in the chapter 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.

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 hospitalization: Treatment administered following admission to a Hospital or medical center on an outpatient basis, including the use of a Hospital room and nursing care, but which does not require an overnight stay and where the patient is discharged the same day.

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.

Paramedical practitioners: A qualified health professional working in a paramedical and who is officially registered, qualified and recognized in the country in which the medical care is delivered and in which they practice and who has the additional experience and qualifications required to deliver this care. Paramedical practitioners are physical therapists, nurses, chiropodists/podiatrists, speech therapists and orthoptists.

Partner: Person under the age of 71 at the time of enrollment 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). See also *Common-law spouse and Spouse.*

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 Cessation of membership and end of coverage (right of withdrawal and termination) p.38.

Periodontics: Dental treatment prescribed for disorders of the structures supporting the teeth (particularly the gums).

Physical therapy: 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.

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 this plan, certain treatments such as mud therapy, Pilates, massage, Rolfing and MILTA therapy.

Plan from the 1st Euro/Dollar: A plan where medical expenses are reimbursed from the 1st euro/dollar spent (within the limits of the selected benefits), i.e. without a contribution from a basic organization (such as a benefits scheme).

Policyholder: The Policyholder is ASFE who has arranged this group plan for the benefit of its insured Members.

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, costly 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.

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.

Prenatal care: Refers to all standard, customary screening and follow-up examinations during Pregnancy.

In respect of high-risk pregnancies, Prenatal care may include:

- amniocentesis and DNA tests if directly linked to amniocentesis covered under the insurance plan;
- tests for Spina Bifida;
- 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, semi-private or shared room: Service offered by healthcare facilities, allowing an inpatient to be accommodated in:

- a single room (private room),
- a room for 2 persons only (semi-private room),
- or a room for 3 persons or more (shared 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).

Refractive surgery: Surgical treatments, usually performed using laser, for visual corrections of myopia, hyperopia, astigmatism and keratoconus.

Registered email: Equivalent to registered mail provided it meets the requirements of Article L.100 of the French Postal and Electronic Communications Code.

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 provided as a series of treatments, costly 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, performed by a General practitioner or Specialist who is a qualified doctor of medicine and is licensed to practice medicine under the laws of 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.

The plan offers 5 coverage zones (see section entitled 'Specific country of residence and Coverage zones under the plan').

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 71 on the date of enrollment. To facilitate the reading of this information booklet serving as the general terms and conditions, the term 'Spouse' will refer generically to the Spouse, partner or Common-law spouse of the Member.

Subrogation: Refers to the rights which the Administrator (MSH International) can exercise on behalf of the Insurer 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, see chapter 5.2.9 Cessation of membership and end of coverage (right of withdrawal and termination) p.38.

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.

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. 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. The abbreviation UCR will be used in this information booklet serving as the general terms and conditions 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.

The Waiting periods apply from the Effective date of enrollment of each person insured under the plan.

3. / HEALTHCARE BENEFITS: / YOUR HEALTHCARE BENEFITS IN DETAIL

3.1. / BENEFITS SCHEDULE FOR MEMBERS WHO SELECTED THE COVERAGE ZONE 1, 2, 3 OR 4[1]

3.1.1. MAIN BENEFIT: HOSPITALIZATION (HOSPI)

When you enroll in the plan, you can choose between 4 levels of coverage. You can also choose the currency in which you want to pay your insurance premium and receive your medical expenses reimbursements.
For RELAIS'EXPAT+ plans, the benefits below already include the CFE reimbursement.

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
AGGREGATE LIMIT ON HEALTHCARE BENEFITS (€)	€500,000	€1,000,000	€1,600,000	€3,000,000
AGGREGATE LIMIT ON HEALTHCARE BENEFITS ($)	$625,000	$1,250,000	$2,000,000	$3,750,000

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) and medical care and expenses related to COVID-19 (4 weeks).

We will cover hospital expenses if:
- The member of the plan is in Hospital, whether on an Outpatient basis or for several consecutive days,
- The need for hospitalization was established by a General practitioner or Specialist,
- The duration of your stay is medically appropriate and approved following a Request for prior approval,
- Your treatment is administered or monitored by a General practitioner and/or Specialist.

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. This medical report must include:
- The diagnosis,
- The treatment you have already received,
- The treatment you require,
- The additional length of time you will need to stay in Hospital.

We do not cover hospital charges if hospitalization is due to one or more of the following reasons:
- **Convalescence,**
- **Pain management (except for palliative care),**
- **Paramedical care with no Specialist treatment, except for palliative care dispensed in a care facility,**
- **Personal assistance services, such as assistance with mobility, washing, preparing meals, etc.,**
- **Treatment that could be classed as Routine healthcare.**

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Hospital room	**Private, semi-private or shared room** €100 / $125 per day	**Private, semi-private or shared room** €150 / $190 per day	**Private, semi-private or shared room** €250 / $310 per day	**Private, semi-private or shared room** 100% 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 16	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 16, 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 (ambulance included)	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. All **services** provided in the Emergency room which are not followed by admission to hospital will be covered under **routine healthcare**. We must be notified of any **emergency hospitalization** within 48 hours of admission.			

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Emergency hospitalization following an accident or **sudden, unexpected and unforeseen illness, requiring an emergency hospitalization outside the selected coverage zone, for any trip of less than 30 consecutive days**	**All zones excluding the USA:** 100% UCR **in the USA:** 80% UCR (up to 15 days of hospitalization)	**All zones excluding the USA:** 100% UCR **in the USA:** 80% UCR (up to 15 days of hospitalization)	**All zones excluding the USA:** 100% UCR **in the USA:** 80% UCR (up to 15 days of hospitalization)	**All zones excluding the USA:** 100% UCR **in the USA:** 80% UCR (up to 15 days of hospitalization)

[1] Excluding zone 5, the only zone including the USA

	The benefits also apply worldwide (excluding the USA), regardless of the geographical coverage zone, **for hospitalization care or emergency treatment following an accident or unforeseen illness** as defined under Article 2 and occurring **during a temporary stay or trip of less than 30 consecutive days** outside the geographical coverage zone. The conditions of implementation are specified in the section **Emergency treatment outside the coverage zone.** However, in the event of an emergency occurring during a temporary stay or trip in the USA of less than 30 consecutive days, following an accident or 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, hospitalization will be covered for a maximum of 15 days and up to 80% of the Aggregate limit applicable to healthcare coverage under the chosen package (Quartz, Pearl, Sapphire or Diamond). In this respect, you must keep any supporting documents showing the duration of your temporary stay outside your usual coverage zone, as they will be requested for control purposes by the plan administrator in case of claim for reimbursement of hospitalization care or emergency treatment following an accident or unforeseen illness as defined under Article 2 and occurring during a temporary stay or trip of less than 30 consecutive days outside the geographical coverage zone. The insurer may deny coverage to the insured member if they are unable to provide these supporting documents. We must be notified of any **emergency hospitalization outside the coverage zone** within 24 hours of admission.

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Hospitalization - 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.			
Hospitalization - 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: - operating room - recovery room - drugs and dressings used in the operating room and the recovery room - drugs and dressings used during your stay in **hospital.** 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.			
Hospitalization - 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.			
Hospitalization - Emergency dental care with hospitalization	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover **emergency** dental 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, **orthodontics** or **periodontics** (these treatments are only covered under the optional benefit Health+).			
Hospitalization - Laboratory tests, MRI, x-rays, scans, tomography	100% UCR	100% UCR	100% UCR	100% UCR
	For your hospitalization covered under the plan, we will cover all expenses related to: - **Medical imaging**, such as x-rays, scans, MRI, etc., - tests such as blood tests or urine samples, - diagnostic tests such as electrocardiograms. If these examinations are prescribed by your **general practitioner** or **specialist** to help diagnose or assess your health during your stay in hospital.			
Hospitalization - 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.			
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.			

Hospitalization - 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'**.			
Hospitalization - Treatment of AIDS	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover any costs related to the treatment of conditions related to HIV.			
Hospitalization - Internal surgical and medical prostheses/devices	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover costs related to **prostheses, devices or appliances** fitted during a surgical procedure.			
Hospitalization - External surgical and medical prostheses/devices	100% UCR up to €1,200 / $1,500 Per prosthesis – max. 2 prostheses	100% UCR up to €1,800 / $2,250 Per prosthesis – max. 2 prostheses	100% UCR up to €2,500 / $3,100 Per prosthesis – max. 2 prostheses	100% UCR max. 2 prostheses
	We will cover: - **essential prostheses or devices** immediately following surgery if medically required, - **medically required prostheses or devices** during the short-term recovery process. 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 for the entire period of membership of the plan.			
Hospitalization - 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: - the cost of a room in a **hospital** or hospice, - the cost of **palliative** home care, - nursing costs - **prescribed drugs.**			
Hospitalization - Organ transplant: room and board, cost of treatment and hospitalization fees during an organ transplant	100% UCR	100% UCR	100% UCR	100% UCR
Hospitalization - 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 / $3,800 per transplant	100% UCR up to €4,500 / $5,600 per transplant	100% UCR up to €6,000 / $7,500 per transplant
	We will cover medical expenses related to a **member** receiving an organ transplant from a verified and certified donor. 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. We will cover the following donor expenses for each event requiring an organ donation whether or not the donor is **covered** under the plan: - transporting the donated organ, - tissue compatibility tests, - the donor's operation and **hospital** costs. **We do not cover organ acquisition costs and 'anti-rejection' drugs.**			
	QUARTZ	**PEARL**	**SAPPHIRE**	**DIAMOND**
Hospitalization - **Physiotherapy/physical therapy, Chiropractic and Osteopathy** **Osteopathy:**	100% UCR up to €1,000 / $1,250 per year	100% UCR up to €2,500 / $3,100 per year	100% UCR up to €5,000 / $6,200 per year	100% UCR
	We will cover consultations, treatments and procedures in **physiotherapy/physical therapy chiropractic** and **osteopathy** prescribed during your **hospitalization**.			
Hospitalization - Psychiatric treatment and care Waiting period: 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') to treat the covered event. By covered event, we mean any treatment of mental illnesses and disorders with respect to this benefit.			

HEALTHCARE FOLLOWING COVERED HOSPITALIZATION

Home hospitalization (on prescription)	Not covered	100% UCR up to €1,500 / $1,900 per year	100% UCR, up to 20 days per year	100% UCR, up to 30 days per year
	We will cover nursing care at home following hospitalization covered under the plan, where such care: - is prescribed by your specialist, - commences immediately after you leave Hospital, - reduces the duration of your stay in Hospital, - 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 / year	100% UCR up to 30 days / year	100% UCR up to 40 days / year	100% UCR up to 50 days / 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. **We do not cover rehabilitation expenses or treatment which do not follow hospitalization covered under the plan.** We will cover rehabilitation: - if you received confirmation of our prior approval before commencing the treatment, - which commences a maximum of 30 days following hospitalization. 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.			

Medical assistance and evacuation benefits are included in your First or Relais'Expat+ plan.
For more information, please refer to section 6 / General provisions of medical evacuation benefits included as standard with your healthcare plan.

The benefits also apply worldwide (excluding the USA), regardless of the geographical coverage zone, **for hospitalization care or emergency treatment following an accident or unforeseen illness** as defined under Article 2 and occurring **during a temporary stay or trip of less than 30 consecutive days** outside the geographical coverage zone. The conditions of implementation are specified in the section **Emergency treatment outside the coverage zone**.

However, in the event of an emergency occurring during a temporary stay or trip in the USA of less than 30 consecutive days, following an accident or 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, hospitalization will be covered for a maximum of 15 days and up to 80% of the Aggregate limit applicable to healthcare coverage under the chosen package (Quartz, Pearl, Sapphire or Diamond).

In this respect, you must keep any supporting documents showing the duration of your temporary stay outside your usual coverage zone, as they will be requested for control purposes by the plan administrator in case of claim for reimbursement of hospitalization care or emergency treatment following an accident or unforeseen illness as defined under Article 2 and occurring during a temporary stay or trip of less than 30 consecutive days outside the geographical coverage zone. The insurer may deny coverage to the insured member if they are unable to provide these supporting documents.

3.1.2. HOSPITALIZATION + ROUTINE HEALTHCARE BENEFIT (HEALTH)

When you enroll in the plan, you can choose between 4 levels of coverage. You can also choose the currency in which you want to pay your insurance premium and receive your medical expenses reimbursements.
For RELAIS'EXPAT+ plans, the benefits below already include the CFE reimbursement.

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
AGGREGATE LIMIT ON HEALTHCARE BENEFITS (€)	€500,000	€1,000,000	€1,600,000	€3,000,000
AGGREGATE LIMIT ON HEALTHCARE BENEFITS ($)	$625,000	$1,250,000	$2,000,000	$3,750,000

The basic coverage, i.e. without any options, includes coverage of hospital costs and routine medical expenses. The schedules below detail the benefits and the levels of coverage for these two categories of costs qualifying for reimbursement.

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) and medical care and expenses related to COVID-19 (4 weeks).

We will cover hospital expenses if:
- The member of the plan is in Hospital, whether on an Outpatient basis or for several consecutive days,
- The need for hospitalization was established by a General practitioner or Specialist,
- The duration of your stay is medically appropriate and approved following a Request for prior approval,
- Your treatment is administered or monitored by a General practitioner and/or Specialist.

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. This medical report must include:
- The diagnosis,
- The treatment you have already received,
- The treatment you require,
- The additional length of time you will need to stay in Hospital.

We do not cover hospital charges if hospitalization is due to one or more of the following reasons:
- **Convalescence,**
- **Pain management (except for palliative care),**
- **Paramedical care with no Specialist treatment, except for palliative care dispensed in a care facility,**
- **Personal assistance services, such as assistance with mobility, washing, preparing meals, etc.,**
- **Treatment that could be classed as Routine healthcare.**

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Hospital room	**Private, semi-private or shared room** €100 / $125 per day	**Private, semi-private or shared room** €150 / $190 per day	**Private, semi-private or shared room** €250 / $310 per day	**Private, semi-private or shared room** 100% 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 16	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 16, 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 (ambulance included)	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. All **services** provided in the Emergency room which are not followed by admission to hospital will be covered under **routine healthcare**. We must be notified of any **emergency hospitalization** within 48 hours of admission.			

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
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. **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).** 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.			
Hospitalization - 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.			
Hospitalization - 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: - operating room - recovery room - drugs and dressings used in the operating room and the recovery room - drugs and dressings used during your stay in **hospital.** 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.			
Hospitalization - 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.			
Hospitalization - Emergency dental care with hospitalization	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover **emergency** dental 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, **orthodontics** or **periodontics** (these treatments are only covered under the optional benefit Health+).			
Hospitalization - Laboratory tests, MRI, x-rays, scans, tomography	100% UCR	100% UCR	100% UCR	100% UCR
	For your hospitalization covered under the plan, we will cover all expenses related to: - **Medical imaging**, such as x-rays, scans, MRI, etc., - tests such as blood tests or urine samples, - diagnostic tests such as electrocardiograms. If these examinations are prescribed by your **general practitioner** or **specialist** to help diagnose or assess your health during your stay in hospital.			
Hospitalization - 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.			
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.			

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Hospitalization - 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'**.			
Hospitalization - Treatment of AIDS	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover any costs related to the treatment of conditions related to HIV.			
Hospitalization - Internal surgical and medical prostheses/devices	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover costs related to **prostheses, devices or appliances** fitted during a surgical procedure.			
Hospitalization - External surgical and medical prostheses/devices	100% UCR up to €1,200 / $1,500 Per prosthesis – max. 2 prostheses	100% UCR up to €1,800 / $2,250 Per prosthesis – max. 2 prostheses	100% UCR up to €2,500 / $3,100 Per prosthesis – max. 2 prostheses	100% UCR max. 2 prostheses
	We will cover: - **essential prostheses or devices** immediately following surgery if medically required, - **medically required prostheses or devices** during the short-term recovery process. 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 for the entire period of membership of the plan.			
Hospitalization - 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: - the cost of a room in a **hospital** or hospice, - the cost of **palliative** home care, - nursing costs - **prescribed drugs.**			
Hospitalization - Organ transplant: room and board, cost of treatment and hospitalization fees during an organ transplant	100% UCR	100% UCR	100% UCR	100% UCR
Hospitalization - 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 / $3,800 per transplant	100% UCR up to €4,500 / $5,600 per transplant	100% UCR up to €6,000 / $7,500 per transplant
	We will cover medical expenses related to a **member** receiving an organ transplant from a verified and certified donor. 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. We will cover the following donor expenses for each event requiring an organ donation whether or not the donor is **covered** under the plan: - transporting the donated organ, - tissue compatibility tests, - the donor's operation and **hospital** costs. **We do not cover organ acquisition costs and 'anti-rejection' drugs.**			
Hospitalization - **Physiotherapy/physical therapy, Chiropractic and Osteopathy** **Osteopathy:**	100% UCR up to €1,000 / $1,250 per year	100% UCR up to €2,500 / $3,100 per year	100% UCR up to €5,000 / $6,200 per year	100% UCR
	We will cover consultations, treatments and procedures in **physiotherapy/physical therapy chiropractic** and **osteopathy** prescribed during your **hospitalization**.			
Hospitalization - Psychiatric treatment and care Waiting period: 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') to treat the covered event. By covered event, we mean any treatment of mental illnesses and disorders with respect to this benefit.			

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
HEALTHCARE FOLLOWING COVERED HOSPITALIZATION				
Home hospitalization (on prescription)	Not covered	100% UCR up to €1,500 / $1,900 per year	100% UCR, up to 20 days per year	100% UCR, up to 30 days per year
	We will cover nursing care at home following hospitalization covered under the plan, where such care: - is prescribed by your specialist, - commences immediately after you leave Hospital, - reduces the duration of your stay in Hospital, - 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 / year	100% UCR up to 30 days / year	100% UCR up to 40 days / year	100% UCR up to 50 days / 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. **We do not cover rehabilitation expenses or treatment which do not follow hospitalization covered under the plan.** We will cover rehabilitation: - if you received confirmation of our prior approval before commencing the treatment, - which commences a maximum of 30 days following hospitalization. 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.			

ROUTINE HEALTHCARE

Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year

Waiting period of 4 weeks for medical care and expenses related to COVID-19.

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Consultations with general practitioners and specialists (other than dentists 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 and psychiatrists) and **Specialist** treatments or procedures. 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 dental care without hospitalization	100% UCR up to €200 / $250 per year	100% UCR up to €300 / $375 per year	100% UCR up to €500 / $625 per year	100% UCR up to €750 / $950 per year
	We will cover consultations for Emergency dental care, such as sudden toothache that does not require hospitalization. Non-emergency dental expenses (e.g.: dental check-up, scaling, dentures, etc.) will be covered under the Health+ Option if selected. 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	100% UCR up to €500 / $625 per year	100% UCR up to €1,500 / $1,900 per year	100% UCR up to €2,000 / $2,500 per year	100% UCR Limited to 52 sessions/year
	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 and **physiotherapy, on prescription**	100% UCR up to €1,000 / $1,250 per year limited to 12 sessions per year	100% UCR up to €2,000 / $2,500 per year limited to 17 sessions per year per year	100% UCR up to €3,500 / $4,400 per year limited to 22 sessions per year	100% UCR limited to 32 sessions per year
	We will cover consultations in physical therapy/physiotherapy prescribed as Routine healthcare. The limit on the number of sessions includes all specialties combined.			

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Osteopathy and **chiropractic**	100% UCR up to 10 sessions, with a maximum of €50 / $60 per session	100% UCR up to 15 sessions, with a maximum of €100 / $125 per session	100% UCR up to 25 sessions, with a maximum of €150 / $190 per session	100% UCR up to 35 sessions
	We will cover consultations in Osteopathy and Chiropractic for which you do not have a prescription. The limit on the number of sessions includes all specialties combined.			
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 sessions of Acupuncture and **Traditional Chinese medicine** and consultations with a **Homeopath**. 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 €3,000 / $3,800 per year	100% UCR up to €9,000 / $11,200 per year	100% UCR up to €15,000 / $18,800 per year	100% UCR
	We will cover (under **Routine healthcare**) the cost of drugs: - prescribed by your **General practitioner** or **Specialist**, - which are used only in case of illness or injury.			
Prescribed contraceptives	100% UCR up to €80 / $100 per year	100% UCR up to €100 / $125 per year	100% UCR up to €200 / $250 per year	100% UCR up to €300 / $375 per year
	We will cover methods of contraception that are mechanical, medicinal or prescribed by a general practitioner or specialist. This includes the pill, condoms, diaphragm, intrauterine device, implants and patches.			
Prescription drugs for chronic conditions Waiting period: 12 months	100% up to €10,000 / $12,600 per year, with a maximum of €50,000 / $63,000 for the duration of membership of the plan €50,000/$63,000	100% up to €15,000 / $18,800 per year, with a maximum of €75,000 / $94,000 for the duration of membership of the plan €75,000/$94,000	100% up to €20,000 / $25,000 per year, with a maximum of €100,000 / $126,000 for the duration of membership of the plan €100,000/$126,000	100% UCR
	We will cover prescription drugs for chronic conditions provided that **you have been covered under the plan for at least one year** and drugs have been prescribed for at least 6 months. If the chronic condition is included in the list attached to the plan, supporting documentation from your specialist doctor or GP is needed. Otherwise, the insurer's approval is required and a medical report specifying the following will have to be submitted: the medical condition for which drugs are being prescribed, and the medical requirement for you to take this drug for at least 6 months. During the 12-month waiting period, the 'Prescription drugs' benefit can be used.			
Psychiatry Waiting period: 12 months	100% UCR Max 5 sessions per year	100% UCR Max 10 sessions per year	100% UCR Max 15 sessions per year	100% UCR Max 20 sessions per 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	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 €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	100% UCR up to €4,000 / $5,000 per year
	We will cover 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

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
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: - Blood tests (complete blood count, biochemical Laboratory tests, lipid profile, and thyroid, liver and kidney function) - Cardiovascular examination (physical examination, electrocardiogram and blood pressure) - Neurological examination (physical examination) - 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.			
Consultations with a Dietitian	Not covered	Not covered	100% UCR maximum 2 sessions per year, up to €150 / $190 per consultation	100% UCR maximum 3 sessions per year, up to €200 / $250 per consultation
	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: - nicotine patches - nicotine gum - nicotine tablets			

3.2. / OPTIONAL BENEFITS FOR MEMBERS (COVERAGE ZONE 1, 2, 3 OR 4[2])

3.2.1. OPTION HEALTH+: DENTAL + VISION BENEFITS

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			
ANNUAL AGGREGATE LIMIT ON DENTAL BENEFITS IN €/$ for the procedures listed below (excluding Orthodontics which has its own limit)	100% UCR up to €250 per tooth and €1,000 per year or $310 per tooth and $1,250 per year	100% UCR up to €400 per tooth and €1,500 per year or $500 per tooth and $1,900 per year	100% UCR up to €500 per tooth and €2,000 per year or $625 per tooth and $2,500 per year	100% UCR up to €600 per tooth and €3,500 per year or $750 per tooth and $4,400 per year
Routine dental care (up to the annual aggregate limit above) Waiting period: 3 months	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover consultations with a dentist as well as all treatments or procedures carried out during these consultations and listed below: -Scaling -Treatment of tooth decay (amalgam) -Sealing of fissures -Dental x-rays -Inlays / onlays -Fluoride application **Tooth whitening is not covered by the Plan.**			
Dentures and dental implants (up to the annual aggregate limit above) Waiting period: 6 months	100% UCR	100% UCR	100% UCR	100% UCR
	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) Waiting period: 6 months	100% UCR	100% UCR	100% UCR	100% UCR
	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) Waiting period: 3 months	Not covered	100% UCR	100% UCR	100% UCR
	We will cover all treatments of **disorders** of the retaining tissue of the tooth, including the gum.			
Orthodontics up to age 16 Waiting period: 12 months	100% UCR up to €400 / $500 per year for 3 years	100% UCR up to €800 / $1,000 per year for 3 years	100% UCR up to €1,200 / $1,500 per year for 3 years	100% UCR up to €1,500 / $1,900 per year for 3 years
	We will cover **Orthodontics** for any treatment commenced before the age of 16 and for a maximum of 3 consecutive years.			
	QUARTZ	PEARL	SAPPHIRE	DIAMOND
VISION	Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year			
Lenses and frames, limited to one pair every 2 years Waiting period: 6 months	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 – refractive surgery: the cost of lenses or contact lenses will not be covered during the year following the reimbursement of the refractive surgery treatment Waiting period: 6 months	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 membership.**			
Corrective contact lenses including disposable lenses Waiting period: 6 months	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.			

Disorders of the eye such as cataracts, retinal detachment, glaucoma, AMD, etc. are covered under **Routine healthcare** or hospitalization if necessary.

[2] Excluding zone 5, the only zone including the USA

3.2.2. OPTION HEALTH+CHILD: MATERNITY BENEFIT

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			
	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
Maternity and childbirth preparation classes, prenatal and postnatal care received by the mother and **Immediate care of newborns** Waiting period: 10 months	We will cover the cost of **Maternity** and childbirth. This includes: - the cost of hospitalization, anesthesia and surgical fees for Childbirth without complications, - **postnatal care** required immediately following Childbirth without complications (removal of stitches following an episiotomy, etc.), - childbirth preparation classes, - diagnostic tests for chromosomal **Disorders**, - routine care of the newborn within 7 days following birth. Treatments due to the following conditions are not covered under this benefit but are covered under Hospitalization: - abnormal growth of cells in the uterus (molar **Pregnancy**), - the fetus growing outside the uterus (ectopic **Pregnancy**).			
Childbirth without complications (single or multiple births) Waiting period: 10 months	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.			
	Annual limit for **Maternity** benefit doubled	Annual limit for **Maternity** benefit doubled	Annual limit for **Maternity** benefit doubled	Annual limit for **Maternity** benefit doubled
Childbirth complications (C-sections are only covered if they **are recognized as required and justified)** Waiting period: 10 months	We will cover room and board fees, obstetrician fees and all other medical costs for delivery by C-section, if the C-section is recognized as medically required and justified; for example if the birthing process is not progressing normally (dystocia, fetal distress, bleeding, etc.). Note: if we are unable to determine that the C-section was not medically required and justified, we will cover you up to the limit of the **Maternity** benefit.			
Fertility treatment Waiting period: 12 months	**Not covered**	100% UCR €900 / $1,100 per attempt (limited to €3,600 / $4,400 for the entire duration of the membership)	100% UCR €1,200 / $1,500 per attempt (limited to €4,800 / $6,000 for the entire duration of the membership)	100% UCR €1,500 / $1,900 per attempt (limited to €6,000 / $7,600 for the entire duration of the membership)
	We will cover 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**: • in vitro fertilization (IVF), • artificial insemination, • hormone treatments, • tubal surgery, • oocyte cryopreservation.			

Coverage in the event of an emergency

Worldwide coverage only applies to treatments provided as an emergency during temporary stays (trips for leisure or business purposes) of less than 60 consecutive days.
Medical emergency means 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.
In the event of a medical emergency as defined under the plan, please contact your claims department as soon as possible. If the insured member traveled to a higher coverage zone 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, unexpected and unforeseen illness requiring surgery, treatment dispensed in this zone will not be covered, even in an emergency.

3.3. / HEALTHCARE BENEFITS FOR MEMBERS WHO SELECTED THE USA COVERAGE ZONE

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

NB: the Hospi basic benefit is not available in zone 5 (USA).

IMPORTANT INFORMATION REGARDING CARE RECEIVED IN THE USA

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 Optum RX.
These agreements mean you can:

- access a selection of Hospitals and healthcare practitioners (UnitedHealthcare) and pharmacies (Optum RX),
- avoid having to make a cash advance and have your medical prescriptions covered directly by the insurance, by presenting the UnitedHealthcare/Optum RX/MSH card beforehand.

IMPORTANT: Your coverage in the USA always gives you the freedom to choose which hospital or pharmacy is best suited to your treatment (including those outside the networks). However, if you choose to be treated or buy drugs prescribed in the United States from a provider that is not part of the networks, 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 networks, 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. Geographical exceptions include cases where, within a 50 kilometer radius of the Insured member's home:

- there is no Hospital, Doctor, clinic or pharmacy belonging to the UnitedHealthcare International and Optum RX networks,
- the treatment or drugs required by the Insured member are not available in Hospitals or from Doctors and clinics or in pharmacies belonging to the networks.

CO-PAYMENT (APPLIES ONLY TO THE USA COVERAGE ZONE)

A Co-payment applies to certain treatments or procedures covered under the plan for medical care received in the USA.
The Co-payment 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, for each treatment, procedure or visit.
It is the responsibility of any Insured member 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 the benefits schedule below. If you have opted for a deductible, it will be applied after the co-payment. The deductible is not included in cost-sharing.

COST-SHARING AND ANNUAL OUT-OF-POCKET MAXIMUM

Cost-sharing applies to hospital costs incurred in respect of medical care received in the USA under the Pearl and Sapphire packages, as well as under the Diamond package for out-of-network medical care.
Cost-sharing is the percentage of each claim that is not covered by your enrollment in the insurance plan.
The annual out-of-pocket maximum is the maximum amount of cost-sharing that you will have to pay during the Insurance year.
The amount of cost-sharing is calculated after deducting the co-payment and any applicable deductible. Only the amounts you actually pay in respect of cost-sharing are included in the calculation of the annual out-of-pocket maximum.

A CHOICE OF 3 LEVELS OF COVERAGE	PEARL		SAPPHIRE		DIAMOND	
AGGREGATE LIMIT ON HEALTHCARE BENEFITS($)	$1,250,000		$2,000,000		$3,750,000	
	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
Out-of-pocket maximum, per year	$4,000	$6,000	$2,000	$4,000	$0	$3,000
Co-payment, per hospitalization	$400	$800	$200	$400	$100	$200

The basic coverage, i.e. without any options, includes coverage of hospital costs and routine medical expenses. The schedules below detail the benefits and the levels of coverage for these two categories of costs qualifying for reimbursement.

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) and medical care and expenses related to COVID-19 (4 weeks).

We will cover hospital charges if:

- The member of the plan is in Hospital, whether on an Outpatient basis or for several consecutive days,
- The need for hospitalization was established by a General practitioner or Specialist,
- The duration of your stay is medically appropriate and approved following a Request for prior approval,
- Your treatment is administered or monitored by a General practitioner and/or Specialist.

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. This medical report must include: the diagnosis, the treatment you have already received, the treatment you require, the additional length of time you will need to stay in Hospital.

We do not cover hospital charges if hospitalization is due to one or more of the following reasons: Convalescence, Pain management (except for palliative care), Paramedical care with no Specialist treatment, except for palliative care dispensed in a care facility, Personal assistance services, such as assistance with mobility, washing, preparing meals, etc., Treatment that could be classed as Routine healthcare.

	PEARL		SAPPHIRE		DIAMOND	
	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
Hospital room	**Private, semi-private or shared room**	**Private, semi-private or shared room**	**Private, semi-private or shared room**	**Private, semi-private or shared room**	**Private, semi-private or shared room**	**Private, semi-private or shared room**
	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	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 16	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 16, 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.					
Emergency hospitalization within the selected coverage zone (ambulance included)	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. All **services** provided in the Emergency room which are not followed by admission to hospital will be covered under **routine healthcare**. We must be notified of any **Emergency hospitalization** within 48 hours of admission.					
Hospitalization - 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.					
Hospitalization - 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: Operating room, Recovery room, Drugs and dressings used in the operating room and the recovery room, Drugs and dressings used during your stay in **hospital**. 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.					

	PEARL		SAPPHIRE		DIAMOND	
	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
Hospitalization - Consultations with General practitioners and Specialists during 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.					

	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Emergency dental care with hospitalization	We will cover **emergency** dental 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, Orthodontics or Periodontics (these treatments are only covered under the optional benefit Health+).					
	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Laboratory tests, MRI, x-rays, scans, tomography carried out as part of your hospitalization covered under this plan	We will cover all expenses related to: - **medical imaging**, such as x-rays, scans, MRI, etc., - tests such as blood tests or urine samples, - diagnostic tests such as electrocardiograms. If these examinations are prescribed by your **general practitioner** or **specialist** to help diagnose or assess your health during your stay in hospital.					
	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Prescription drugs	We will cover the cost of any **drugs prescribed** by the **general practitioner** or **specialist** in charge of your treatment during your hospitalization.					
	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Renal dialysis	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.					
	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Oncology (Treatment of cancer)	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'**.					
	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Treatment of AIDS	We will cover any costs related to the treatment of conditions related to HIV.					
	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Internal surgical and medical prostheses/devices	We will cover costs related to **prostheses, devices or appliances** fitted during a surgical procedure.					
	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
Hospitalization - External surgical and medical prostheses/devices	Per prosthesis – max. 2 prostheses We will cover: - **essential prostheses or devices** immediately following surgery if Medically required, - Medically required Prostheses or devices during the short-term recovery process. 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.					
	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
Hospitalization - Palliative care*	If a **member** is diagnosed with a terminal **illness** and can no longer be treated with a view to being cured, we will cover: - the cost of a room in a **hospital** or hospice (even if palliative home care is also covered), - nursing costs, - **prescribed drugs.**					

**No co-payment to be applied to these benefits.*

	PEARL		SAPPHIRE		DIAMOND	
	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
Hospitalization - Organ transplant: room and board, cost of treatment and hospitalization fees during an organ transplant *	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - 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 $3,800 per transplant	60% UCR up to $3,800 per transplant	90% UCR up to $5,600 per transplant	70% UCR up to $5,600 per transplant	100% UCR up to $7,500 per transplant	80% UCR up to $7,500 per transplant
	We will cover medical expenses related to a **member** receiving an organ transplant from a verified and certified donor. 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. We will cover the following donor expenses for each event requiring an organ donation whether or not the donor is **covered** under the plan: transporting the donated organ, tissue compatibility tests, the donor's operation and **hospital** costs. **We do not cover organ acquisition costs and 'anti-rejection' drugs.**					
Hospitalization – Physiotherapy/physical therapy, chiropractic and osteopathy*	80% UCR up to $3,100 per year	60% UCR up to $3,100 per year	90% UCR up to $6,200 per year	70% UCR up to $6,200 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* Waiting period: 12 months	30% 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') to treat the covered event. By covered event, we mean any treatment of mental **illnesses** and disorders with respect to this benefit.					

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 20 days per year	70% UCR up to 20 days per year	100% UCR up to 30 days per year	80% UCR up to 30 days per year
	We will cover nursing care at home following hospitalization covered under the plan, where such care: - is prescribed by your **specialist**, - commences immediately after you leave **hospital**, - reduces the duration of your stay in **hospital**, - is provided as medical care and does not constitute personal assistance.					
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* 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.	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. **We do not cover rehabilitation expenses or treatment which do not follow hospitalization covered under the plan.** We will cover rehabilitation: - if you received confirmation of our prior approval before commencing the treatment, - which commences a maximum of 30 days following hospitalization.					

**No co-payment to be applied to these benefits.*

Good to know

Medical assistance and evacuation benefits are included in your First'Expat+ plan.
For more information, please refer to section 6 / "General provisions of medical evacuation benefits included as standard with your healthcare plan", p52.

ROUTINE HEALTHCARE	Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year					
Co-payment per visit, treatment or procedure	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
	$35	$45	$25	$35	$15	$25
Waiting period of 4 weeks for medical care and expenses related to COVID-19.						
Consultations with general practitioners and specialists (other than dentists 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 and psychiatrists) and **specialist** treatments or procedures. 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 dental care without hospitalization*	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover consultations for **emergency** dental care, such as sudden toothache that does not require hospitalization. Non-emergency dental expenses (e.g.: dental check-up, scaling, dentures, etc.) 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 up to **52 prescribed sessions** per year 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 and physiotherapy on prescription *	80% UCR limited to 17 sessions per year	60% UCR limited to 17 sessions per year	90% UCR limited to 22 sessions per year	70% UCR limited to 22 sessions per year	100% UCR limited to 32 sessions per year	80% UCR limited to 32 sessions per year
	The limit on the number of sessions includes all specialties combined.					
Osteopathy and chiropractic*	80% UCR up to 15 sessions	60% UCR up to 15 sessions	90% UCR up to 25 sessions	70% UCR up to 25 sessions	100% UCR up to 35 sessions	80% UCR up to 35 sessions
	We will cover consultations in **osteopathy** and **chiropractic** without prescription. The limit on the number of sessions includes all specialties combined.					
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: - prescribed by your **general practitioner** or **specialist**, - which are used only in case of illness or injury.					
Prescribed contraceptives	80% UCR up to $125 per year	60% UCR up to$125 per year	90% UCR up to $250 per year	70% UCR up to $250 per year	100% UCR up to $375 per year	80% UCR up to $375 per year
	We will cover methods of contraception that are mechanical, medicinal or prescribed by a general practitioner or specialist. This includes the pill, condoms, diaphragm, intrauterine device, implants and patches.					

** No co-payment to be applied to these benefits.*

	PEARL		SAPPHIRE		DIAMOND	
	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
Psychiatry Waiting period: 12 months	80% UCR Maximum of 10 sessions per year	60% UCR Maximum of 10 sessions per year	90% UCR Maximum of 15 sessions per year	70% UCR Maximum of 15 sessions per year	100% UCR Maximum of 20 sessions per year	80% UCR Maximum of 20 sessions per 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

Co-payment per visit, treatment or procedure	PEARL		SAPPHIRE		DIAMOND	
	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
	$35	$45	$25	$35	$15	$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: Blood tests (complete blood count, biochemical **laboratory tests**, lipid profile, and thyroid, liver and kidney function), cardiovascular examination (physical examination, electrocardiogram and blood pressure), neurological examination (physical examination) and 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	Every year for men aged 45 and over.					
Screening for oral cancer	Every 5 years, for all **members.**					
Screening for skin cancer	Every 5 years, for all **members.**					
Colonoscopy, from age 50 (every 5 years)	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	Every 5 years for all **members** aged 45 and over.					
Dietitian	Not covered	Not covered	90% UCR 2 sessions per year	70% UCR 2 sessions per year	100% UCR 3 sessions per year	80% UCR 3 sessions per year
	We will cover consultations with a dietician 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	80% UCR $60 per year per year	60% UCR $60 per year	90% UCR $90 per year	70% UCR $90 per year	100% UCR $125 per year	80% UCR $125 per year
	We will cover the following costs related to smoking cessation support: - nicotine patches - nicotine gum - nicotine tablets					

**No co-payment to be applied to these benefits.*

3.4. / OPTIONAL BENEFITS FOR MEMBERS WHO SELECTED THE USA COVERAGE ZONE

3.4.1. 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					
ANNUAL AGGREGATE LIMIT ON **DENTAL BENEFITS** FOR 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 $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
Co-payment per visit, treatment or procedure	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
	$35	$45	$25	$35	$15	$25
Routine dental care Waiting period: 3 months	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover 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: scaling, treatment of tooth decay (amalgam), sealing of fissures, dental x-rays, inlays/onlays, fluoride application. **Tooth whitening is not covered by the plan.**					
Dentures and dental implants Waiting period: 6 months	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover inlay cores, posts, bridges, crowns, dentures and implant supports. **Facets are not covered.**					
Dental surgery Waiting period: 6 months	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover any surgical procedures, with or without anesthesia, including tooth extraction, bone or gum grafts and the fitting of implants.					
Periodontics Waiting period: 3 months	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover all treatments of **disorders** of the retaining tissue of the tooth, including the gum.					
Orthodontics up to age 16 Waiting period: 12 months	80% UCR up to $1,000 per year for 3 years	60% UCR up to $1,000 per year for 3 years	90% UCR up to $1,500 per year for 3 years	70% UCR up to $1,500 per year for 3 years	100% UCR up to $1,900 per year for 3 years	80% UCR up to $1,900 per year for 3 years
	We will cover **orthodontics** for any treatment commenced before the age of 16 and for a maximum of 3 consecutive years.					

VISION	Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year					
Co-payment per visit, treatment or procedure	PEARL		SAPPHIRE		DIAMOND	
	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
	$35	$45	$25	$35	$15	$25
Lenses and frames, limited to one pair every 2 years Waiting period: 6 months	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 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.					
Refractive surgery (cost of surgical treatments for visual corrections) Waiting period: 6 months	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	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 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. **The cost of lenses, frames or contact lenses will not be covered during the year following the reimbursement of the refractive surgery treatment.**					
Corrective contact lenses including disposable lenses Waiting period: 6 months	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 the cost of corrective contact lenses on prescription.					

Disorders of the eye such as cataracts, retinal detachment, glaucoma, AMD, etc. are covered under **routine healthcare** or hospitalization if necessary.

3.4.2. 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					
Co-payment per visit, treatment or procedure	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
	$35	$45	$25	$35	$15	$25
	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
Maternity and childbirth preparation classes, prenatal and postnatal care received by the mother and immediate care of newborns Waiting period: 10 months	We will cover the cost of **Maternity** and childbirth after expiration of the 10-month **Waiting period**. This includes: - the cost of hospitalization, anesthesia and surgical fees for Childbirth without complications, - **postnatal care** required immediately following Childbirth without complications (removal of stitches following an episiotomy, etc.), - childbirth preparation classes, - diagnostic tests for chromosomal **Disorders**, - routine care of the newborn within 7 days following birth. Treatments due to the following conditions are not covered under this benefit but are covered under Hospitalization: - abnormal growth of cells in the uterus (molar **Pregnancy**), - the fetus growing outside the uterus (ectopic **Pregnancy**).					
Childbirth without complications (single or multiple births) Waiting period: 10 months	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) Waiting period: 10 months	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**. 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.). 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 up to $1,100 per attempt (limited to $6,000 for the entire life of the plan)	70% UCR up to $1,500 up to $1,100 per attempt (limited to $6,000 for the entire life of the plan)	100% UCR up to $1,900 up to $1,100 per attempt (limited to $7,600 for the entire life of the plan)	80% UCR up to $1,900 up to $1,100 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:** • in vitro fertilization (IVF), • artificial insemination, • hormone treatments, tubal surgery.					

4. / 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;
- the cost of an ambulance or the taxi fare to attend scheduled appointments or to return home following surgery with anesthesia, except in case of chemotherapy.
- any medical or surgical expenditure prescribed by a medical authority which is not recognized (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 or 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;
- with respect to physical therapy/physiotherapy, only conventional treatments approved by the medical advisor are covered. Lymphatic drainage, massage and colonic irrigation are not covered;
- 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, formula milks, vitamins, probiotics, gluten-free 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;
- pre-exposure prophylactic treatment for HIV (pre-exposure);
- growth hormones unless supporting medical documents are provided and approved by the medical advisor;
- medication for and treatment of erectile dysfunction;
- 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;
- consultations for Mental illnesses or disorders (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);
- 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;
- repatriation and evacuation costs, including medical evacuation from a ship to a medical center on land. However, some of these costs will be covered by the assistance company under the terms and conditions of 'Medical Evacuation and Medical Transportation' benefits and under the 'Repatriation' option if selected;

- the cost of medical or surgical 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 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;
- termination of pregnancy (unless there is a threat to the health of the mother);
- 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;
- sleep disorders, including insomnia, unless the Insured member is diagnosed as suffering from severe sleep apnea;
- pre and postnatal care costs during the waiting period or 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 the Insured member has not submitted a Request for prior approval; the level of reimbursement of medical care provided under the plan may then be reduced. The plan administrator applies a penalty to the benefit amount of between 40% and 100%. This penalty is in addition to any penalties that may apply if the medical care is received in zone 5 outside the UnitedHealthcare International medical network;
- life-sustaining treatments, 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;
- 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 outside the selected geographical Coverage zone, if in a Coverage zone higher than the 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 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 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 return 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 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.

The consequences of the following are also excluded from the insurance:
- 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 and any conflict or disaster, if the Insured member has endangered themselves by entering a conflict zone recognized by the Government of their country of nationality, 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 and

trekking requiring special equipment (ropes, ice axes and crampons), 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.

5. / GENERAL OPERATING PROCEDURES

5.1. / YOUR PLAN

5.1.1. 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, subject to prior acceptance by the insurer and 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 at least 18 and under the age of 71.

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,
- occupations including activities on oil platforms.

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.

5.1.2. 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 territories under US jurisdiction (Porto Rico, United States Virgin Islands, Northern Mariana Islands, United States Minor Outlying Islands, American Samoa) as well as countries of Zones 1, 2, 3 and 4
- Zone 4: Bahamas, Brazil, China, Hong Kong, Jersey, Mexico, St. Barthelemy, St. Martin, Singapore, Switzerland and United Kingdom + Zones 1, 2, 3
- Zone 3: Australia, Austria, Canada, French Polynesia, Greece, Ireland, Israel, Italy, Japan, New Zealand, Portugal, Qatar, Russia, Saint Pierre and Miquelon, Spain, Taiwan, Turkey, United Arab Emirates and Vanuatu + Zones 1 and 2
- Zone 2: Andorra, 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, Georgia, Germany, Guatemala, Hungary, Iceland, Kazakhstan, Kuwait, Latvia, Lebanon, Liechtenstein, Luxembourg, Malaysia, Monaco, Mozambique, Netherlands, Nigeria, Norway, Oman, Panama, Peru, Saudi Arabia, Slovakia, South Africa, Sweden, Thailand, Ukraine, Uruguay, Venezuela, Vietnam and Wallis and Futuna + Zone 1
- Zone 1: Worldwide (including France) excluding the countries in Zones 2 to 5

It should be noted that, as a result of events (civil or foreign war, insurrection, etc.) which may be taking place there and, in all circumstances, in accordance with the classification of at-risk countries published by the French Ministry of Foreign Affairs, coverage may be excluded, **both at the time of enrollment and during the period of membership of the plan**, for certain countries or zones to which travel is classed by this Ministry as highly inadvisable (red zone). **During the period of membership of the plan, if a country or zone to which travel is classed as highly inadvisable (red zone) is excluded, coverage will be suspended for the entire duration of the red zone classification by this Ministry. At the time of enrollment in the plan, membership will also be subject to prior acceptance by the Insurer if travel to that country is discouraged by this Ministry unless for compelling reasons (orange zone).**

This list of countries or zones varies and is regularly updated by the French Ministry of Foreign Affairs.

The benefits apply in the Selected coverage zone. However, stays in the home country, if it is in the chosen Coverage zone, are covered only if the stays do not exceed a cumulative duration of 5 months per year.

The benefits also apply, in respect of Emergency care only, worldwide 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.

5.2. / LIFE OF YOUR PLAN

5.2.1. EFFECTIVE DATE AND RENEWAL OF THE PLAN BETWEEN ASFE AND THE INSURER

The Open group insurance plan arranged between the Insurer and the Contracting association took effect on July 1, 2015 for an initial period ending December 31, 2015. It is automatically renewed on January 1 of each year for successive periods of one year, unless terminated by either party with notification at least two months before each renewal date or in the event of the contracting association exercising its right to terminate the plan mid-year in accordance with Article L.113-15-2 of the French Insurance Code.
The contracting association's request for termination must be sent to the insurer by mail, email or, failing that, by any other means provided for in Article L.113-14 of the French Insurance Code. Termination at the insurer's initiative must be notified by registered letter.

5.2.2. YOUR 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 2 p.5 (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 the healthcare package, 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 package and level of benefits for all of the Member's Dependents, as well as the deductible and Co-payments, must be the same as those selected for the Member themselves.

- 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.
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 period of membership is an absolute minimum of 6 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, or its amendment, 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, the Deductible, the Co-payment where applicable, the corresponding Premium and, if applicable, the fixed term of membership.

5.2.3. ADDING ONE OR MORE DEPENDENTS TO YOUR MEMBERSHIP OF THE PLAN

You can request the addition of a Dependent family member during the enrollment in the plan by filling out the Application for coverage provided for this purpose. Any addition of a Dependent will result in the recalculation of the annual premium as defined in paragraph 5.4.1 Calculating your premium.

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, and send us the birth certificate issued by the hospital.

If the insurer is informed of the addition of a newborn more than 30 days after birth, medical formalities will be required for this child will and they will only be covered from the date of the insurer's acceptance.
Please note that all children from multiple births, children adopted from a care home or foster family and children born from surrogacy must be subject to prior acceptance in order to be registered on enrollment.

5.2.4. THE VARIOUS COMPONENTS OF YOUR MEMBERSHIP

Your membership of the FIRST'EXPAT+ or RELAIS'EXPAT+ plan is formalized by all of the following documents:

- **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 membership of the 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 Premium and the Period of coverage. The insurance Premium is paid on the date shown on the Premium notice.
- **This information booklet serving as the 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.

IMPORTANT

When you enrolled in the plan, you received a welcome letter by email, containing your MSH International card. Keep it safe; it will help facilitate your dealings with healthcare professionals.

5.2.5. OBTAINING A CERTIFICATE OF ENROLLMENT FOR A NEW DEPENDENT

On enrollment of a new dependent, subject to their prior acceptance where applicable, following the medical formalities 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.

5.2.6. CANCELING YOUR MEMBERSHIP BEFORE IT TAKES EFFECT: THE CANCELATION PERIOD

- **If the member has been subject to door-to-door selling at their home, residence or place of work:**

In accordance with Article L.112-9 of the French Insurance Code relating to door-to-door selling, any individual who has been subject to door-to-door selling at their home, residence or place of work, even at their own request, and who signs an insurance contract in this context for purposes that do not fall within the scope of a commercial or professional activity, may cancel their membership of the plan during a period of 14 calendar days from the date of enrollment in the plan, without having to provide reasons for the cancelation or pay penalties. The occurrence of an event triggering a claim under the plan during the 14-day cancelation period makes it impossible to exercise the right to cancel.

- **If the enrollment was processed remotely (by internet, telephone, mail or fax):**

In accordance with Article L.112-2-1 of the French Insurance Code relating to distance selling, the member may cancel their membership of the plan during a period of 14 days from either the date of enrollment or the date of dispatch of their certificate of enrollment, if this is later, without having to provide a reason or pay a penalty.
The occurrence of an event triggering a claim under the plan during the 14-day cancelation period makes it impossible to exercise the right to cancel.

- **How to exercise the right to cancel in the two cases mentioned above?**

The member may cancel by registered letter or by registered email, with proof of receipt, sent to the insurer using the following wording:
'I, the undersigned ..... (last name - first names) declare my express wish to cancel my membership of the FIRST' EXPAT or RELAIS' EXPAT plan no. 210 / XXXX (name of plan and membership number) purchased as a result of door-to-door selling at my home(*)
or remotely(*) on .../.../... and request the reimbursement of the Premium paid, less the portion corresponding to the period during which the plan was in force. ' (Date and signature). "
(*) as appropriate
Termination of membership of the plan takes effect from the date of receipt of the registered mail or registered email by the Administrator, MSH International.

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 insurer is required to reimburse the balance of the premium 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.

5.2.7. START OF MEMBERSHIP AND EFFECTIVE DATE OF BENEFITS

For the Member:
The effective date of membership is subject to acceptance by the insurer 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 1st day or 15th day of the month following the date of notification of acceptance of membership. This date is 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 6 months or for an annual period ending after 365 days of coverage with automatic annual renewal on the anniversary of enrollment under the conditions of paragraph 5.2.8 below and 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 also 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 first 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.

For the Member's Dependents:
Subject to acceptance by the insurer based on the required 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 date of acceptance by the Insurer 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 (unless the waiting period for medical care related to COVID-19 applies, as shown below).

- 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 Waiting periods detailed below (depending on the benefits selected):

Waiting periods in detail:

- Waiting period of 4 weeks for medical care and expenses related to COVID-19 covered under Medical or surgical hospitalization - Surgical procedures and fees, General medicine - Specialties – Laboratory tests, Pharmacy items, Preventive medicine and Alternative medicine,
- 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 and Dental (HEALTH+) (excluding dental consultations and care): dentures, dental implants, bone grafts and dental surgery,
- Waiting period of 10 months in respect of the following benefits: Maternity (HEALTH+CHILD) (including pre and postnatal care),
- Waiting period of 12 months in respect of the following benefits: orthodontics, fertility treatment (including medically assisted reproduction), prescription drugs for chronic conditions (zone 1 to 4) 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. **This provision does not apply to Maternity (including pre and postnatal care) and fertility treatment benefits, for which the 10 and 12-month waiting periods remain applicable.**
It is specified that the Insurer will only cover expenses incurred in respect of treatments and procedures prescribed from the Effective date of benefits.

5.2.8. RENEWING OR TERMINATING YOUR MEMBERSHIP OF THE PLAN

Except where the membership has a fixed term, it is purchased for an initial period of one year.
Membership is automatically renewed on each anniversary date for successive periods of one year, unless terminated by one of the parties.
The member may terminate the membership by mail, email or, failing that, by any other means provided for in Article L.113-14 of the French Insurance Code:

- at least 2 months before each anniversary date of the plan, in accordance with Article L.113-12 of the French Insurance Code,
- at any time, after one year of insurance has elapsed in accordance with Article L.113-15-2 of the French Insurance Code, to take effect one month after the date of dispatch or delivery of the notification to the insurer.

Other cases of termination:
Membership ends in the event of termination notified in accordance with the provisions set out above as well as those set out in Article 5.2.9 "Cessation of membership and end of coverage".
The insurer may terminate membership of the plan in accordance with the provisions provided for:

- in case of non-payment of the premiums (Article 5.4.5),
- in case of refusal to accept a change in the premium (Article 5.4.2)
- in case of misrepresentation (Article 5.5.8).

In addition, during the period of membership, the rights and obligations of the member may be modified by amendments to the contract entered into by the contracting association and the insurer. In this case, the member will be informed of the changes at least three months before the date on which they are due to come into force. If the member does not accept these changes, they may, within one month of the date on which they were informed, terminate their membership by mail, email or, failing that, by any other means provided for in Article L.113-14 of the French Insurance Code.

5.2.9. 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.
- Ii 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. This request may be made at any time but at the earliest after 6 months of membership of the plan.
- on the date of termination of membership as set out in Article 5.2.8 "Renewing or terminating your membership of the plan".
- **in the event of non-payment of the premiums:** if the Premium corresponding to the membership is no longer being paid.
- **during the course of the year:** as soon as the insured member does no longer qualify for membership of the plan, for example in the event of a return to the home country, enrollment by the employer in a similar plan or the French or local social security; termination of membership will take effect on the 1st or 15th of the month following the date of receipt of the letter of termination together with official supporting documentation. Requests to terminate the plan

will not be accepted unless official supporting documentation[3] is provided. The end date of the plan will be determined by the date of receipt of the supporting documentation and will not be effective until the expiration of a minimum notice period of one month. For example, if we receive a request for termination, together with an official document proving that you have returned home, on January 26, the plan will not end until March 1. The administrator, MSH International, reserves the right to check that the official supporting documents are authentic. If the supporting documents prove to be false, termination will not take place during the course of the year and the premiums will remain due until a mid-year termination where applicable or termination on the anniversary date of enrollment.

- **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 5.2.2 Your enrollment in the plan and persons insured p.36 in chapter 5.2 / Life of your plan.
  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 termination of their membership of 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,
- on the date of permanent return to the home country (uninterrupted stay of more than 3 months),
- 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.

5.2.10. MAKING CHANGES TO YOUR MEMBERSHIP

We will send all important communications and information about your membership 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**

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 you and/or your Dependents.

- **DEATH OF THE PRIMARY MEMBER OR A DEPENDENT**

If 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 age of 18) 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.

---

[3] By Official supporting documentation we mean:
- a copy of a certificate from the employer specifying their obligation to provide coverage,
- a certificate of enrollment in the French or local Social Security scheme,
- proof of payment of rent or an electricity or water bill from your main residence in your name if you are returning to your country of nationality.

- **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.** If the deductible is removed or reduced, MSH International may require the primary Member and their dependents if applicable, to complete a new medical questionnaire and may apply new specific restrictions or exclusions.

- **CHANGING THE LEVEL OF COVERAGE (FROM THE 1ST EURO/DOLLAR IN ADDITION TO CFE BENEFITS (CAISSE DES FRANÇAIS DE L'ÉTRANGER))**

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.

5.3. / 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).

5.3.1. 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.**

5.3.2. 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 United Nations 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.

You will receive your reimbursement either:

- by check,
- or by wire transfer in the currency of your bank account.

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.

5.3.3. REIMBURSEMENTS AND DEDUCTIBLES

The Deductible is the amount any Insured member must pay towards their medical expenses, per Insurance year, before we can begin to reimburse them. It is the amount payable by the Member and each of their 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 the claim for reimbursement exceeds the total amount of the Deductible, or the remaining amount of the 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.

5.3.4. REIMBURSEMENT FOLLOWING A REQUEST FOR PRIOR APPROVAL

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.

5.4. / YOUR PREMIUM

5.4.1. CALCULATING YOUR PREMIUM

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

- the age of the insured person,
- the Selected coverage zone,
- the package selected (Quartz, Pearl, Sapphire or Diamond),
- the benefits selected (Basic benefits only (HEALTH) or Basic benefits + Optional benefits: Vision/Dental (HEALTH+) or Vision/Dental + Maternity (HEALTH+CHILD)),
- 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. In other words, when at least 3 children are covered in respect of the membership of an Insured member, Premiums will only be payable for the 2 children with the highest amounts.
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) as set out in paragraph 5.4.2 Changes in the level of your premium.

5.4.2. CHANGES IN THE LEVEL OF YOUR PREMIUM

- Any changes made to the plan or the membership (e.g. change of option or addition of a dependent) will result in the recalculation of the annual premium as defined in section 5.4.1 Calculating your premium.

- 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.

- 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.

- 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 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.

5.4.3. 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 or Monaco), 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 or Monaco), 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.msh-intl.com, via your Members' Area, under the Online payment section.
- BY DIRECT DEBIT (ONLY FROM A BANK ACCOUNT IN FRANCE OR MONACO):
  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.

5.4.4. ONLINE INFORMATION ON PAYING YOUR PREMIUM

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.

5.4.5. PROCEDURE IF YOU FAIL TO PAY YOUR PREMIUM

In accordance with the provisions of article L.113-3 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 L.141-3 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.

5.4.6. BANK CHARGES

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

5.4.7. REIMBURSEMENT OF THE PREMIUM

In case of Termination of membership of the plan (at the earliest 6 months after the date of enrollment), membership and benefits are maintained until the end of the period covered by the last Premium paid.

5.5. / LEGAL INFORMATION

5.5.1. 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.

5.5.2. 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.

5.5.3. 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.

5.5.4. LIMITATION PERIOD

In accordance with Article L.114-1 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 Assistance provider 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.

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

In accordance with Article L.114-2 of the French Insurance Code: "The limitation period" is interrupted by one of the **following** ordinary causes of interruption:

- 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).

A summons served on one of the joint and several debtors by means of legal action or an enforcement order or the recognition by the debtor of the right of the person against whom they were prescribing interrupts the limitation period against all the others, even against their heirs.

However, a summons served on one of the heirs of a joint and several debtor or the recognition by that heir does not interrupt the limitation period with regard to the other joint heirs, even in the case of a mortgage debt, if the obligation is divisible. Such a summons or recognition interrupts the limitation period with regard to the other co-debtors only for the share of the obligation for which that heir is liable.

To interrupt the limitation period entirely, with regard to the other co-debtors, the summons needs to be served on all the heirs of the deceased debtor or the right needs to be recognized by all of these heirs (Article 2245 of the French Civil Code).

A summons served on the principal debtor or their recognition of the right interrupts the limitation period for taking action against the surety (Article 2246 of the French Civil Code).

The limitation period can also be interrupted by:

- the appointment of experts following a loss,
- a registered letter with proof of delivery sent by the insurer to the insured member regarding action for payment of the premium and from the insured member to the insurer regarding payment of the claim.

It should be noted that membership of the plan is null and void if its implementation, the settlement of a claim or the provision of any benefits or services were to expose 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.

5.5.5. COMPLAINTS PROCEDURES AND MEDIATION SERVICE

In the event of a disagreement, the Member must notify MSH International within 6 months of this disagreement.

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

- the Administrator, MSH International, by writing to the following address: MSH International, Service réclamation, 23 allées de l'Europe 92587 Clichy Cedex, France;

or

- the Insurer's customer relationship department at the following address:
  Service des relations avec les consommateurs Groupama Gan Vie – Immeuble West Park 2 – 2 Boulevard de Pesaro - 92024 Nanterre, France – by email: src-collectives@ggvie.fr

If the complainant is not satisfied with the initial response, the complaint may be submitted to the Insurer's Complaints department at the following address:
Groupama Gan Vie – Service Réclamations – TSA 91414 - 35090 Rennes Cedex, France - https://reclamations.ggvie.fr. In both these cases, the complainant will receive an acknowledgment of their complaint within a maximum of 10 working days of receipt. A final response to their complaint will be sent to the complainant within 2 months at the most. If the processing time needs to be extended due to special circumstances, the complainant will be informed.

Lastly, subject to having exhausted all the avenues of remedy set out above, the Member or the Dependent may refer the matter to the Insurance Ombudsman:

- by mail: La Médiation de l'Assurance, Pôle PLANETE CSCA, TSA 50110, 75441 PARIS CEDEX 09, France
- online: https://www.mediation-assurance.org/Saisir+le+mediateur
- by email: le.mediateur@mediation-assurance.org

Details of complaint processing procedures are available from the usual advisor and in the "Legal notices" section of the website www.gan-eurocourtage.fr.
If the opinion of the Insurance Ombudsman is not deemed to be satisfactory, the matter may be taken before the courts.

5.5.6. CONFIDENTIALITY AND PROTECTION OF PERSONAL DATA – PAPERLESS COMMUNICATIONS IN RESPECT OF THE INSURANCE PLAN – ANTI-MONEY LAUNDERING AND THE FINANCING OF TERRORISM

5.5.6.1. PROTECTION OF PERSONAL DATA

Personal data are collected by the insurer at different stages of its commercial or insurance activities with respect to members or persons involved in or affected by the insurance plans.
These personal data are processed by the insurer, in its capacity as data controller, in accordance with the regulations in force relating to the processing of such data and the protection of privacy, in particular the provisions of the French Data Protection and Freedom of Information Act No. 78-17 of January 6, 1978 (amended) and the General Data Protection Regulation (Regulation 2016/679 of April 27, 2016).
Personal data are stored for the duration required for the implementation of the insurance plan and then archived until the expiration of the applicable statutory limitation periods.

5.5.6.2. RIGHTS OF THE INDIVIDUAL

The above-mentioned persons, subject to providing proof of identity, have the right to:

- read the information held by the insurer and request additions or corrections (rights of access and rectification);
- request the erasure of their data or the restriction of their use (right to erasure or restriction of data);
- object to the use of their data, in particular with regard to direct marketing (right to object);
- retrieve data which they have personally provided to the insurer for the implementation of their insurance plan or for which they have given their consent (right to data portability);
- set guidelines for the storage, erasure and disclosure of their data after their death.

These rights may be exercised by mail, email or via the Internet, by contacting Groupama Gan Vie, Direction Risques et Conformité - Délégué Relais à la Protection des Données - Immeuble West Park 2 – 2 boulevard de Pesaro – 92024 Nanterre - France – contact.dpo@ggvie.fr.
With regard to health data, these rights can be exercised by sending a letter to the insurer's Medical Advisor at **Groupama Gan Vie: Médecin-conseil - Service Médical Collectives - Immeuble West Park 2 – 2 Boulevard de Pesaro – 92024 Nanterre – France.**
Data subjects may also file a complaint with the French Data Protection Authority, Commission Nationale de l'Informatique et Libertés (CNIL) if they feel the insurer has failed to meet its obligations with respect to their data.
As part of its obligations, the insurer is required to regularly check that personal data are accurate, complete and up-to-date. To this end, the insurer may be required to contact the aforementioned persons to check or complete this information.

5.5.6.3. WHY DOES THE INSURER COLLECT PERSONAL DATA?

The processing of personal data is required for the execution, administration and implementation of the insurance plan and the benefits, the management of commercial and contractual relations, the management of the risk of fraud or the implementation of the legal, regulatory or administrative provisions in force, for the purposes listed below.

Execution, administration and implementation of the insurance plans and the commercial management of clients and prospects

The data collected by the insurer at various stages of the application for or administration of insurance plans are required for the following purposes:

- the analysis of insurance needs in order to recommend plans to suit individual circumstances;
- the assessment, acceptance, control and monitoring of the risk;
- the administration of the plans (from the pre-contractual phase to termination of the plan), and the implementation of the benefits provided under the plan;
- client management;
- the exercise of remedies and the management of complaints and disputes;
- the production of statistics and actuarial studies;
- the introduction of preventive measures;
- compliance with legal or regulatory obligations;
- research and development activities during the life of the plan.

The recipients of this information are, within the limits of their respective remits, the usual advisor or point of contact, the insurer's departments in charge of the commercial management or the execution, administration and implementation of the plans, and its delegated administrators, intermediaries, partners, agents, processors, or other entities of the Groupama Group in the exercise of their duties.

This information may also be passed on, where appropriate, to the insurance organizations of the data subjects or those providing supplementary benefits, to co-insurers, reinsurers, professional bodies and guarantee funds, as well as to all persons directly or indirectly involved in the plan and its implementation, and to all persons accredited as Authorized Third Parties (courts, arbitrators, mediators, relevant government ministries, guardianship and supervisory authorities and all

public bodies authorized to receive it, as well as to supervisory services such as statutory auditors, internal auditors and internal control departments).

Health data may be processed if they are required for the execution, administration and implementation of insurance or assistance plans. This information is processed in compliance with medical confidentiality and with your consent. In the case of employee benefits, data subjects expressly agree to these data being collected and the required processing being carried out.

This information is intended exclusively for the insurer's medical advisors or the medical advisors of entities of the Groupama Group responsible for the administration of the benefits, its medical department or specially authorized internal or external persons (including its delegated administrators or medical specialists). This information may also be used by authorized persons in matters of fraud prevention.

When an insurance contract has been entered into, the data are stored for the duration of the plan, extended by the duration of the management of any ongoing claims or disputes, and until the expiration of the statutory limitation periods.

If no insurance contract has been entered into (prospect-related data):

- health data are stored for a maximum of five (5) years for evidentiary purposes;
- other data may be stored for a maximum of three (3) years.

Marketing

The insurer and the companies of the Groupama Group (Insurance, Banking and Services) have a legitimate interest in canvassing their clients or prospects, and carry out the required data processing for the purposes of:

- performing operations with regard to prospect management;
- data on clients or prospects in compliance with the rights of individuals;
- carrying out research and development activities in the context of client management and marketing activities.

The use of certain methods of carrying out marketing activities is subject to obtaining the agreement of the prospects. These are:

- using their email address or telephone number for electronic marketing purposes;
- using browsing data to recommend personalized offerings (see cookies notice on the website for further information);
- passing on data to partners.

Any person may opt out of advertising by mail, email or telephone at any time by contacting the insurer (see above Rights of the individual).

With respect to telephone or electronic marketing (by email or SMS/MMS), the above-mentioned persons may also opt out by changing their preferences in their personal online area or by using the unsubscribe link provided in the insurer's messages.

With respect to telephone marketing, they may also opt out by registering free of charge with the BLOCTEL opt-out directory (www.bloctel.gouv.fr), which prohibits professionals with whom they do not have a current contractual relationship from contacting them by telephone for marketing purposes.

Combating insurance fraud

The above-mentioned persons are also informed that the insurer operates a system for the purpose of combating insurance fraud, which may lead to their inclusion on a list of persons presenting a risk of fraud. This may result in longer processing times in respect of applications for insurance or claims, or even the reduction or denial of a right, benefit, plan or service provided by entities of the Groupama Group.

In this context, the personal data of the above-mentioned persons may be processed by all authorized persons working within the entities of the Groupama Group as part of its anti-fraud measures. These data may also be passed on to authorized personnel of organizations directly affected by fraud (other insurance organizations or intermediaries; social or professional bodies; legal authorities, mediators, arbitrators, court officials, ministry officials; third party organizations authorized by a legal provision and, where applicable, victims of acts of fraud or their representatives).

Data for this purpose may be passed on to the French Insurance Fraud Prevention Agency (Agence pour la Lutte contre la Fraude à l'Assurance or ALFA).

These persons are also informed that ALFA operates a system whereby data from insurance plans and claims made to insurers are shared for the purpose of combating fraud. Rights in respect of these data may be exercised at any time by writing to ALFA, 1, rue Jules Lefebvre - 75431 Paris Cedex 09 France.

Data processed for the purpose of combating fraud are stored for a maximum of five (5) years from the closure of the fraud file. In the event of legal proceedings, the data will be stored until the end of the proceedings and the expiration of the applicable limitation periods.

Individuals added to a list of suspected fraudsters will be de-registered after five (5) years from the date of registration on this list.

Anti-money laundering and the financing of terrorism

To meet its legal obligations, the insurer has implemented a procedure the purpose of which is to combat money laundering and the financing of terrorism, as well as the implementation of restrictive measures and the freezing of assets. Data used for this purpose are stored for a minimum of five (5) years from the completion of the operations or the end of the business relationship. The right of access to data relating to the procedures in place for the purposes of combating money laundering and the financing of terrorism may be exercised by contacting the French Data Protection Authority (Commission Nationale de l'Informatique et Libertés).

Satisfaction/Quality of service

In its own interest and that of its clients, the insurer measures and seeks to continuously improve the quality of its services and products. This may include the carrying out of satisfaction surveys. In this context, communications by mail, email or telephone between the insurer and the above-mentioned persons may be recorded and analyzed. Telephone recordings are

kept for a maximum period of six (6) months and the other elements required for the purpose of improving quality of service are kept for a maximum period of three (3) years.

Research and statistics

The insurer and the entities of the Groupama Group (or their processors) may also use and process personal data involving the above-mentioned persons for statistical or research purposes, particularly with a view to developing their product and service offerings and personalizing their relationship with the data subject. These data may be linked, combined or include personal data in respect of the above-mentioned persons and collected automatically or provided by the person themselves. They may also be combined with statistical or aggregated data from various internal or external sources.

5.5.6.4. TRANSFER OF INFORMATION OUTSIDE THE EUROPEAN UNION

Personal data are processed within the European Union. However, data may be transferred to countries outside the European Union in compliance with data protection rules and subject to the appropriate safeguards (e.g. standard European Commission contractual clauses, countries with a level of data protection recognized as adequate, etc.).

These transfers may be carried out for the implementation of insurance contracts, anti-fraud measures, compliance with legal or regulatory obligations, the management of actions or disputes enabling the insurer to ensure the establishment, exercise or defense of its rights in law or for the needs of the defense of the data subjects. Certain types of data, which are strictly necessary for the provision of assistance services, may also be transferred outside the European Union in the interest of the data subject or the protection of human life.

5.5.6.5. PAPERLESS COMMUNICATIONS IN RESPECT OF THE INSURANCE PLAN

Paperless communications with the Contracting association and the member

With regard to information and documentation relating to their insurance plan, the Contracting association and the member should be aware that the insurer may exchange information and documents in a paperless manner and in particular provide or make this information and documentation available to them using a medium other than paper, including email and/or via their respective secure client areas.

By providing their email address when purchasing the insurance or during the life of the plan, the Contracting association and the member accept that paperless communications are appropriate to their circumstances.

The Contracting association and the member may at any time opt out of paperless communications and ask the insurer, by any means, to use paper-based communications, at no cost to them.

To do this, the Contracting association and the member may send a letter or email to the insurer or call them. They can also change their preferences in their secure client area.

The Contracting association and the member agree to inform the insurer without delay if there are any changes to their email address and, more generally, if there are any changes in their situation that may have any impact on the administration of their plan.

Provision of a secure client area

The insurer may provide the Contracting association and the member with a secure client area where they can:

- read information and documents from the insurer. This may include information and documents (including at the pre-contractual or contractual stage) provided by the insurer on a durable medium other than paper, or on any other medium, and placed in the secure client area where the member can refer to them.
- benefit from a service for viewing and managing their insurance plan.

Access code

Access to the secure client area is by means of an access code consisting of a username and a password. The password is sent to the Contracting association and the member in a secure manner using the identifiers provided by them. This confidential, strictly personal access code is used to identify the Contracting association and the member, thus ensuring that they are authorized to consult and manage their insurance plan in the client area.

The Contracting association and the member agree to keep their respective access codes confidential.

If the confidential access code is lost or stolen, the Contracting association and the member must inform the insurer immediately so that a new password can be assigned to them. The Contracting association and the member will be solely responsible for any direct or indirect consequences resulting from a failure to report the loss or theft of the access code to the insurer or a delay in doing so.

In the event of negligence on their part, they will be solely responsible for any viewing of or administrative operations carried out on their insurance plan as a result of fraudulent, misappropriated or unauthorized use of their confidential access code by a third party.

Acceptance of the General Terms and Conditions of Use (GTCU)

When first logging in to the secure client area using their access code, the Contracting association and the member must read and accept the general terms and conditions of use of this client area in order to view or carry out administrative operations on their insurance plan and read the information and documents made available by the insurer.

Agreement on evidence

This agreement on evidence applies to:

- the provision by the insurer of information or documents sent to the Contracting association and the member by email;
- the provision by the insurer of information or documents in the secure client area;

- the viewing and management of their insurance plan by the Contracting association and the member in their respective secure client areas.

The Contracting association, the member and the insurer jointly accept and acknowledge that:

- any viewing or administrative operations, and more generally any operations carried out in their secure client area, following authentication using their confidential access code, will be deemed to have been carried out by the Contracting association and the member;
- the information contained in the viewing or administration screens and linked to the operations carried out by the Contracting association and the member in their secure client areas and stored electronically by the insurer will be binding on the Contracting association and the member and will have evidentiary value;
- with respect to paperless communications between the Contracting association, the member and the insurer, the data relating to these communications and recorded in the insurer's information system will be binding on the Contracting association and the member and will have evidentiary value.

5.5.6.6. ANTI-MONEY LAUNDERING AND THE FINANCING OF TERRORISM

As an insurance company, Groupama Gan Vie is subject to the legal and regulatory provisions relating to measures to combat money laundering and the financing of terrorism under the provisions of Articles L. 561-1 and following of the French Monetary and Financial Code. Groupama Gan Vie is therefore under obligations to identify and know its clients and exercise constant vigilance, which justify the collection of information from its clients.

5.5.7. 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.

5.5.8. FRAUD AND CONCEALMENT OF FACTS - MISREPRESENTATION

In accordance with the provisions of Article L.113-8 of the French Insurance Code, membership of the insurance plan is null and void in the event of intentional concealment or misrepresentation.

In accordance with the provisions of Article L.113-9 of the French Insurance Code, any unintentional omissions or inaccuracies in the reporting of the risk will result in:

- a premium increase or termination of membership of the plan if the omission or inaccurate reporting is discovered before any claims have been made;
- a reduction in compensation in proportion to the premium rate which would actually have been due against the premium paid, and termination of membership of the plan if the omission or inaccurate reporting is discovered after a claim has been made.

5.5.8.1. FORFEITURE OF COVERAGE

The insurer may deny coverage to the insured member if it is discovered that they have intentionally made a false claim for coverage under the plan, or have provided false information or used fraudulent or falsified documents when making a claim.

5.5.9. SUBROGATED CLAIMS

This refers to the insurer's right to recover the amounts of claims they have settled from the person who was responsible for a loss.
If the member is suffering from a disease or is the victim of an accident for which compensation may be paid by a liable third party, the insurer may make a subrogated claim against the person liable to pay the compensation, or their insurer. A member who has suffered injuries caused by a third party must inform the insurer at the time of the claim for benefits.

If the member is the victim of a road traffic accident (involving a motor vehicle), they must provide the insurer of the person having caused the accident, when requested, with the name of their insurer in their capacity as third party payer. Failure to do so may result in denial of coverage.

In accordance with the French Insurance Code, the insurer is subrogated to the rights of the recipient of the benefits in the seeking of remedy from any liable third parties.

5.5.10. LIABILITY

The Insurer's liability in respect of insured persons is limited to the amounts shown in the Benefits schedule. 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.

5.5.11. COMMUNICATING WITH DEPENDENTS

With respect to the management of the membership 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.

6. / GENERAL PROVISIONS OF MEDICAL EVACUATION BENEFITS INCLUDED AS STANDARD WITH YOUR HEALTHCARE PLAN

6.1. / GENERAL

6.1.1. PURPOSE OF THE PLAN

Assistance plan no. 58.224.508 (General Terms and Conditions / Agreement no.: MH7) purchased by ASFE from EUROP ASSISTANCE.

The purpose of these General Provisions of the "ASFE Inclusion" plan agreed between EUROP ASSISTANCE, a company governed by the French Insurance Code, and the Policyholder is to provide Insured members who meet the conditions of coverage with the emergency medical assistance and emergency transportation/evacuation services purchased on their behalf by ASFE, the Policyholder of this plan.

Insurance contract agreed between:

EUROP ASSISTANCE
A French limited company ("Société Anonyme") with a capital of €46,926,941, registered with the Nanterre Trade and Companies Register under number 451 366 405, a company governed by the French Insurance Code whose registered office is located at 1 Promenade de la Bonnette - 92230 GENNEVILLIERS, France.

Hereinafter referred to as "**EUROP ASSISTANCE**" or "**the Assistance provider**"

AND

ASSOCIATION OF SERVICES FOR EXPATRIATES (ASFE)
governed by the French law of 1901 on associations,
Season, 39 rue Mstislav Rostropovitch
75815 Paris cedex 17, France

Hereinafter referred to as "**the Policyholder**" or "**ASFE**"

Through the intermediary of:

MSH INTERNATIONAL
A French simplified joint stock company ("Société par actions simplifiée") with a capital of €2,500,000,
a French insurance broker registered with the Paris Trade and Companies Register under number 352 807 549 and with ORIAS under number 07 002 751, intra-Community VAT identification number FR 78 352 807
whose registered office is located at Season, 39 rue Mstislav Rostropovitch
75815 Paris cedex 17, France

Hereinafter referred to as "**the Broker**" or "**the Administrator**".

6.1.2. DEFINITIONS

For the purposes of this plan, the following definitions apply:

Abroad: The term Abroad means any country outside your Home country.

Accident (personal): A sudden and fortuitous event affecting the Insured member, 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 governed by the French Insurance Code, a French limited company ("société anonyme") with a capital of 46,926,941 euros, registered with the French "Registre du Commerce et des Sociétés" 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 in any country 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): This term refers to the Primary member and their dependents who are members of ASFE, 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 ASFE, which has arranged this group plan for the benefit of its Insured members.

Trip: All of your private and business trips in your Country of expatriation regardless of the duration, and for a maximum of 180 days for trips outside your Country of expatriation during the period of validity of your plan.

6.1.3. WHAT TYPES OF TRIP ARE COVERED UNDER THE PLAN?

The assistance services provided under the plan 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.

The Policyholder is responsible for ensuring that Insured members meet the conditions of membership 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.

6.1.4. GEOGRAPHICAL COVERAGE OF THE PLAN AND INTERNATIONAL SANCTIONS

6.1.4.1. TERRITORIAL COVERAGE

THE ASSISTANCE SERVICES DESCRIBED IN CHAPTER 6.2 BELOW APPLY WORLDWIDE, WITH THE EXCEPTION OF THE EXCLUSIONS SET OUT IN THESE PROVISIONS.

6.1.4.2. TERRITORIAL EXCLUSIONS

EXCLUSIONS: in general, countries which, **at the date of departure**, are in a state of civil or foreign war, or manifest political instability, or **affected by natural disasters**, popular movements, riots, acts of terrorism, reprisals, restrictions on the free movement of persons and goods (for any reason, including health, security, weather, etc.), or decay of the atomic nucleus, or any radioactive irradiation from an energy source.

6.1.4.3 INTERNATIONAL SANCTIONS

EUROP ASSISTANCE will not provide any coverage or benefits and will not provide any service described in this document if this could expose them to any international sanctions, prohibitions or restrictions as defined by the United Nations, or the European Union, or the United States of America. Further information is available at https://www.europ-assistance.com/en/who-we-are/international-regulatory-information (in English) or https://www.europ-assistance.com/fr/nous-connaitre/informations-reglementaires-internationale (in French).

As such, and cumulatively with any other territorial exclusions defined in this document, benefits are not provided in the following countries and territories: North Korea, Syria, Crimea, Iran and Venezuela.

For U.S. citizens traveling to Cuba, the implementation of assistance services or payment of benefits is conditional on the provision of proof that the trip to Cuba complies with the laws of the United States. U.S. nationals are deemed to include any person, wherever they are located, who is a U.S. citizen or who usually resides in the United States (including Green Card holders) and any joint stock company, partnership, association or other organization, whether incorporated or conducting business in the United States that is owned or controlled by such persons.

6.1.5. 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, 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.

6.1.6. USING OUR SERVICES

6.1.6.1. 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 full name,
- your precise location and the address and telephone number where you can be reached,
- your plan number.

You must:

- call us without delay on: +33 (0)1 41 85 94 06,
- fax: +33 1 41 85 85 71,
- contact us by email at: asfeevac@ea-gcs.com, asfeevac@ea-gcs.com,
- 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.

- **Any expenses incurred without our agreement will not be reimbursed or covered after the event.**

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.

6.1.6.2. 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 (death certificate, proof of family relationship, proof of parents' age, proof of Domicile or Place of residence, proof of expenses, and 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, day hospitalization or outpatient hospitalization in the 6 months preceding the request for assistance. This applies equally to the manifestation and 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.

6.1.6.3. 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 L. 121-4) as soon as you become aware of this information and at the latest when making the claim.

6.1.6.4. MISREPRESENTATION

When it changes the subject of the risk or decreases 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 claim payment of all due premiums in accordance with the French Insurance code, article L. 113-8,
- 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 and/or application of the reduction in compensation specified in the French Insurance Code, Article L.113-9.

6.1.6.5. FORFEITURE OF COVERAGE DUE TO FRAUDULENT DECLARATIONS

In the event of a loss or a request for the provision of assistance services (as specified 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.

6.1.7. WHAT TO DO WITH YOUR TRAVEL TICKETS?

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

6.2. / DESCRIPTION OF OUR SERVICES AND BENEFITS

6.2.1. ASSISTANCE SERVICES

Scope of assistance services during your expatriation.

6.2.1.1. DESCRIPTION OF OUR SERVICES AND BENEFITS

Transportation/repatriation

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.
The decision to transfer you, the choice of means used for this transfer, and the place of hospitalization, where required, are based solely on your medical condition and in compliance with the health regulations in force.

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**. The evacuation will be carried out primarily by road ambulance or by air if your location is: - inaccessible by road, - 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.**

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 fulfillment of services resulting from longer timescales for the completion of 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.

6.2.1.2. WHAT IS EXCLUDED

Under no circumstances can we replace local emergency rescue organizations. In addition to the general exclusions listed p.48, the following are excluded:

- the consequences of 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 carried out 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 and 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 6.2.1.1 Description of our services and benefits p.50 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,
- cosmetic 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 luggage when traveling by air and the cost of forwarding the bags if they cannot travel with you,
- trip cancellation costs,
- restaurant costs,
- customs duties.

6.3. / FRAMEWORK OF THE PLAN

This plan is subject to French law.

6.3.1. OBLIGATIONS OF THE POLICYHOLDER

6.3.1.1. 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.

6.3.2. LIABILITY - COMPLAINTS

Each party will bear the consequences of failures in 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.

6.3.3. LIMITATION PERIOD

In accordance with Article L.114-1 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 Assistance provider 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.

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

In accordance with Article L.114-2 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 compensation. "
The ordinary causes of interruption of the limitation period are described under Articles 2240 to 2246 of the French Civil Code: the acknowledgment 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."

6.3.4. SUBROGATION

Having incurred costs in respect of our insurance coverage and/or assistance services, other than payments made under "personal travel accident", described in chapter II.B.5, we are subrogated to the rights and actions which the Insured member may have or take against the third parties liable for the Loss as specified in Article L.122-12 of the French Insurance Code.
Our subrogation is limited to the amount of the costs we incurred in fulfillment of this plan.

6.3.5. 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 fulfillment, nonfulfillment 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.

6.3.6. EFFECTIVE DATE AND DURATION OF THE PLAN AND THE BENEFITS

6.3.6.1. 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.

6.3.6.2. 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 member 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.

6.3.7. TERMINATION OF THE PLAN AND CESSATION OF BENEFITS

6.3.7.1. CANCELATION OF THE GROUP PLAN BETWEEN THE INSURER AND THE POLICYHOLDER

In addition to the option of annual termination specified above (in paragraph 6.3.6 "Effective date and duration of the plan and the benefits") the plan may be terminated:

1. by the Insurer:

- in the event of non-payment of the premium, under the conditions of Article L.113-3 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 L.113-9 of the French Insurance Code),
- in case of aggravation of the risk under the conditions of Article L.113-4 of the French Insurance Code.

2. 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.

3. automatically:

- in the event of withdrawal of the Insurer's official authorization (Article L. 326-12 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.

6.3.8. CESSATION OF BENEFITS

Your coverage comes 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 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.

- 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.

6.3.9. 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 fulfillment 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,

- processing timescales 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).

6.3.10. 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 6.2.1

Assistance services with respect to the health of the Insured member or an unborn child.)

6.3.11. 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:

- civil or foreign war, riots and civil unrest,
- voluntary participation by an Insured member in riots or strikes, brawls or unlawful acts,
- the consequences of nuclear disintegration or radiation from a source of radioactive energy,
- 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,
- the consequences of the use of medication, drugs, narcotics and similar products which are not medically prescribed and alcohol abuse,
- any intentional act on your part which may give rise to a claim under the plan.

WHAT ARE THE LIMITATION PERIODS?

In accordance with Article L.114-1 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 member against the insurer arises from a claim made by a third party, the limitation period shall run only from the day on which this third party brings a legal action against the insured member or has received compensation from him or her. "

In accordance with Article L.114-2 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 a loss. The limitation period can also be interrupted by a registered letter with proof of delivery sent by the insurer to the insured member regarding action for payment of the premium and from the insured member to the insurer regarding payment of the claim."

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 party against whom they were prescribing (Article 2240 of the French Civil Code), a legal claim (Articles 2241 to 2243 of the French Civil Code) or an act of enforcement (Articles 2244 to 2246 of the French Civil Code).

In accordance with Article L.114-3 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."

6.3.12. COMPLAINTS AND SUPERVISORY AUTHORITY

6.3.12.1. 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 Complaints Department at:

Europ Assistance
Service Réclamations Clients
1 promenade de la Bonnette
92633 Gennevilliers Cedex France

Service.qualité@europ-assistance.fr

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.

If the Insured member purchased their insurance plan through an intermediary and their request relates to their duty to

advise and inform or concerns the conditions under which their plan was marketed, their complaint must be addressed exclusively to this intermediary.

If the dispute persists after examination of their request by the Complaints Department, they may refer the matter to the Ombudsman by mail or internet:

La Médiation de l'Assurance
TSA 50110
75441 Paris Cedex 09 France
http://www.mediation-assurance.org/

The Insured member remains free to refer the matter to the competent court at any time.

6.3.12.2. SUPERVISORY AUTHORITY

The supervisory authority is the "Autorité de Contrôle Prudentiel et de Résolution – A.C.P.R." (French Prudential Supervision and Resolution Authority), 4 place de Budapest - CS 92459 - 75436 Paris Cedex 09, France.

6.3.13. PROTECTION OF PERSONAL DATA AND RIGHT TO OPT OUT OF TELEPHONE MARKETING

6.3.13.1. PROTECTION OF PERSONAL DATA

EUROP ASSISTANCE, a company governed by the French Insurance Code, with its registered office located at 1 Promenade de la Bonnette - 92633 Gennevilliers Cedex, France (hereinafter referred to as "the Insurer"), acting in its capacity as data controller, processes the Insured member's personal data for the following purposes:

- the management of requests for assistance and insurance;
- the organization of satisfaction surveys with insured members having benefited from assistance and insurance services;
- the production of trade statistics and actuarial studies;
- the assessment, acceptance, control and monitoring of the risk;
- the management of potential disputes and the implementation of legal provisions;
- the implementation of due diligence requirements as part of the prevention of money laundering and the financing of terrorism, financial sanctions, including the activation of alerts and the reporting of suspicious activities;
- the introduction of measures to combat insurance fraud;
- the management of the recording of telephone conversations with the Insurer's employees or those of its processors for the purposes of staff training and evaluation and quality control, as well as the management of potential disputes.

The Insured member is informed and accepts that their personal data will be processed for the abovementioned purposes. This processing is conducted in application of the plan.

The data collected are mandatory. If these data are not provided, the management of the Insured member's requests for assistance or insurance may be rendered more complex or even impossible.

In this regard, the Insured member is informed that the recipients of their personal data are the Insurer, as the data controller, and the Insurer's processors, subsidiaries and agents, as well as the providers selected to deliver assistance services to you (breakdown and ambulance services, airlines, taxis, etc., as applicable).

With a view to complying with legal and regulatory obligations, the Insurer may have to provide information to legally authorized administrative or judicial authorities.

The Insured member's personal data are stored for a duration that varies depending on the final purpose (2 months for telephone records), which may be extended by the mandatory storage durations for accounting purposes and the legal duration of the limitation period (10 years for data processed as part of a medical assistance case, and 5 years for other types of data).

The Insured member is informed and accepts that their personal data may be transferred to recipients located in third countries outside the European Union guaranteeing an equivalent level of protection. Transfers of data to these third countries are subject to:

- a cross-border flow agreement established in accordance with standard contractual clauses currently in force for data transfers from controllers to processors, as issued by the European Commission;
- contracts of adherence of the Insurer's entities to internal rules in compliance with recommendation 1/2007 of the Article 29 Working party on the standard application for approval of binding corporate rules for the transfer of personal data.

The Insured member may request a copy of these appropriate safeguards governing the transfers of data from any of the addresses indicated below.

The purpose of these flows is the management of requests for assistance or insurance. This applies to the following categories of data:

- data relating to identity (including: full name, gender, date of birth, phone number, and email address) and personal life (including: family status and number of children),
- location data,
- where applicable, health data, including the Social Security number and provided the data subject's consent has been obtained.

The Insured member, in their capacity as data subject, is informed that they benefit from a right of access, rectification, erasure and portability of their data, as well as the right to limit their processing. They also have the right to opt out of the use of their data.

The Insured member has the right to withdraw their consent at any time without affecting the lawfulness of the processing based on consent before said withdrawal. In addition, they have the right to set specific and general guidelines for the storage, erasure and disclosure of their data after their death.

The Insured member's rights may be exercised by sending a letter to the Data Protection Officer at one of the addresses below, with a photocopy of a signed identity document:

- by email: protectiondesdonnees@europ-assistance.fr, protectiondesdonnees@europ-assistance.fr,
- by mail: EUROP ASSISTANCE - A l'attention du Délégué à la protection des données - 1, promenade de la bonnette – 92633 Gennevilliers, France.

The Insured member is informed that they have the right to file a complaint with the French Data Protection Authority, Commission Nationale de l'Informatique et Libertés (CNIL).

The data protection agreement between ASFE and EUROP ASSISTANCE is attached as Appendix 2. It is effective as of May 25, 2018.

6.3.13.2. CONSUMERS' RIGHT TO OPT OUT OF TELEPHONE MARKETING

In accordance with the French Act 2014-344 of March 17, 2014, EUROP ASSISTANCE informs the Insured member that they may opt out of telephone marketing from professionals with whom they do not have a pre-existing contractual relationship by registering free of charge with the opt-out directory by mail or via internet:

SOCIETE OPPOSETEL - Service Bloctel - 6, rue Nicolas Siret - 10 000 TROYES, France
www.bloctel.gouv.fr

7. / GENERAL PROVISIONS - PERSONAL THIRD-PARTY LIABILITY BENEFITS

The personal third-party liability benefits described below are included as standard with your healthcare plan.
Policy no. FRCANA 19808 purchased by ASFE from CHUBB.
ACE has acquired Chubb, forming an insurance world leader operating under the prestigious Chubb brand. ACE European Group Limited, an insurance company governed by English law, with a capital of £544,741,144 and its registered office located at 100 Leadenhall Street, London, EC3A 3BP, registered under number 01112892 and whose French subsidiary is located at Le Colisée, 8 avenue de l'Arche, Courbevoie (92400), identification number 450 327 374 R.C.S. Nanterre. ACE European Group Limited is regulated by the Prudential Regulation Authority PRA (20 Moorgate, London EC2R 6DA, United Kingdom) and by the Financial Conduct Authority, FCA (25 The North Colonnade, Canary Wharf, London E14 5HS, United Kingdom).
This plan is governed by the French Insurance Code and by this information booklet serving as the General Terms & Conditions.

7.1. / DEFINITIONS

Claim: Filing of a liability claim, either by means of a letter sent to the Insured member or the Insurer, or by a summons to appear before a civil or administrative court. The same Loss may generate several Claims, either from the same victim or from several victims.

Country of origin: The country of origin is the Primary insured member's usual country of residence.

Deductible: Amount which the Insured member must pay towards each Claim. Coverage by the Insurer applies over and above this amount.

Insured event: Fact, act or event giving rise to the Loss, damage or injury suffered by the victim for which a Claim is made.

Insured member: The insured is the ASFE member declared as the Primary insured member on the application for coverage. These members will be referred to in this document as expatriates.
Family members who travel abroad with the expatriate, including their spouse and children, their domestic partner, the children of their domestic partner and any children who normally live in the household and who are dependent on the expatriate. This also includes children under the age of 26 who are not living at home but who are financially dependent on their parents, irrespective of the children's country of residence, particularly during their education.
Expatriates who are not insured under the same membership (who are not part of the same household) have third party status with respect to each other.
Insurer:
ACE European Group Limited
A Chubb Company
Le Colisée8 avenue de l'Arche
92419 Courbevoie Cedex

Loss: Any Loss, damage or injury or set of Losses, damages or injuries caused to Third Parties, incurring the liability of the Insured member, resulting from an Insured event and having given rise to one or more Claims.

Loss, damage or injury:

- Bodily injury: Any physical or mental harm suffered by an individual and the resulting damage to the victim or their dependents.
- Material damage: Any deterioration, destruction, alteration, loss or theft of an object or substance and any bodily injury to animals.
- Financial loss: Any Loss other than Bodily injury or Material damage.
- Consequential financial loss: Any Financial loss which is the direct consequence of Bodily injury or Material damage covered under this plan.

Policyholder: ASFE, Association of Services For Expatriates, a non-profit association governed by the French law of 1901 on behalf of its members.

Temporary stays in the country of origin: "Temporary stays in the country of origin" apply only to vacations, training courses and assignments occurring during a period of expatriation in a given country. Stays occurring between two periods of expatriation are not covered under the plan.

Third party: Any person other than the Insured member as defined above.

7.2. / COVERAGE

By means of this insurance plan, the Insurer covers the Insured member for damage and the financial consequences of the risks listed below.

7.2.1. COVERAGE

The financial consequences of Third Party Liability which may be incurred by the Insured member under any laws or regulations in force in the place of the loss are covered up to the amount shown under chapter 7.3/ Upper limits of coverage p.57
The financial consequences of the Insured member's liability as a tenant or occupier of a property where they are living free of charge are also covered:

- with respect to the owner for material damage affecting the occupied property,
- with respect to the owner for loss of rental of their premises and for the loss of use by the owner of the occupied premises,
- with respect to neighbors and third parties for material damage and consequential financial loss resulting from an insured event occurring in the property being rented or which has been entrusted to the Insured member including damage caused by other tenants and constituting interference of enjoyment.

The Tenant's Liability coverage supplements any insurance purchased locally or, in exceptional cases, if compulsory local insurance has not been purchased, and in all cases within the limits of the coverage provided under the plan.

The Insurer also agrees:

- to defend the Insured member before any court or commission, if the member is summoned to appear as a result of loss or damage covered under this plan,
- to make an out-of-court or legal claim for compensation for loss or damage suffered by the Insured member, if this

loss or damage is caused by a third party and results from material damage or a bodily injury which would have been covered under this plan if the Insured member's liability had been incurred.

Coverage includes fees and expenses incurred in respect of the investigation, trial, expertise, attorneys and court fees. If, due to the location in which the damage occurred, the Insurer cannot conduct the Insured member's defense or seek remedy, they agree to reimburse the Insured member's defense or remedy expenses within the limits specified under chapter p.57 of this plan.

7.2.2. EXCLUSIONS

The liability of the Insured member is excluded only:

- as a result of the exercise of their profession. However, this exclusion does not apply to the Insured member when they are using non-motorized land vehicles for the commute to and from work. Similarly, the liability of the Insured member's spouse is covered when participating in educational and/or sporting activities on a voluntary basis,
- as a result of the use of firearms during all hunting activities for which insurance is mandatory under local regulations,
- as a result of driving motorized land, air, river and sea vehicles (damage caused and/or suffered). However, this exclusion does not apply if the said vehicles are used without the knowledge of the expatriate or their spouse by persons for whom they are liable and if these vehicles do not belong to these persons nor to the expatriate or their spouse. The user's liability, even if they do not have a driver's license, is also covered if they are using a boat less than 8 meters in length, with or without an engine under 5 HP,
- as a result of their participation as a competitor in sporting competitions with legal insurance requirements,
- as a result of any property owned by the insured persons,
- as a result of damage caused by the insured persons when these persons are in the country of origin. Coverage applies during temporary stays,
- a result of damage intentionally caused or instigated by the Insured member or with their knowledge,
- as a result of the Insured member's active participation in brawls or fights, except in self-defense,
- as a result of the Insured member's domestic staff, unless the Insured member is pursued in their capacity as the liable principal,
- as a result of loss or damage caused to items entrusted to them.

7.3. / UPPER LIMITS OF COVERAGE

Coverage applies, per claim and per Insured member, up to the following amounts:

NATURE OF BENEFITS	UPPER LIMITS OF BENEFITS	DEDUCTIBLES
Bodily injury	€3,000,000/$3,000,000 per claim	€300/$300
Material damage	€1,500,000/$1,500,000 per claim	€300/$300
Consequential financial loss	€300,000/$300,000	€300/$300
Defense/Remedy (excluding expatriates in the USA)	€16,000/$16,000	Nil
Defense/Remedy (expatriates in the USA)	€30,000/$30,000	Nil

7.4. / GEOGRAPHICAL SCOPE

Coverage applies worldwide.

7.5. / EMBARGO CLAUSE

The Insurers are not deemed to be providing coverage and the Insurers will not be obliged to settle any claims or pay any resulting compensation if the provision of such coverage or the settlement of such claims or compensation exposes the Insurers or their parent companies or the ultimate controlling holding company to any sanctions, prohibitions or restrictions enforced under United Nations resolutions or under economic and commercial sanctions or the laws or regulations of the European Union, the United Kingdom, France or the United States of America.

7.6. / ACQUISITION AND DURATION OF COVERAGE

Coverage is acquired throughout the entire period of the Insured member's international mobility and during temporary stays in the country of origin or other countries where the Insured member may be staying in either a personal or professional capacity.

Coverage is acquired from the date on which the Insured member and their family members go abroad and, if they are traveling separately, from the day of each of their departures.

Coverage comes to an end 1 month following the Insured member's permanent return to the country of origin.

7.7. / APPLICATION OF COVERAGE

Coverage triggered by an insured event covers the Insured member against the financial consequences of the loss or damage, provided the insured event occurs between the initial effective date of coverage and its date of termination or expiration, regardless of the date of other constituent elements of the claim.

7.8. / MANAGEMENT AND PAYMENT OF CLAIMS

The Insured member must:

- report the loss in writing to MSH International as soon as they become aware of it and at the latest within five days,
- send MSH International, as soon as possible following the loss, a statement indicating the circumstances of the loss, its known or suspected causes and the nature and approximate amount of the damage,
- in the event of a loss incurring the Insured member's third party liability and if, as a result of the location in which the loss occurred, the Insurer cannot defend the Insured member, appoint a local lawyer and provide MSH International with their name and address,
- send MSH International, as soon as possible, copies of all letters and summonses and legal and procedural documents.

If any of these formalities are not completed due to the wrongful or negligent behavior of the Insured member, except in cases of force majeure, the Insurer will have the right to reduce the level of compensation in proportion to the damage which this delay may have caused them.

The Insurer will not be bound by an acknowledgment of liability or a settlement made without their involvement or consent. Acceptance of a material fact is not deemed to be an acknowledgment of liability.

For Losses or damage covered under Third Party Liability in this plan and within the limits which apply to this coverage, the Insurer may decide to take full charge of any legal proceedings brought against the Insured member and use any means of obtaining remedy.
The Insurer will cover costs and fees related to investigation and inquiry, expert testimony and legal representation as well as the cost of the defense and proceedings. These costs and fees will be deducted from the amount of the coverage.
By directing the Insured member's defense, the Insurer should not be considered to be relinquishing their right to make use of any exceptions to coverage of which they were unaware at the time of taking up the direction of the defense. In the event of criminal proceedings where civil compensation is or will be sought, at this or any other subsequent level of hearing, the Insured member agrees to involve the Insurer in their defense without this commitment affecting the scope of coverage under this plan.
Subject to forfeiture of their rights, the Insured member must not attempt to interfere in the direction of proceedings when the subject of the proceedings falls under Third Party Liability coverage in this plan.

7.9. / MISCELLANEOUS PROVISIONS

7.9.1. OTHER INSURANCE ARRANGEMENTS

If there any other insurance arrangements in place covering the same risks, this Policy will serve only to supplement the existing coverage, unless otherwise specified under the provisions of that coverage.

7.9.2. LIMITATION PERIOD

All legal actions arising from this policy are barred two years from the event that gave rise to them under the terms of articles L.114-1 and L.114-2 of the French Insurance Code.

7.9.3. APPLICABLE LEGISLATION AND JURISDICTION

This plan is governed by French Law. Any disputes arising from the application of this plan will fall within the jurisdiction of the French Courts.

7.9.4. TAX EXEMPTION

Under article 1000 of the French General Tax Code, the Insured member is exempt from the special insurance tax. However, by virtue of that article, the insurance plan can only be utilized by public deed or before any established Authority in the country of origin if a visa has been obtained and the corresponding stamp duty has been paid.
Accordingly, the Insured member agrees to pay the insurance tax, where applicable following the issue of a reminder, at any time whatsoever, either in the case specified in the above paragraph or if the Registration Services consider that, for any reason, this plan does not qualify for exemption. For expatriates in France who are not entitled to exemption from insurance taxes under article 1000 of the General Tax Code, the corresponding taxes must be paid by the policyholder.

7.10. / APPENDIX: CRIMINAL DEFENSE AND REMEDY

The benefit described below applies only if it is specified in the Schedule. This benefit is implemented by: GIE CIVIS, 90, avenue de Flandre, 75019 Paris, telephone +33 (0)1.53.26.25.25, who has been mandated by ACE European Group Ltd, a Chubb Company, to deliver the insured services.

7.10.1. PURPOSE OF THE BENEFIT

The purpose of this benefit is to provide the Insured member with the legal and financial means required:

❶ to seek an out-of-court settlement, and if necessary by legal proceedings, in respect of financial compensation for Damage suffered by the Insured member, subject to three conditions:
- that the Damage is covered and incurs the liability of an individual or a company that is not insured under this plan,
- that this Damage occurred in circumstances where Third Party Liability coverage under this plan would have been granted to the Insured member if they had caused the damage to a Third Party,
- that this Damage is of an amount equal to or greater than the coverage threshold specified in the Schedule.

❷ to defend the Insured member before the law courts and administrative commissions if they are prosecuted for a felony or misdemeanor following an event covered by the Third Party Liability benefit under this plan.

7.10.2. INSURED SERVICES

The Insurer agrees, subject to the implementation conditions listed under paragraph "Implementation of the coverage":

❶ to provide the Insured member with all the required information on the extent of their rights and how to assert these rights, and to implement any interventions, procedures and legal means to resolve the dispute*;

❷ to instruct the lawyer appointed by the Insured member and, if no lawyer has been appointed, to provide them with one:
- where it is necessary to defend, represent or serve the Insured member's interests before a court or commission,
- in the event of a conflict of interest, meaning if GIE CIVIS must simultaneously defend interests related to those of the Insured member's adversary.

❸ to cover the fees of the legal officers (lawyers, correspondents, bailiffs, experts) and any other necessary expenses, insofar as these expenses and fees are payable by the Insured member, to assert their rights and have them enforced within the limits specified in the Schedule.

The following are not covered:
- fines and penalties of any kind which the Insured member must ultimately pay or reimburse to the opposing party,
- investigations to identify or locate the adversary,
- contingency fees.

7.10.3. GEOGRAPHICAL SCOPE OF THE COVERAGE
Coverage applies Worldwide.

7.10.4. IMPLEMENTATION OF THE COVERAGE

7.10.4.1. DECLARATION
Any event likely to give rise to a claim under this coverage must be declared in writing to GIE CIVIS.

IMPORTANT

Under penalty of forfeiture and without prejudice to the provisions of paragraph “Prior agreement to cover costs” below, the Insured member must, other than in unforeseeable circumstances or in cases of force majeure, make this declaration before appointing a lawyer or taking any legal action.

7.10.4.2. PREPARATION OF THE CASE
The Insured member must pass on, at the time of making the declaration and subsequently, and as soon as they become available, any documents, information and evidence relating to the dispute which would assist with the verification of entitlement to benefits, the investigation of the case and the search for a solution. In particular, the Insured member must provide all information which will help identify and locate the opposing party and quantify and support their Claim, as well as any information regarding any other insurance to which they may be entitled in connection with the declared events.

IMPORTANT

The Insured member will lose their entitlement to any right to benefits and will be obliged to reimburse costs already incurred if they knowingly make inaccurate statements (even if only by concealing certain documents or information) regarding the nature, causes or consequences of the dispute or any information regarding the search for a solution.

7.10.4.3. PRIOR AGREEMENT TO COVER COSTS
The management of the case, the appointment of legal officers and the action to be taken is decided by mutual agreement between the Insured member and GIE CIVIS.
In the event of a disagreement, the Insured member may request the implementation of the arbitration procedure but may also, after informing GIE CIVIS in writing, bring the action themselves. If the Insured member obtains a more favorable final solution, GIE CIVIS will reimburse, subject to the provision of supporting documents and within the coverage limits, the expenses they would have incurred and which will not be charged to the opposing party.

IMPORTANT

Other than in this particular case, any initiatives which the Insured member may take without the prior approval of GIE CIVIS will remain payable by the member unless they constitute genuinely urgent interim measures in respect of which the Insured member has been unable to reach GIE CIVIS, even by telephone, and insofar as these measures prove to be appropriate.

7.10.4.4. SELECTING AND APPOINTING A LAWYER
Where it is necessary to appoint a lawyer, the Insured member has the right to choose this lawyer (i.e. provide their details to GIE CIVIS).
If the Insured member chooses their own lawyer, they must never appoint them directly, but entrust this responsibility to GIE CIVIS. The amount of coverage provided by the Insurer is assessed by mutual agreement between GIE CIVIS and the Insured member or, failing that, depending on the nature and complexities of the case.
The Insurer will not cover any additional costs incurred as a result of the intervention of a lawyer who has no local jurisdiction (travel expenses, representation fees, etc.).
Where the coverage provided by the Insurer is less than the lawyer’s fees or the estimated amount of these fees, the Insured member may either appoint another lawyer or continue with their first choice and cover any additional costs themselves.

7.10.4.5. SETTLEMENTS AND SUBROGATION
GIE CIVIS will directly settle any covered fees and expenses without the Insured member having to make an advance payment, unless the Insured member recovers the value added tax, in which case GIE CIVIS will reimburse them, on production of supporting documents, the amount of these expenses and fees excluding VAT.
GIE CIVIS will refund to the Insured member the amounts and indemnities obtained on behalf of the insured member within thirty days of the date on which they themselves received these amounts and indemnities.
For their part, the Insured member is responsible for any deposits, bonds or payments which may be required in order to cover costs which are not insured under the plan.
The Insurer is subrogated to the rights and actions of the Insured member against Third Parties in accordance with Article L.121-12 of the French Insurance Code and up to the amounts paid by the Insurer.
The Insured member agrees to preserve these rights and, if necessary, to pay back to the Insurer any sums which have been directly received in this respect, in particular those obtained under Article 700 of the French Civil Procedure Code or any other equivalent texts.

7.10.5. RESOLUTION OF CONFLICTS ARISING BETWEEN GIE CIVIS AND THE INSURED MEMBER
At the Insured member’s request, any disagreements between GIE CIVIS and the Insured member regarding the implementation of this benefit will be submitted by joint application to the President of the court (Tribunal d’Instance) in the Insured member’s home district, with this magistrate ruling as an arbitrator.
This joint application is covered by the Insurer and does not prevent the Insured member from seeking any other legal remedies at their own expense.

7.11. / THE INSURANCE CONTRACT

7.11.1. FORMATION OF THE INSURANCE CONTRACT
The insurance contract is formed on agreement by the parties. It is signed by them and is evidence of their mutual commitment.
Coverage is acquired from the effective date shown in the Schedule.

7.11.2. DURATION OF THE CONTRACT

Unless otherwise agreed, the contract is concluded for a period of one year. When it expires, it is automatically renewed from year to year, unless terminated by one or other of the parties, in accordance with one of the conditions set out below, at least two months before the premium's annual due date. This period runs from the date shown on the postmark.
While the contract is in force, the parties may terminate it in the cases set out under article "Termination".

7.11.3. TERMINATION

7.11.3.1. CASES OF TERMINATION

The contract may be terminated:

1. By the Policyholder or the Insurer:
   - Each year, on the main due date of the annual premium, with at least two months' notice.
2. By the Insurer:
   - If the premium is not paid (article L.113-3 of the French Insurance Code),
   - If the risk is aggravated (article L.113-4 of the French Insurance Code),
   - In cases of omission or inaccuracy in spontaneous responses or statements made to the Insurer when the insurance was purchased, or in cases of omission or inaccuracy in the reporting of new circumstances while the contract is in force (Article L.113-9 of the French Insurance Code),
   - Following a Claim, with the Policyholder then having the right to terminate the other plans purchased by them from the Insurer (Article R.113-10 of the French Insurance Code).
3. By the Policyholder:
   - If there is a reduction in the risks covered under the policy and if the Insurer refuses to reduce the premium as a result (article L.113-4 of the French Insurance Code),
   - If the Insurer terminates another of the Policyholder's plans following a Claim (article R.113-10 of the French Insurance Code),
   - If the premium is increased,
   - If their company ceases trading or is dissolved.
4. Automatically:
   - In the event of the total withdrawal of the Insurer's official authorization (article L.326-12 of the French Insurance Code).

7.11.3.2. TERMINATING THE INSURANCE CONTRACT

If the Policyholder has the option of terminating the contract, they may do so either by registered letter, or by a statement for which a receipt is obtained at the Insurer's head office or from the Insurer's local representative, or by means of an extrajudicial document.
Termination by the Insurer must be notified to the Policyholder by registered letter sent to their last known home address. If a registered letter is sent, any termination notice period (except in the case of 7.11.3.1 "By the Insurer", first bullet point) will run from the date shown on the postmark.
In case of termination during an Insurance year, the portion of the premium for the remaining period is refunded to the Insured member if it is collected in advance. However, if the insurance contract is terminated by the Insurer for non-payment of the premium, the Insurer is entitled to a termination indemnity equal to the portion of the annual premium for the period after the effective date of termination.

7.12. / OBLIGATIONS OF THE INSURED MEMBER

7.12.1. AT THE TIME OF PURCHASING THE INSURANCE

7.12.1.1. REPORT THE RISK

The insurance contract is established on the basis of the responses provided by the Insured member to the questions put to them by the Insurer with the premium being set accordingly.
The Insured member must therefore give accurate responses to the questions put to them by the Insurer in accordance with Article L.113-2 of the French Insurance Code.

7.12.1.2. DECLARE OTHER INSURANCE COVERAGE

If the risks covered under this plan are covered by another insurance policy, the Policyholder must declare this to the Insurer (Article L.121-4 of the French Insurance Code).
Repercussions of non-disclosure or inaccurate reporting:
Any intentional non-disclosure or misrepresentation on the part of the Policyholder or the Insured member in the responses made to the Insurer will render the contract null and void under the conditions provided for in Article L.113-8 of the French Insurance Code with due premiums being payable to the Insurer by way of Damages.
Any omission or inaccurate reporting in the responses provided to the Insurer by the Policyholder or the Insured member, the bad faith of which has not been established, entitles the Insurer:

- If it is discovered before any Claims have been made, either to uphold the plan subject to a premium increase being accepted by the Policyholder, or to terminate the plan within the timescales and under the terms of article L.113-9 of the French Insurance Code;
- If it is only discovered once a Claim has been made, to reduce the compensation in proportion to the premium rates paid against the premium rates which would have been due if the risks had been fully and accurately reported.

7.12.2. DURING THE LIFE OF THE PLAN

7.12.2.1. PAY THE PREMIUM

The Policyholder agrees to pay the premiums to the Insurer and, where applicable, any incidental expenses, the amount of which is specified in the Schedule, as well as the taxes and duties in force.
These amounts are payable at the Insurer's head office, unless the General Conditions specify that they can be paid elsewhere.
Payment of the premiums is made according to the following provisions as chosen by the parties:

- fixed premium: the premium is payable in advance on the due date specified in the General Conditions,
- adjustable premium: a minimum premium amount is payable annually and in advance on the date specified in the

General Conditions with the balance being paid at the end of the Insurance Year by applying the agreed premium rate.

Calculation and payment of the adjustable premium
For the purposes of calculating the adjustable premium, the Policyholder agrees to:

- Send the information listed in the Schedule for the calculation of the premium in respect of all activities which were declared and which are covered under this plan. This information must be sent within three months of the end of each Insurance Year,
- Pay the resulting additional premium, if any, on request.

The Policyholder agrees to make available to the Insurer's representatives, on request from them, during the life of the plan and for two years following its expiration, all supporting documents which they deem to be useful. The issuing and payment of the premiums does not free the Policyholder from this obligation.
If the Policyholder fails to provide the information specified in the General Conditions within the agreed timescales, the Insurer may send a registered letter of formal notice to the Policyholder to comply with this obligation within ten days of receipt of the letter of formal notice. If, after this period, the information has not been sent, the Insurer may issue a demand for an interim payment corresponding to one and a half times the amount of the last premium. This action alone cannot give rise to an increase in the final premium amount due. If this interim payment is not made, the Insurer may suspend coverage followed by termination of the plan, or take legal action under the conditions provided for in Article L.113-3 of the French Insurance Code.
Once the Insurer has received the information, they will calculate the outstanding amounts which will be paid by the Policyholder. If there are any errors or omissions in the information provided, the Policyholder will pay, in addition to the amount of the premium, an indemnity equal to 50% of the premium in respect of the omitted information.
If the errors or omissions by their nature, importance or repetition, are of a fraudulent nature, the Insurer will be entitled to claim back any payments already made, regardless of the indemnity specified above (Article L.113-10 of the French Insurance Code).

Non-payment of the premium
If the premium or a portion of the premium is not paid within ten days of its due date, the Insurer, irrespective of their right to enforce the contract by legal means, may send a registered letter of formal notice to the Policyholder or the person responsible for payment of the premiums at their last known home address, and suspend coverage thirty days after this letter has been sent.
Suspension of the coverage means the Insurer is released from any commitment to the Insured member in the event of a Loss occurring during this period of suspension; it does not free the Policyholder from the obligation to pay any premiums which are due.
The Insurer has the right to terminate the plan ten days after the expiration of the above-mentioned thirty-day period; in this case the portion of the premium for the remaining period is due to the Insurer.
If the annual premium is payable in several installments, the non-payment of one installment of the premium on its due date will result in all outstanding installments of the premium for the current Insurance year becoming payable.

7.12.2.2. REPORT ANY CHANGES TO THE RISK

The Policyholder must report to the Insurer, by registered letter and within a period of fifteen days from the time they become aware of it, new circumstances which either aggravate the risks or create new ones, thereby rendering inaccurate or obsolete the responses provided to the Insurer during the initial risk reporting phase.
The Insurer may withdraw the Insured member's coverage as a result of late reporting, other than in unforeseeable circumstances or cases of force majeure, if they can prove that the delay has been prejudicial to them.
If this change in circumstances constitutes an aggravation of the risk such that, if the new state of affairs had existed at the time of purchase of the plan or its renewal, the Insurer would not have entered into the contract or would only have done so with a higher premium, the new circumstances must be reported, subject to the penalties provided for in Articles L.113-8 and L.113-9 of the French Insurance Code, and the Insurer may, under the terms of Article L.113-4 of the French Insurance Code, either terminate the plan by registered letter with ten days' notice, or propose a new premium rate. If the Policyholder does not accept the new premium rate, the Insurer may terminate the plan.

8. / GENERAL PROVISIONS OF LEGAL ASSISTANCE BENEFITS

The legal assistance benefits are included as standard with your healthcare plan.
Policy no. 08152901Z purchased by ASFE from AREAS CIVIS.

8.1. / LEGAL EXPENSES INSURANCE FOR EXPATRIATES AND IMPATRIATES

8.1.1. 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.

IMPORTANT

This service is available 24/7:
By telephone:
- From France: 0825 814 000 (N°INDIGO, €0.15 inc. tax/min, rate as at 01/01/2017)
- From abroad: international country code +331 40 05 52 15

Via internet: **http://www.civis.fr.** You can contact a legal expert by chat through a Web Call Center.

8.1.2. LEGAL EXPENSES INSURANCE

8.1.2.1. PURPOSE OF YOUR COVERAGE

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.

8.1.2.2. 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, condominium, 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.

8.1.2.3. EVENTS THAT ARE NOT COVERED

- If the prejudicial event or reprehensible action causing the litigation is brought to your attention before your enrollment in the plan purchased 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,
    - the protection of your patents, intellectual property or copyright,
    - 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.

8.1.2.4. IN THE EVENT OF LITIGATION

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

8.1.2.5. DECLARATION OF YOUR LITIGATION

As soon as you are made aware of a litigation 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, coverage may be forfeited.

8.1.2.6. 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/$550 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	-Any fines and amounts that you have to pay or reimburse to a third party (or third parties) -Expenses and costs incurred by the third party (or third parties) and to be borne by you -Attorney fees based on performance -Expenses and actions made necessary or more serious due to an action on your part -Investigations to identify or locate the third party (or third parties) -Expenses incurred without our approval
Assistance during the out-of-court phase (if the third party is assisted by an attorney)	€450/$550	
Administrative commission, District judge (Juge de proximité) (for criminal matters), Police Court (1st to 4th category) Criminal mediation, Police Court (5th category), Correctional Court, Summary Proceedings	€450/$550	
Institution of civil action proceedings	€380/$475	
Liquidation of civil interests	€460/$575	
Other procedures	€450/$550	
Assistance for appraisal, investigation measures	€245/$305	
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	€800/$1,000	
Administrative court		
Board in Industrial Disputes (Conseil de Prud'hommes)		
- Conciliation	€305/$380	
- Judgment Board	€580/$725	
- Deciding judge	€380/$475	
Appeal Court (Cour d'Appel)		
- Defense (criminal matters)	€580/$725	
- Other	€800/$1,000	
Highest Court of Appeal (Cour de Cassation), Council of State (Conseil d'État)		
- appeal for defense	€1,500/$1,900	
- appeal for a petition	€2,000/$2,500	
- Criminal Court (Cour d'Assises)	€1,525/$1,900	
Settlement in the judicial phase:		
- without drafting of minutes	50% of the maximum amount set for the jurisdiction in question	
- with drafting of minutes	100% of the maximum amount set for the jurisdiction in question	
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)). However, they do not include judicial officers' fees or, where applicable, fees incurred for representatives before the Commercial Court. 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. 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.		

8.1.2.7. 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 paragraph IN THE EVENT OF LITIGATION, you can either:

- launch the litigation procedure that we 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).
- 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 by mutual agreement 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.

8.1.3. 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.

8.1.4. DEFINITIONS

Conflicts of interest: When we must defend your interests and those of the third party(ies) simultaneously.

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.

Forfeit: Loss of the right to coverage.

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.

Legally inadmissible: Indefensible character of your position or of your litigation with regard to legislation and case law currently in force.

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.

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 taken legal action.

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).

Us: GIE CIVIS economic interest group acting on behalf of the insurer.
GIE CIVIS 90 avenue de Flandre 75019 PARIS Tel: +33 (0)1.53.26.25.25 - Fax: +33 (0)1.53.26.36.34

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.

8.2. / SERVICES AND ASSISTANCE FOR EXPATRIATES AND IMPATRIATES

In the event of the loss or theft of, or technical damage to means of payment:

❶ 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.

❷ 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.

❸ 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:

❹ Delivery of the following items by international courier in order to meet set timescales: (Chronopost / UPS / Federal Express / Jet Service / official GIE CIVIS courier):

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

Under this benefit, we undertake to send you those via all means available if these are essential and cannot be delivered via

the benefits purchased as part of your assistance plans.

❺ 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 via 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.

❻ 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/$1,000.

❼ 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.

❽ 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): 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, aluminum) – 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 TURNAROUND 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.

8.3. / Complaints procedure

In the event of a complaint 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 France.

If your complaint 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.

9. /MEDICAL ASSISTANCE AND REPATRIATION OPTION – GENERAL PROVISIONS OF BENEFITS

Assistance plan no. 58.662.558 (General Terms and Conditions / Agreement no.: 346) purchased by ASFE from EUROP ASSISTANCE.

These General Provisions relating to optional medical assistance and repatriation benefits 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 ASFE, the Policyholder of this plan.

Insurance contract agreed between:

EUROP ASSISTANCE
A French limited company ("Société Anonyme") with a capital of €46,926,941, registered with the Nanterre Trade and Companies Register under number 451 366 405, a company governed by the French Insurance Code whose registered office is located at 1 Promenade de la Bonnette - 92230 GENNEVILLIERS, France.

Hereinafter referred to as "**EUROP ASSISTANCE**" or "**the Assistance provider**"

AND

ASSOCIATION OF SERVICES FOR EXPATRIATES (ASFE)
governed by the French law of 1901 on associations,
Season, 39 rue Mstislav Rostropovitch
75815 Paris cedex 17, France

Hereinafter referred to as **"the Policyholder"** or **"ASFE"**

Through the intermediary of:

MSH
A French simplified joint stock company ("Société par actions simplifiée") with a capital of €2,500,000,
a French insurance broker registered with the Paris Trade and Companies Register under number 352 807 549 and with ORIAS under number 07 002 751, intra-Community VAT identification number FR 78 352 807
whose registered office is located at Season, 39 rue Mstislav Rostropovitch
75815 Paris cedex 17, France

Hereinafter referred to as "**the Broker**" or "**the Administrator**".

IMPORTANT

If you need medical assistance/repatriation services, please contact immediately Europ Assistance, 24/24, to obtain prior approval, before taking any action or making any payment:

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

And provide:

- Your first and last names.
- The name of your plan: ASFE.
- The telephone number you are calling from or where you can be reached.
- The name, location and telephone number of the healthcare facility where you are receiving care and the name of the local doctor.

9.1. / Some helpful tips…

9.1.1. BEFORE YOUR LEAVE

❶ Check that your plan covers you in the country you are traveling to and for the entire duration of your trip.

❷ Make sure you have the right forms for the duration and nature of your trip as well as the country you are traveling to (there is specific legislation for the European Economic Area). These different forms are issued by your public health insurance provider (Caisse d'Assurance Maladie) so that this organization can settle you medical expenses directly in the event of illness or accident.

❸ To benefit from the "Advance of hospital charges" services, you will need to provide our teams with a certificate from your medical expenses insurance provider.

❹ If you are on medication, don't forget to take it with you and check if any conditions apply to carrying this type of medicine depending on your means of transport and your destination.

❺ As we are unable to replace local emergency services, we recommend, particularly if you are involved in a high-risk physical or motor activity, or if you are traveling in a remote area, that you first ensure emergency services are provided by the

competent authorities in the relevant country to respond to any requests for assistance.

❻ If your keys are lost or stolen, it may be useful to know their numbers. Take the precaution of making a note of these codes.

❼ Similarly, if your ID documents or means of payment are lost or stolen it will be easier to replace them if you have made photocopies and noted down your passport, ID card and bank card numbers and kept them separate.

9.1.2. DURING YOUR TIME ABROAD

If you become ill or are injured, get in touch with us as soon as possible. However, we are unable to replace local emergency services (ambulance, fire service, etc.) who should be contacted in the first instance.

IMPORTANT

Some illnesses may be outside the scope of the plan. We recommend reading the plan General Provisions carefully.

Your ASFE ASSISTANCE plan is made up of the following 2 parts:

- these General Provisions: they are intended to define the terms and conditions of implementation of the assistance services and insurance coverage and their exclusions, with respect to the beneficiaries of the ASFE ASSISTANCE plan purchased on their behalf by the Policyholder,
- the Schedule: this document contains the statements made by the Policyholder, the benefits and the zones selected and the amounts of benefits applicable to the Insured members.

For further details, contact the Policyholder who is responsible for providing you with this information. In order to be implemented, the services and benefits described below must have been purchased and listed in the Schedule.

9.2. / GENERAL

9.2.1. PURPOSE OF THE PLAN

The purpose of these General Provisions of the insurance and assistance plan, ASFE EXPAT ASSISTANCE, contracted between EUROP ASSISTANCE, a company governed by the French Insurance Code, and the ASFE (ASSOCIATION OF SERVICES FOR EXPATRIATES), is to provide Insured members who meet the conditions of coverage with the assistance services and/or insurance coverage purchased on their behalf by the Policyholder of this plan.

9.2.2. DEFINITIONS

9.2.2.1. DEFINITIONS COMMON TO ALL ASSISTANCE SERVICES AND INSURANCE COVERAGE

For the purposes of this plan, the following definitions apply:

Abroad: The term “Abroad” means any country outside your Home country.

Accident (personal): A sudden and fortuitous event affecting the Insured member, not intended by them and resulting from sudden action with an external cause.

Assault: Any physical injury not intended by the insured person, resulting from a deliberate, sudden and violent action on the part of another person or group of persons.

Attack: Any act of violence constituting a criminal or illegal action committed against persons and/or property in the country in which you are traveling and with the aim of seriously disrupting public order by means of intimidation and terror and which has received media coverage.
The Attack must be identified as such by the French Ministry of Foreign and European Affairs.

Country of origin: Your Country of origin is your country of citizenship as shown on your ID document, or the usual country of residence prior to the Beneficiary going abroad as specified on the certificate of enrollment in this plan and for which the Beneficiary holds a passport.

Country of residence: The Country of residence is the country of expatriation where you have your main and usual residence.

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 Insurer/ 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, his or her father and mother, a brother or sister and one of his or her parents-in-law.

France: The term “France” means mainland France and the Principality of Monaco.

Home: Home is your main and usual place of residence specified as your home on your income tax assessment notice before your date of departure abroad. 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 or dependent (you): ASFE members who have purchased the “Medical repatriation assistance” option. In this plan, Insured members are also referred to as “you”.

Insurer/Assistance provider: In this plan, the company Europ Assistance is referred to as "We" or "Us". The insurance coverage and assistance services are provided and implemented by Europ Assistance, a company governed 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" in Nanterre under number 451 366 405. Its registered office is located at 1 Promenade de la Bonnette - 92230 GENNEVILLIERS, France.

Loss or damage to the Place of residence: Fire, burglary or water damage occurring in your absence at your Place of residence while you are on a Trip, and supported by the documents specified for the benefit "EARLY RETURN IN THE EVENT OF LOSS OR DAMAGE TO YOUR PLACE OF RESIDENCE DURING A TRIP".

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 residence is deemed to be your Place of residence.

Policyholder: The Policyholder is the ASFE on behalf of its Insured members covered under this Plan.

Trip: All of your trips, both in and outside your Country of expatriation, which do not exceed 12 consecutive months.

9.2.2.2. DEFINITIONS SPECIFIC TO THE INSURANCE COVERAGE

Bodily injury: Any physical harm (trauma, death) suffered unintentionally by an individual.

Consequential financial loss: Any financial loss resulting from the deprivation of enjoyment of a right, interruption of a service rendered by a person or property or loss of a benefit which is caused by a bodily injury or material damage covered under the present policy.

Cumulative event: A single insured event with the same original cause (same place and date) giving rise to multiple claims from Insured members of the same Policyholder.

Dilapidation: Depreciation of the value of goods caused by time on the day of the Loss.

Loss: A Loss is any unforeseeable event triggering coverage of an Insured member under this plan.

Material damage: Any accidental deterioration or destruction of goods or property.

Serious accident: A sudden and fortuitous event affecting any individual, not intended by them and resulting from sudden action with an external cause and preventing them from traveling by their own means.

Wear and tear: Depreciation of the value of goods through usage or maintenance conditions on the day of the Loss.

9.2.3. WHAT TYPES OF TRIP ARE COVERED UNDER THE PLAN?

The assistance services and insurance coverage provided under the plan apply to all stays Abroad on a business or personal trip, for a minimum period of 6 months, automatically renewed, during the Beneficiary's period of coverage.
The Policyholder is responsible for ensuring that Insured members meet the conditions of membership set out in these General Provisions.

9.2.4. GEOGRAPHICAL COVERAGE OF THE PLAN

9.2.4.1. TERRITORIAL COVERAGE

THE ASSISTANCE SERVICES AND THE INSURANCE COVERAGE DESCRIBED IN CHAPTER 10 BELOW APPLY WORLDWIDE, WITH THE EXCEPTION OF THE EXCLUSIONS SET OUT IN THESE PROVISIONS.

9.2.4.2. TERRITORIAL EXCLUSIONS

EXCLUSIONS: Countries in a state of civil or foreign war, or manifest political instability, or affected by natural disasters, popular movements, riots, acts of terrorism, reprisals, restrictions on the free movement of persons and goods (for any reason, including health, security, weather, etc.), or decay of the atomic nucleus, or any radioactive irradiation from an energy source.

9.2.5. INTERNATIONAL SANCTIONS

EUROP ASSISTANCE will not provide any coverage or benefits and will not provide any service described in this document if this could expose them to any international sanctions, prohibitions or restrictions as defined by the United Nations, or the European Union, or the United States of America. Further information is available at https://www.europ-assistance.com/en/who-we-are/international-regulatory-information (in English) or https://www.europ-assistance.com/fr/nous-connaitre/informations-reglementaires-internationale (in French).

As such, and cumulatively with any other territorial exclusions defined in this document, benefits are not provided in the following countries and territories: North Korea, Syria, Crimea, Iran and Venezuela.

For U.S. citizens traveling to Cuba, the implementation of assistance services or payment of benefits is conditional on the provision of proof that the trip to Cuba complies with the laws of the United States. U.S. nationals are deemed to include any person, wherever they are located, who is a U.S. citizen or who usually resides in the United States (including Green Card holders) and any joint stock company, partnership, association or other organization, whether incorporated or conducting business in the United States that is owned or controlled by such persons.

9.2.6. CONDITIONS OF COVERAGE

We will use every possible and necessary means to assist you wherever you are in the zone specified in the Schedule 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, 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.

9.2.7. USING THE SERVICES OF EUROP ASSISTANCE? (WHEN THE OPTION HAS BEEN PURCHASED)

9.2.7.1. 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:

❶ We recommend you prepare your call.

❷ We will ask you for the following information:

- your full name,
- your precise location and the address and telephone number where you can be reached,
- your plan number.

❸ You must:

- call us (in France) without delay on: 01 41 85 84 46 (from abroad call +33 1 41 85 84 46),
- email: ASFE@EA-GCS.COM,
- 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.

9.2.7.2. WHAT ARE THE CONDITIONS OF IMPLEMENTATION OF THE ASSISTANCE SERVICES AND THE INSURANCE COVERAGE?

We reserve the right to request any documentation required in support of requests for assistance or insurance (death certificate, proof of family relationship, proof of family members' age, proof of Home address or Place of residence, proof of expenses or a 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).
For the / PRIOR APPROVAL PROCEDURE FOR THE "ADVANCED OF HOSPITAL CHARGES" SERVICE WIHTH ASSISTANCE, chapter 9.7 p. 80, certain documents and certificates must be provided before any advance is made.
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, day hospitalization or outpatient hospitalization in the 6 months preceding the request for assistance. This applies equally to the manifestation and 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 charged to the Policyholder and will be payable on receipt of invoice. The Policyholder may, if they wish, recover the amount from the party who requested the assistance if this party is not the Insured member.

9.2.7.3. MAKING A CLAIM UNDER THE INSURANCE COVERAGE

You, or any person acting on your behalf, must make the claim within 2 working days from the time you become aware of the Loss in cases of theft, and within 5 days in all other cases. Claims should be sent to:

EUROP ASSISTANCE
Service Indemnisations
1, promenade de la Bonnette 92633 Gennevilliers cedex, France
Fax: 01 41 85 85 61 / E-mail: **slv@europ-assistance.fr**
Or submitted online via our website: **https ://sinistre.europ-assistance.fr/**

9.2.7.4. 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 L. 121-4) as soon as you become aware of this information and at the latest when making the claim.

9.2.7.5. MISREPRESENTATION

When it changes the subject of the risk or decreases our assessment of that risk:

- any concealment or intentional misrepresentation on the part of the Policyholder or on your part, 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 claim payment of all due premiums in accordance with the French Insurance code, article L. 113-8,
- any omission or inaccurate statements on the part of the Policyholder or on your part, the bad faith of which has not been established, will result in termination of the plan 10 days after you have been notified by registered mail and/or application of the reduction in compensation specified in the French Insurance Code, article L. 113-9.

9.2.7.6. FORFEITURE OF SERVICES AND COVERAGE DUE TO FRAUDULENT STATEMENTS

In the event of a Loss or a request for the provision of assistance services and/or insurance coverage (as specified 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 statements, you will forfeit any right to the assistance services and insurance coverage provided for in these General Provisions, for which these statements are required.

9.2.8. WHAT TO DO WITH YOUR TRAVEL TICKETS?

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

9.3. / SCHEDULE OF ASSISTANCE BENEFITS AVAILABLE AS AN OPTION

ASSISTANCE SERVICES	MAXIMUM AMOUNTS PER PERSON (INCLUDING TAXES) FOR THE ENTIRE DURATION OF THE PLAN
PERSONAL ASSISTANCE IN THE EVENT OF ILLNESS OR INJURY	
- Medical information and emergency recommendations (hospitals, clinics, etc.)	Information
- Medical liaison	Liaising with the local doctor
- Extension of Stay of the Insured member or an insured companion	Hotel €150/$190 per night (max. €1,500/$1,900)
- Return of an insured companion	Return ticket
OR	
- Hospital visit	Round-trip ticket + €150/$190 per night (max €1,500/$1,900)
- Accompanying children under the age of 18:	
· Organization and coverage of the trip for a family member or a hostess	Round-trip ticket
· Accommodation	Hotel €150/$190 per night (max 2 nights)
- Return to the Place of residence (within two months of repatriation)	Return ticket
- Early return in the event of Hospitalization of a family member	Round-trip ticket (max 1 per year/Insured member)
- Second medical opinion	Assistance with organization
- Psychological support in case of Accident, Assault or attempted assault, death of a family member, Attack or Natural Disaster	3 telephone conversations
ASSISTANCE ON RETURNING HOME FOLLOWING REPATRIATION (France only)	
- Childcare	Round-trip tickets
- Home help	10 hours
- Care of pets (dogs/cats)	Transportation + boarding €155/$195
- Hospital comforts: television rental	€80/$100
ADVANCE OF HOSPITAL CHARGES	Within the limits of the healthcare plan provided by the ASFE
ASSISTANCE IN THE EVENT OF DEATH	
- Transportation of the body	Actual costs
- Cost of a coffin or urn	€2,000/$2,500
- Identification of the body and death formalities	2 round-trip tickets and hotel €150/$190 per night per person (max 2 nights)
- Early return in the event of a family member's death	Round-trip ticket
- Return of an insured companion	Return ticket
TRAVEL ASSISTANCE	
- Early return in the event of Loss or damage to your Place of residence	Return ticket
- Early return or transportation to a secure zone in the event of an Attack	Return ticket or round-trip ticket to/from a secure zone
- Early return or transportation to a secure zone in the event of a Natural disaster	Return ticket or round-trip ticket to/from a secure zone
- Transmission of urgent messages	
- Delivery of medication	Delivery charges
- Assistance in the event of the theft, loss or destruction of identity documents or means of payment:	
· Information on formalities	Information
· Advance of funds	€2,300/$2,880
· Accommodation	€150/$190 per night (max €1,500/$1,900)
- Health information	Information
- Travel information	Information
- Assistance with unplanned changes to travel plans	Organization
- Mountain, sea and desert search and rescue costs	
- Access to "123 Classez", the Europ Assistance data vaulting service	€15,000/$18,750
AGGREGATE LIMIT ON ASSISTANCE SERVICES IN THE EVENT OF ATTACKS OR ACTS OF TERRORISM	€700,000/$875,000 per event for all Insured members
LUGGAGE AND PERSONAL EFFECTS	
- Theft or total or partial destruction or loss during transportation by a carrier	€2,000/$2,500
- Limits for certain items (see General Provisions)	50% of the benefit amount
- *Deductible for damage to suitcases*	*€25/$32 per Claim*

- Deductible applicable to laptop computers	*10%*
- Compensation for delays in delivery of luggage	Fixed amount of €300/$380
- Cost of replacing identity documents only in case of theft	€150/$190
TRAVEL INCIDENTS - Flight delay leading to a missed connection, for technical reasons or due to weather conditions	Payment of a fixed amount of €300/$380

9.4. / ASSISTANCE SERVICES

9.4.1. PERSONAL ASSISTANCE IN THE EVENT OF ILLNESS OR INJURY

9.4.1.1. EXTENSION OF STAY OF THE INSURED MEMBER OR AN INSURED COMPANION

If you are hospitalized during a Trip and, based on the information provided by the local doctors, our doctors consider that this Hospitalization needs to be extended beyond your original date of return to your Place of residence, we will cover accommodation costs for an insured companion up to a maximum of €150/$190 per night and a total of €1,500/$1,900 to enable them to stay with you until you are in a position to return to your Place of residence.
If, during a Trip, you are unable to travel and are obliged to extend your stay and, based on the information provided by the local doctors, our doctors consider that your condition does not require Hospitalization, we will cover the cost of your extended stay up to a maximum of €150/$190 per night and a total of €1,500/$1,900.
We will cease to cover your costs from the day on which our doctors decide, based on the information provided by the local doctors, that you are in a position to return to your Home country.
This benefit cannot be combined with the "HOSPITAL VISIT" benefit.

9.4.1.2. RETURN OF AN INSURED COMPANION

If we organize your repatriation based on the opinion of our Medical Department, we will also arrange for an insured person who was traveling with you, where possible, to accompany you on your return journey.
This person may travel:

- with you,
- independently.

We will cover the cost of this insured person traveling by train in 1st class or by air in economy class.
This benefit cannot be combined with the "HOSPITAL VISIT" benefit.

9.4.1.3. HOSPITAL VISIT

If you are hospitalized in the place where you became ill or had your Accident and if, based on the information provided by the local doctors, our doctors consider your return trip cannot be made for a further five days, we will organize and cover the cost of a round trip from your Home country or your Country of expatriation by train in 1st class or by air in economy class to enable a person of your choice to be with you.
We will also cover hotel expenses for this person (room and breakfast) up to a maximum of €150/$190 per night and a total of €1,500/$1,900.
This benefit cannot be combined with the "RETURN OF AN INSURED COMPANION" benefit and the "EXTENSION OF STAY OF THE INSURED MEMBER OR AN INSURED COMPANION" benefit.

9.4.1.4. ACCOMPANYING YOUR CHILDREN

If you become ill or are injured and are unable to care for your insured children under the age of 18 who are living with you, we will organize and cover the cost of a round trip by train in 1st class or by air in economy class from your Country of expatriation or your Home country to enable a person of your choice or one of our hostesses to take your children to your Place of residence in your Country of expatriation or to the home of a person chosen by you in your Home country by train in 1st class or by air in economy class. You will need to cover the cost of the children's tickets.
We will also cover hotel expenses (room and breakfast) for this person, up to a maximum of €150/$190 per night and a total of 2 nights.

9.4.1.5. EARLY RETURN IN THE EVENT OF HOSPITALIZATION OF A FAMILY MEMBER

If you learn of the serious and unforeseen hospitalization for a minimum period of 5 days of a Family member in your Country of expatriation or your Home country,
we will organize your round trip (limited to one round trip per insured person) to enable you to visit the hospitalized person in your Country of expatriation or your Home country.
If you do not provide supporting documents (patient status report, proof of family relationship) within 30 days of the hospitalization, we reserve the right to charge you the full cost of the trip.
The date of this Family member's admission to hospital must be later than the date on which you leave to go abroad or take up an expatriate assignment.

9.4.1.6. RETURN TO THE PLACE OF RESIDENCE

If you have been transported under the conditions specified in the chapter 9/MEDICAL ASSISTANCE AND REPATRIATION OPTION – GENERAL PROVISIONS OF BENEFITS p.67 of this booklet and your medical condition allows you to travel alone under normal transportation conditions with the full agreement of the treating doctors and our medical team, we will organize and cover the cost of your return trip by train in 1st class or by air in economy class to your Place of residence.
The return trip must be made within 2 months of the date of the transportation/repatriation.

9.4.1.7. SECOND MEDICAL OPINION

If, during your expatriation, you develop a medical condition that may require specialist medical treatment and/or surgery and, following an initial consultation, you wish to seek a second medical opinion, our assistance team is available to help you arrange a second consultation with a specialist in your Country of expatriation (or in a neighboring country).
It is agreed that, for both the pre-expatriation medical check-up and the second opinion, the choice of practitioner and the final decision is yours; you are free to accept or reject the opinion of the practitioner you consulted.

9.4.1.8. PSYCHOLOGICAL SUPPORT

In the event of an Accident (including in a vehicle), an Assault or attempted Assault, the death of a Family member or an Attack

or Natural Disaster causing psychological trauma, we will provide a Listening and Support helpline which puts you in touch with clinical psychologists by telephone. This service is available 24 hours a day, 7 days a week and 365 days a year. The helpline is manned by professionals who will listen carefully while remaining neutral. You will be able to confide in them and clarify the situation you are facing following this event.
Psychologists operate in strict compliance with the Code of Ethics applicable to the psychology profession, and will under no circumstances initiate psychotherapy by telephone.
We will arrange and cover the cost of three telephone conversations.
Please be advised that these telephone conversations can only be conducted in French and that you are responsible for the cost of the calls.
Depending on your circumstances and your wishes, an appointment may be arranged with a nearby qualified psychologist chosen by you from 3 names provided by us. We will arrange this appointment after having offered you a choice of several practitioners close to your Home in France.
The choice of practitioner is yours alone and you are responsible for the cost of the consultation.
It should be noted that these appointments can only take place in France during the period of validity of the plan.

9.4.1.9. ADVANCE OF HOSPITAL CHARGES

If necessary, and with the prior agreement of the ASFE, EUROP ASSISTANCE will make an advance payment of your hospital charges or make a direct payment to the hospital abroad, up to the maximum level of the benefits purchased by the Insured member from the ASFE.
The amounts advanced by EUROP ASSISTANCE, in the name and on behalf of the ASFE, will be billed to the ASFE, in accordance with the procedure specified in chapter 9.7 p.80 of this Plan.

9.4.2. ASSISTANCE ON RETURNING HOME FOLLOWING REPATRIATION (FRANCE ONLY)

9.4.2.1. CHILDCARE

If you are confined to your Home for more than 8 days and/or are hospitalized for more than 8 days, we will arrange and cover the cost of one of the following services:

- Either the care of a sick child under the age of 18 at their Home for a maximum of 20 hours by a competent person sourced by us. The person we send to the insured child's Home will take up and relinquish their duties while a parent is present. This service is available Monday to Friday between 8am and 7pm, excluding public holidays, for a minimum of 4 hours and a maximum of 10 hours per day;
- Or we will cover the cost for your children to travel to and from the home of one of your close friends or relatives chosen by the Insured member and residing in mainland France. They will be accompanied by a hostess appointed by our team.

9.4.2.2. HOME HELP

We will arrange for a home help to carry out household tasks at your Home either on your return Home from hospital or from the date of your Hospitalization or while you are confined to the Home.
We will cover the cost of the home help for up to 10 hours at times of your choosing during the month following the date of your Hospitalization or your return Home or while you are confined to the home (at a minimum of 2 hours at a time).
If you do not provide supporting documents (hospital certificate, medical certificate), we reserve the right to charge you the full cost of the service.

9.4.2.3. CARE OF PETS

We will arrange the transportation of your pets (dogs or cats) to an appropriate care facility close to your Home or to a place of your choice in France and less than 50km from your place of Hospitalization.
We will cover the cost of transporting your pets and the cost of boarding them in the care facility up to a maximum of €155/$195 for the duration of your stay in hospital or while you are confined to the Home.
This benefit is subject to the conditions of transportation, reception and boarding specified by the service providers and care facilities (up-to-date vaccinations, payment of any deposit required, etc.).
This service can only be provided if you, or a person authorized by you, can meet with the service provider to hand over the animals.

9.4.2.4. HOSPITAL COMFORTS

If you are hospitalized under the conditions specified above, we will cover the cost of renting a television up to a maximum of €80/$100 for the duration of your stay in hospital.

9.4.3. ASSISTANCE IN THE EVENT OF DEATH

9.4.3.1. TRANSPORTATION OF THE BODY AND COST OF A COFFIN IN THE EVENT OF AN INSURED MEMBER'S DEATH

If the Insured member dies, we will arrange and cover the cost of transporting the deceased member to the place of funeral in their Home country.
We will also cover all the costs involved in preparatory care and specific transportation arrangements, to the exclusion of all other expenses. In addition, we will contribute to the cost of a coffin or urn purchased by the family from the funeral director of their choice, up to a maximum of €2,000/$2,500, and on presentation of the original invoice.
Other costs (such as those related to the ceremony, local transportation, burial, cremation and burial plots) are the responsibility of the family. Family members are also responsible for arranging the funeral.

9.4.3.2. RETURN OF AN INSURED COMPANION

Where applicable, we will arrange and cover the cost of the return trip for an insured companion to the place of funeral by train in 1st class or by air in economy class.

9.4.3.3. IDENTIFICATION OF THE BODY AND DEATH FORMALITIES

If the Insured member dies while alone abroad and if the presence of 2 Family members or 2 close friends is required to identify the body and arrange the repatriation or cremation at the place of death, we will arrange and cover the cost of the round trip by train in 1st class or by air in economy class for these 2 persons from their Country of residence or from the deceased Member's Home country to the place of death. We will also cover their accommodation costs up to a maximum of €150/$190 dollars per night per person and for a total of 2 nights.

9.4.3.4. EARLY RETURN IN THE EVENT OF A FAMILY MEMBER'S DEATH

If you learn of the death of a Family member in your Country of expatriation or in your Home country, we will arrange your

round trip and cover the cost of your 1st class train ticket(s) or economy class airline ticket(s) to enable you to attend the funeral of the deceased in your Country of expatriation or in your Home country.
If you do not provide supporting documentation (death certificate, proof of family relationship) within 30 days of the death, we reserve the right to charge you the full cost of the trip.
This benefit is provided if the date of the funeral is earlier than the date originally scheduled for your return.

9.4.4. TRAVEL ASSISTANCE

9.4.4.1. EARLY RETURN IN THE EVENT OF LOSS OR DAMAGE TO YOUR PLACE OF RESIDENCE

If, during a Trip, you learn of Loss or damage to your Place of residence and your presence there is essential to complete administrative procedures, we will arrange and cover the cost of your return journey, by train in 1st class or by air in economy class from the place where you are staying abroad to your Place of residence.
If you do not provide supporting documentation (insurance claim, expert report, police report, etc.) within a maximum period of 30 days following the loss or damage, we reserve the right to charge you the full cost of the trip.
This benefit is extended to Business premises if the Insured member making the Trip is the manager of the company.

9.4.4.2. EARLY RETURN OR TRANSPORTATION TO A SECURE ZONE IN THE EVENT OF AN ATTACK

If, during your Trip, an Attack occurs within a maximum radius of 100km around your location, and if you wish to curtail your Trip, we will arrange and cover the cost of your journey by train in 1st class or by air in economy class from your location abroad to your Home or to a secure zone if the reception and security conditions there are deemed to be satisfactory. The request for an early return Home must be made within a maximum period of 72 hours following the Attack.
If you opt for transportation to a secure zone, we will arrange and cover the cost of your return journey to your place of residence once it has become safer, provided this request is made within a maximum period of 8 days following the Attack.
A "secure zone" is the part of the territory defined by the authorities in the country where you are located or defined by the diplomatic services of your Home country, located within a radius of 100km around the place where you are staying.

9.4.4.3. EARLY RETURN OR TRANSPORTATION TO A SECURE ZONE IN THE EVENT OF A NATURAL DISASTER

If, during your Trip, a Natural disaster occurs in the place where you are staying and you are not injured but want to curtail your Trip, we will arrange and cover the cost of your journey by train in 1st class or by air in economy class from the place where you are staying to your Home or to a secure zone if the reception and security conditions there are deemed satisfactory.
This request for an early return must be made within a maximum period of 72 hours following the occurrence of the Natural disaster.
If you opt for transportation to a secure zone, we will arrange and cover the cost of your return journey to the place where you are staying abroad once it has become safer, provided this request is made within a maximum period of 15 days following the Natural disaster.
A "secure zone" is the part of the territory defined by the authorities in the country where you are staying abroad or defined by the diplomatic services of your Home country, located within a radius of 100km around the place where you are staying.

9.4.5. TRANSMISSION OF URGENT MESSAGES

If, during your Trip, you are unable to contact a person in your Home country, we will pass on the message you gave us by phone at the time and on the day of your choice.

IMPORTANT

This service does not accept collect calls. Moreover, we will not under any circumstances be held liable for the content of your messages which are subject to French law, including criminal and administrative legislation. Failure to comply with this legislation may result in our refusal to pass on the message.

9.4.6. DELIVERY OF MEDICATION ABROAD

If you are in your Country of expatriation or on a Trip Abroad and drugs which are essential to the continuation of your treatment, the interruption of which would, in the opinion of our doctors, be detrimental to your health, are lost or stolen, we will source equivalent drugs locally and, in this case, arrange an appointment with a local doctor who can prescribe them for you. You will be responsible for the medical expenses and the cost of the medication.

If there is no equivalent medication available locally, we will arrange for the medicines prescribed by your usual doctor to be sent (from France only) provided they send our doctors a copy of the prescription issued to you and if this medication is available in retail pharmacies.

We will cover shipping costs and you will be billed for customs duties and the cost of the medication. You agree to reimburse us on receipt of invoice.

These shipments are subject to the terms and conditions of the carriers we use. In all cases they are subject to the regulations and conditions in force in France and the national legislation of each country in respect of the import and export of medicines.

We will not be held liable for the loss or theft of the medication or for any regulatory restrictions which may delay or prevent its shipment, or for any consequences thereof. Under no circumstances will the following be shipped: blood products and derivatives, products restricted to hospital use or products requiring special storage conditions, including refrigeration, and more generally products which are not available in pharmacies in France.

Moreover, if the medication is no longer in production or has been withdrawn from the market or is unavailable in France this will constitute force majeure which may delay or prevent the service from being delivered.

9.4.7. ASSISTANCE IN THE EVENT OF THE THEFT, LOSS OR DESTRUCTION OF YOUR IDENTITY DOCUMENTS OR MEANS OF PAYMENT

Information on formalities

If your identity documents are lost or stolen, you can call our "Information" service every day between 8am and 7.30pm (French time), excluding Sundays and public holidays, for information on the formalities to be completed (declaring the loss or theft, replacing your identity documents, etc.).
This information is provided for reference only, as defined under article 66.1 of the amended French legislative Act of 12.31.71, and in no circumstances should be construed as legal advice. Based on each individual case, we will refer you to organizations or groups of professionals who may be able to assist you. Under no circumstances shall we be held liable for either the

interpretation or the use you may make of the information provided to you.

Provision of funds
If your means of payment, credit card(s) or checkbook(s) are lost or stolen and on presentation of the declaration of loss or theft issued by the local authorities, we will provide you with an advance of funds up to a maximum of €2,300/$2,880 to enable you to cover the purchase of essential items. This advance is subject to the following conditions:

- either a credit card payment by a third party of the corresponding amount,
- or a payment from your bank of the corresponding amount. You will be required to sign a receipt when the funds are issued.

Extension of stay
If, during a Trip, your identity documents are lost or stolen and you are unable to leave the territory of the country where you are located on the original date scheduled for your return, we will cover the cost of your accommodation until the date on which your new identity documents are issued and in all cases up to a maximum of €150/$190 per night and a total of €1,500/$1,900.
In this case accommodation costs are taken to mean hotel expenses incurred following an insured event, excluding the cost of food and drinks. You will need to submit original receipts for accommodation costs actually incurred along with your claim as well as the declaration of loss or theft.

Travel information[4]
(Every day from 8am to 7.30pm, French time, excluding Sundays and public holidays)
Service provided in French only.
At your request, we can provide you with information on:

- the medical precautions to take before going on a trip (vaccinations, medication, etc.),
- the administrative formalities to be completed before or during a trip (visas, etc.),
- travel conditions (transportation options, flight times, etc.),
- local living conditions (temperature, climate, food, etc.).

9.4.8. HEALTH INFORMATION

This service is designed to listen to you and offer you guidance and information. In a medical emergency, your first priority should be to call the local emergency services.

By calling us at any time 24/7 we will make every effort to provide you with the healthcare information you need. This information is provided for reference purposes only.
If we cannot give you an immediate response, we will make the necessary enquiries and call you back as soon as possible. Information is provided in compliance with medical ethics.

Under no circumstances is the purpose of the service to deliver a personalized telephone consultation or prescription, to promote self-medication or to question your doctors' treatment choices. If you are seeking this type of advice, you should consult a local doctor or your general practitioner.

We will answer your questions objectively on the basis of established facts and will not be held liable for your interpretation or any consequences of our answers.

9.4.9. ASSISTANCE IN THE EVENT OF CHANGES TO TRAVEL PLANS

If, during a Trip, your travel plans are affected by one of the following unforeseen events: strike, hijack, accident or illness which does not require your transportation/repatriation, we may, at your request and in accordance with your instructions, make changes to your airline and hotel reservations.
You are responsible for covering any change fees or additional expenses incurred at your request.

9.4.10. MOUNTAIN, SEA AND DESERT SEARCH AND RESCUE COSTS

We will cover the cost of search and rescue missions at sea, in the mountains (including off-piste ski slopes) and in the desert in order to locate you following an event occurring during your Trip, up to a maximum of €15,000/$18,750.
Only costs charged by a company duly authorized to carry out these missions will be reimbursed. Under no circumstances shall we be responsible for the organization of rescue services.
You or your dependents should send us:

- the detailed insurance claim,
- the paid invoice issued by the organization which carried out the rescue mission, showing the date, nature and reasons for the intervention,
- the medical certificate, police report or death certificate as appropriate.

9.4.11. ACCESS TO A CLASSIC SUBSCRIPTION TO "123CLASSEZ" (THE EUROP ASSISTANCE ELECTRONIC DATA VAULTING SERVICE)

You may only use the CLASSIC version of the "123Classez" service offered by EUROP ASSISTANCE while you are covered under this plan and if you comply with the following conditions.
EUROP ASSISTANCE provides this service free of charge.

To access this service, you will need the code which EUROP ASSISTANCE issued to you in order to register online on the website www.123classez.com/classic. You will also need to accept the General Terms & Conditions of Use which are available on the site. You will then be provided with a user's account accessible from this site which allows you to store, view and manage your documents for the duration of your subscription. The CLASSIC version of the "123Classez" service is provided subject to the conditions and limits set out in the General Terms and Conditions of Use of the "CLASSIC" subscription which are available on the website.

Please note that electronic storage of documents is not a substitute for retaining a paper version of the original document which has greater probative value than copied documents and which may need to be produced. Accordingly, you accept that the purpose of the CLASSIC version of the "123Classez" service is not to enable you to destroy your paper documents.

[4] This service is also available before you go abroad as an expatriate.

9.4.12. WHAT IS EXCLUDED

Under no circumstances can we replace local emergency rescue organizations. In addition to the general exclusions listed p. 70 in the paragraph 9.2.6. Conditions of coverage the following are excluded:

- the consequences of intentional acts carried out 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 and 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 those occurring beyond the scheduled 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 chapter 9/MEDICAL ASSISTANCE AND REPATRIATION OPTION – GENERAL PROVISIONS OF BENEFITS p.67 of this booklet 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,
- cosmetic 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,
- costs related to excess luggage when traveling by air and the cost of forwarding the bags if they cannot travel with you,
- trip cancelation costs,
- restaurant costs,
- customs duties.

9.5. / INSURANCE SERVICES

9.5.1. / LUGGAGE AND PERSONAL EFFECTS

9.5.1.1. WHAT WE WILL COVER

Loss and/or accidental damage to luggage and personal items and effects

During a Trip, we will cover up to a maximum of €2,000/$2,500 the luggage, personal items and effects that you took with you on the trip, against:

- theft,
- total or partial destruction,
- loss during transportation by a carrier.

Reimbursement limits for certain items

For valuables, pearls, jewelry and watches when being worn, furs and laptop computers, the reimbursement value will not under any circumstances exceed 50% of the insured amount shown in the Benefits Schedule. Furthermore, the items listed above are only insured against theft.

If you are using a private car, the risks of theft are covered provided the luggage and personal effects are stored in the locked trunk of the vehicle and out of sight. Only forced entry to the vehicle is covered. If the vehicle is parked on the public road, the coverage will apply only between 7am and 10pm (local time).

9.5.1.2. DELAY IN DELIVERY OF LUGGAGE

If, during a Trip, your personal luggage which was checked in with the carrier is not delivered to you at the destination airport of your outward journey and if it is delivered with a delay of more than 12 hours, you will receive a lump sum of €300/$380 to contribute to the reimbursement of the costs you incurred for the purchase of essential items.

This benefit cannot be combined with the main benefit of €2,000/$2,500.

9.5.1.3. THEFT OF IDENTITY DOCUMENTS

If your passports, identity card (or residence permit), vehicle registration documents or driver's license are stolen during the trip, we will reimburse the cost of replacing these documents, on submission of supporting documents, up to a maximum of €150/$190.

9.5.1.4. WHAT IS EXCLUDED

In addition to the general exclusions listed p.80, the following are excluded:

- theft of luggage, personal effects and items left unattended in a public place or stored on premises accessible by several people,
- forgotten or lost items (unless by a carrier) and misidentified luggage,
- theft without forced entry which has been documented and for which a report has been drawn up by an authority (police, gendarmerie, carrier, purser, etc.),
- theft committed by your staff in the course of their professional duties,
- accidental damage due to the leakage of liquids, oils, colorants or corrosive materials stored in your luggage,
- confiscation of property by the authorities (customs or police),
- damage caused by mites and/or rodents and burns from cigarettes or from a non-incandescent source of heat,
- theft from a convertible vehicle and/or station wagon or any other vehicle which does not have a trunk; coverage is granted if the cargo cover provided with the vehicle had been used,
- trade collections and samples,
- stolen, lost, forgotten or damaged cash, identity documents, books, travel tickets and credit cards,
- theft of jewelry not stored in a locked strongbox or when not being worn,
- breakage of fragile items such as items made of porcelain, glass, ivory, pottery or marble,
- indirect damage such as depreciation or loss of use,
- the following items: all prostheses, appliances of any kind, bicycles, trailers, negotiable securities, paintings, spectacles and contact lenses,
- keys of any kind (other than keys to the Home), documents stored on tape or film and professional equipment (other than laptop computers), cellphones, CDs, DVDs, all kinds of multimedia equipment (MP3, MP4, PDA, etc.), GPS devices, sports equipment, musical instruments, food products, lighters, pens, cigarettes, liquors, art objects, fishing rods, cosmetics, photographic film and items purchased during your trip.

9.5.1.5. How much will we pay?

The amount shown in the Benefits Schedule is the maximum reimbursement in respect of all Losses occurring during the period of coverage.
A Deductible of €25/$32 (in respect of damage to luggage only: suitcases, bags, etc.) will be applied to each Claim.

9.5.1.6. How is your compensation calculated?

Your compensation will be based on the replacement value of equivalent items of the same type with deductions made for Dilapidation, Wear and tear and the Deductible. Under no circumstances will the proportional rule provided for under article L. 121-5 of the French Insurance Code be applied.

9.5.1.7. Documents required when making a claim

Your claim must be accompanied by the following documents:

- declaration of loss or theft made within 48 hours to an authority (police, gendarmerie, carrier, purser, etc.) in the event of theft or loss,
- property irregularity reports obtained from the carrier (sea, air, rail or road) if your luggage or items were lost while legally in the care of the carrier,
- receipt for checked-in luggage which was delivered late by the carrier and proof of late delivery. If you do not provide these documents we will be entitled to claim compensation from you equal to the resulting prejudice suffered by us. The insured amounts cannot be considered as proof of the value of the goods for which you are claiming compensation, nor as proof of the existence of these goods.

You are required to provide proof, by all means in your power and by any documents in your possession, of the existence and value of these goods at the time of the Loss, and the extent of the damage. With regard to business equipment, such as laptop computers, your company may be asked to attest to their value and confirm that you had these items with you when you left on the trip.
If you have also claimed compensation from the carrier, you must notify us of this when declaring the loss.

9.5.1.8. Forfeiture of coverage due to a fraudulent claim:

If you knowingly submit supporting documents which are inaccurate or use fraudulent means or make inaccurate or incomplete statements, you will forfeit all rights to compensation.

9.5.1.9. What happens if you recover all or some of the stolen items covered under the luggage insurance?

You must notify us immediately by registered letter as soon as you receive this information.
If we have not yet settled the claim, you must recover your property. We will then be liable for payment only in respect of any damaged or missing items.
If we have already settled the claim, you have 15 days to choose between these two options:

- relinquish the items,
- take back the items and return the compensation you received less any payments due in respect of damaged or missing items.

If you have not chosen one of the options within 15 days, we will assume you are opting to relinquish the items.

9.5.2. / Travel incidents

9.5.2.1. What we will cover

This coverage applies to:

- scheduled outbound or inbound airline flights whose flight times are published,
- outbound or inbound charter flights whose flight times are shown on the outbound airline ticket.

If the arrival of the Insured member's aircraft is delayed for more than four hours after the original scheduled time resulting in a missed connection, we will pay you compensation up to the maximum amount shown in the Benefits Schedule.
For the calculation of compensation, the delay on the outbound flight cannot be added to the delay on the inbound flight; only one leg of the journey is taken into account. However, the coverage may apply to both the outbound and the inbound flight if on each leg of the journey the delay exceeds four hours and results in a missed connection. Coverage comes into force on the date and time shown on the airline ticket and expires on arrival at the destination airport.
This coverage does not apply if you are transferred to another airline for travel at the original flight times.

9.5.2.2. What is excluded

- civil or foreign war, riots, civil unrest, strikes, acts of terrorism, hostage-taking or sabotage, any manifestation whatsoever of radioactivity, any effect of nuclear origin or caused by any source of ionizing radiation in the country of departure, transfer or destination,
- any event threatening the security of your journey where travel to your destination has been discouraged by the French Ministry of Foreign Affairs,
- a decision by the airport authorities, civil aviation authorities or any other authority where the announcement was made 24 hours prior to your departure date,
- events that occurred between the date of booking your trip and the date of taking out this insurance,
- failure to travel on the flight on which your booking was confirmed for any reason whatsoever,
- denial of boarding due to failure to meet the deadline for luggage check-in and/or presentation for boarding.

9.5.2.3. HOW TO MAKE A CLAIM? YOU MUST:

- complete and/or have a flight delay statement stamped by an authorized person from the airline with which you are traveling or from an authorized person from the airport,
- on your return and within the following 156 days send us the duly completed flight delay statement, a photocopy of your airline ticket, the purchase invoice for the covered ticket and the stub of your boarding pass.

9.6. / FRAMEWORK OF THE PLAN

This plan is subject to French law.

9.6.1. EFFECTIVE DATE AND DURATION OF THE PLAN

This plan takes effect on the date specified in the Schedule, which cannot be earlier than the date on which the plan was purchased.
Unless otherwise specified in the Schedule, the plan is valid for a period of one year from the effective date specified in the Schedule. When it expires, it is automatically renewed from year to year unless terminated by the Insurer or by the Policyholder under the conditions specified in the Schedule.

9.6.2. CESSATION OF BENEFITS

Your coverage comes to an end:

- on the day on which you no longer belong to the insurable group insofar as you no longer meet the conditions of membership (see definition of Insured member),
- in the event of non-payment of the premiums by the Policyholder,
- on the date of termination of the contract between the Policyholder and us.

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

9.6.3. 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 fulfillment 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,
- processing timescales 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).

9.6.4. 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 deny 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 9/MEDICAL ASSISTANCE AND REPATRIATION OPTION – GENERAL PROVISIONS OF BENEFITS p.67 with respect to the health of the Insured member or an unborn child.

9.6.5. WHAT ARE THE GENERAL EXCLUSIONS APPLICABLE TO THE PLAN?

The general exclusions under the plan are the exclusions common to all the assistance services and insurance coverage described in these General Provisions.
The following are excluded:

- civil or foreign war, riots and civil unrest,
- voluntary participation by an Insured member in riots or strikes, brawls or unlawful acts,
- the consequences of nuclear disintegration or radiation from a source of radioactive energy,
- unless otherwise stated in the plan (services 9.4.4.3. Early return or transportation to a secure zone in the event of a natural disaster p.74), earthquakes, volcanic eruptions, tidal waves, floods or natural cataclysms except under the provisions arising from the French legislative Act No 82-600 of July 13, 1982 regarding the compensation of victims of natural disasters (in respect of insurance coverage),
- the consequences of the use of medication, drugs, narcotics and similar products which are not medically prescribed and alcohol abuse,
- any intentional act on your part which may give rise to a claim under the plan.

9.6.6. WHAT IS THE PROCEDURE FOR ASSESSING MATERIAL DAMAGE COVERED BY THE INSURANCE?

If the damage cannot be determined by mutual agreement, it is evaluated by means of a mandatory, jointly-agreed expert assessment, subject to our respective rights.

Each of us appoints an expert. If these experts do not agree, they appoint a third expert: the three experts work together and rule by majority vote.
If one of us fails to appoint an expert or if the two experts are unable to agree on the selection of a third expert, the appointment is made by the President of the Tribunal de Grande Instance in the district where the Loss occurred. This appointment is made by written request signed by at least one of us, with the other party being summoned by registered letter. Each party pays the fees and expenses of its own expert and half of the fees of the third expert, if appointed.

9.6.7. INSURANCE COVERAGE: WHEN WILL YOU RECEIVE YOUR COMPENSATION?

In respect of insurance coverage, payment will be made within 5 days of an agreement being made between us or of the enforceable court decision.

9.6.8. SUBROGATION

Having incurred costs in respect of our insurance coverage and/or 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 under article L.121-12 of the French Insurance Code.
Our subrogation is limited to the amount of the costs we incurred in fulfillment of this plan.

9.6.9. WHAT ARE THE LIMITATION PERIODS?

In accordance with Article L.114-1 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:
❶ 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;
❷ 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 member against the Assistance provider arises from a claim made by a third party, the limitation period shall run only from the day on which this third party brings a legal action against the insured member or has received compensation from him or her. "
In accordance with Article L.114-2 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 a loss. The limitation period can also be interrupted by a registered letter with proof of delivery sent by the insurer to the insured member regarding action for payment of the premium and from the insured member to the insurer regarding payment of the claim. "
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 party against whom they were prescribing (Article 2240 of the French Civil Code), a legal claim (Articles 2241 to 2243 of the French Civil Code) or an act of enforcement (Articles 2244 to 2246 of the French Civil Code).
In accordance with Article L.114-3 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."

9.6.10. 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: Europ Assistance, Service "Remontée Clients", 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.

9.6.11. SUPERVISORY AUTHORITY

The supervisory authority is the 'Autorité de Contrôle Prudentiel et de Résolution – A.C.P.R.' (French Prudential Supervision and Resolution Authority) – 4 place de Budapest - CS 92459 - 75436 Paris Cedex 09, France.

9.6.12. PROTECTION OF PERSONAL DATA AND RIGHT TO OPT OUT OF TELEPHONE MARKETING

9.6.12.1. PROTECTION OF PERSONAL DATA

EUROP ASSISTANCE, a company governed by the French Insurance Code, with its registered office located at 1 Promenade de la Bonnette - 92633 Gennevilliers Cedex, France (hereinafter referred to as "the Insurer"), acting in its capacity as data controller, processes the Insured member's personal data for the following purposes:

- the management of requests for assistance and insurance;
- the organization of satisfaction surveys with insured members having benefited from assistance and insurance services;
- the production of trade statistics and actuarial studies;
- the assessment, acceptance, control and monitoring of the risk;
- the management of potential disputes and the implementation of legal provisions;
- the implementation of due diligence requirements as part of the prevention of money laundering and the financing of terrorism, financial sanctions, including the activation of alerts and the reporting of suspicious activities;
- the introduction of measures to combat insurance fraud;
- the management of the recording of telephone conversations with the Insurer's employees or those of its processors for the purposes of staff training and evaluation and quality control, as well as the management of potential disputes.

The Insured member is informed and accepts that their personal data will be processed for the abovementioned purposes. This processing is conducted in application of the plan.

The data collected are mandatory. If these data are not provided, the management of the Insured member's requests for assistance or insurance may be rendered more complex or even impossible.

In this regard, the Insured member is informed that the recipients of their personal data are the Insurer, as the data controller, and the Insurer's processors, subsidiaries and agents, as well as the providers selected to deliver assistance services to you (breakdown and ambulance services, airlines, taxis, etc., as applicable).

With a view to complying with legal and regulatory obligations, the Insurer may have to provide information to legally

authorized administrative or judicial authorities.

The Insured member's personal data are stored for a duration that varies depending on the final purpose (2 months for telephone records), which may be extended by the mandatory storage durations for accounting purposes and the legal duration of the limitation period (10 years for data processed as part of a medical assistance case, and 5 years for other types of data).

The Insured member is informed and accepts that their personal data may be transferred to recipients located in third countries outside the European Union guaranteeing an equivalent level of protection. Transfers of data to these third countries are subject to:

- a cross-border flow agreement established in accordance with standard contractual clauses currently in force for data transfers from controllers to processors, as issued by the European Commission;
- contracts of adherence of the Insurer's entities to internal rules in compliance with recommendation 1/2007 of the Article 29 Working party on the standard application for approval of binding corporate rules for the transfer of personal data.

The Insured member may request a copy of these appropriate safeguards governing the transfers of data from any of the addresses indicated below.

The purpose of these flows is the management of requests for assistance or insurance. This applies to the following categories of data:

- data relating to identity (including: full name, gender, date of birth, phone number, and email address) and personal life (including: family status and number of children),
- location data,
- where applicable, health data, including the Social Security number and provided the data subject's consent has been obtained.

The Insured member, in their capacity as data subject, is informed that they benefit from a right of access, rectification, erasure and portability of their data, as well as the right to limit their processing. They also have the right to opt out of the use of their data.

The Insured member has the right to withdraw their consent at any time without affecting the lawfulness of the processing based on consent before said withdrawal. In addition, they have the right to set specific and general guidelines for the storage, erasure and disclosure of their data after their death.

The Insured member's rights may be exercised by sending a letter to the Data Protection Officer at one of the addresses below, with a photocopy of a signed identity document:

- by email: protectiondesdonnees@europ-assistance.fr, protectiondesdonnees@europ-assistance.fr,
- by mail: EUROP ASSISTANCE - A l'attention du Délégué à la protection des données - 1, promenade de la bonnette – 92633 Gennevilliers, France.

The Insured member is informed that they have the right to file a complaint with the French Data Protection Authority, Commission Nationale de l'Informatique et Libertés (CNIL).

9.6.12.2. CONSUMERS' RIGHT TO OPT OUT OF TELEPHONE MARKETING

In accordance with the French Act 2014-344 of March 17, 2014, EUROP ASSISTANCE informs the Insured member that they may opt out of telephone marketing from professionals with whom they do not have a pre-existing contractual relationship by registering free of charge with the opt-out directory by mail or via internet:

SOCIETE OPPOSETEL - Service Bloctel - 6, rue Nicolas Siret - 10 000 TROYES, France - www.bloctel.gouv.fr

9.7. / PRIOR APPROVAL PROCEDURE FOR THE "ADVANCE OF HOSPITAL CHARGES" SERVICE WITH ASSISTANCE

BENEFICIARY: Any member enrolled in this plan.

THE ADMINISTRATOR:
MSH
ASFE Prise en charge ASFE Gestion
23 allées de l'Europe 92587 Clichy Cedex - France
Tel: +33 (0)1 44 20 48 07
Fax: +33 (0)1 44 20 48 79
Email: admineurope@asfe-expat.com

THE ASSISTANCE PROVIDER:
EUROP ASSISTANCE
1 promenade de la Bonnette 92633 GENNEVILLIERS
Tel: +33 (0)1 41 85 84 46
Fax: +33 (0)1 41 85 85 71

9.7.1. OPERATING PROCEDURE BETWEEN THE PARTIES

9.7.1.1. THE BENEFICIARY

The Beneficiary contacts EUROP ASSISTANCE on + 33 (0)1 41 85 84 46 to request prior approval for the advance of hospital charges (at least one night in hospital). They should provide the full name of and contact details for the care facility and, if possible, their admission date.

9.7.1.2. EUROP ASSISTANCE

For all requests for the advance of hospital charges combined with assistance, EUROP ASSISTANCE will email the completed prior approval form to the ASFE at: admineurope@asfe-expat.com or by fax to +33 (0) 1 44 20 48 79.
Requests for prior approval are valid for 10 days. When this 10-day period has expired, a new request for prior approval must be submitted.
A new agreement must also be obtained if the Beneficiary is transferred to a different medical department or hospital or if any changes are made to their diagnosis.

9.7.1.3. MSH/ASFE PRISE EN CHARGE

On receipt of this information, MSH/ASFE Prise en charge send their agreement and the amount of coverage being granted to EUROP ASSISTANCE by faxing the completed prior approval form to +33 (0)1 41 85 85 71.

This agreement is only valid for 10 days and must be renewed once this 10-day period has expired.
In cases where agreement from MSH/ASFE Prise en charge cannot be sought given the urgency of the request, MSH/ASFE Prise en charge will authorize EUROP ASSISTANCE to make the necessary advances in their name and on their behalf, subject to subsequent checks on the applicant's entitlement to the service.

9.7.1.4. EUROP ASSISTANCE

EUROP ASSISTANCE may then settle the medical bill within the limits of the benefits set by MSH/ASFE Prise en charge.
Medical bills settled by EUROP ASSISTANCE are reinvoiced and sent to MSH/ASFE Prise en charge as follows:

- one bill per file,
- original medical bills enclosed marked "payé/paid" without the EUROP ASSISTANCE stamp.

9.7.1.5. REIMBURSEMENT PROCEDURES FOR THE ADVANCE OF HOSPITAL CHARGES

MSH International/ASFE Prise en charge agree to reimburse advances of hospital charges made in their name and on their behalf to EUROP ASSISTANCE within one month, on receipt of the corresponding invoice. The exchange rate used for the billing of medical expenses will be the one in force on the day on which payment is made to the hospital.

10. / CONTACT MSH

GET YOUR LOGIN DETAILS

1. Go to www.msh-intl.com, on your 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.

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

AMERICAS
MSH
2900, 605 – 5th Avenue S.W. Calgary, Alberta, T2P 3H5
CANADA
Tel: +1 403 538 2365
Fax: +1 403 265 9425
adminamerica@asfe-expat.com

EUROPE
MSH
23 allées de l'Europe
92587 Clichy cedex FRANCE Tel: +33 (0)1 44 20 48 07
Fax: +33 (0)1 44 20 48 79
admineurope@asfe-expat.com

MIDDLE EAST AND AFRICA
MSH
19th Floor, One by Omnyat, Business Bay
P.O. BOX: 506537 Dubai - UAE
Tel: +971 4 365 1305
Fax: +971 4 363 7327
adminmea@asfe-expat.com

ASIA
MSH
5/F, North Tower, Building 9, Lujiazui Software Park, Lane 91, E Shan Rd,
Shanghai – P.R. CHINA, 200127 Tel: +86 21 6187 0593
Fax: +86 21 6160 0153

11. APPENDIX 1: LIST OF CHRONIC CONDITIONS

Drugs on prescription for chronic conditions are those prescribed for the chronic conditions listed below:

- debilitating stroke
- bone marrow failure and other chronic cytopenias
- chronic arterial disease with ischemic events
- bilharzia with complications
- severe heart failure, severe arrhythmias, severe valvular heart disease and severe congenital heart disease
- active chronic liver disease and cirrhosis
- severe primary immunodeficiency requiring prolonged treatment and infection with the human immunodeficiency virus (HIV)
- type 1 diabetes and type 2 diabetes
- severe forms of neurological and muscular disorders (including myopathy) and severe epilepsy
- severe acquired and constitutional chronic hemoglobinopathies and hemolysis
- hemophilia and serious constitutional hemostasis disorders
- coronary heart disease
- severe chronic respiratory failure
- stage 2 and 3 Alzheimer's disease and other dementias
- stage 3 Parkinson's disease
- hereditary metabolic diseases requiring prolonged specialist treatment
- cystic fibrosis
- severe chronic nephropathy and primary nephrotic syndrome
- paraplegia
- vasculitis, systemic lupus erythematosus and systemic sclerosis
- progressive rheumatoid arthritis
- progressive ulcerative colitis and Crohn's disease
- stage 3 multiple sclerosis
- progressive structural idiopathic scoliosis (where the angle is equal to or greater than 25 degrees) until spinal maturity
- severe ankylosing spondylitis
- complications of organ transplants
- active tuberculosis and leprosy
- malignant tumor and malignant disorders of the lymphatic or hematopoietic tissue.

12. APPENDIX 2: DATA SHARING AGREEMENT BETWEEN MSH AND EUROP ASSISTANCE ON THE PROTECTION OF PERSONAL DATA

In the context of their contractual relationship, the Parties agree to comply with the regulations in force applicable to the processing of personal data and, in particular, Regulation (EU) 2016/679 of the European Parliament and of the Council of April 27, 2016 applicable as of May 25, 2018 (hereinafter referred to as the "GDPR").

A. DEFINITIONS

Data Controller: the natural or legal person, public authority, agency, or other body which, alone or jointly with others, determines the purposes and means of the Processing.

Data Processor: the natural or legal person, public authority, agency, or other body which processes Personal Data on behalf of the Data Controller.

European legislation on the protection of personal data: the GDPR as well as any law or regulation of the member states of the EEA related to it.

French Data Protection Act: Law no.78-17 of January 6, 1978 relating to data processing, files and freedoms as amended, including its modifications subsequent to the signing of the Agreement.

GDPR: Regulation (EU) no. 2016/679 of the European Parliament and of the Council on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC.

Insurer's Personal Data: Personal data contained in the documents, data and files, regardless of the medium, paper or digital, sent by the Insurer to the Policyholder or the Broker, or to which the Broker will have access at the Insurer's premises or in its systems, including by remote access, or which it will have collected directly and/or processed in any other way on behalf of the Insurer within the framework of the delivery of the Services provided for in this Agreement.

Personal Data: any information relating to an identified or identifiable natural person (hereinafter referred to as a "**Data Subject**"); an "identifiable natural person" is one who can be identified, directly or indirectly, in particular by reference to an identifier, such as a name, an identification number, location data, an online identifier, or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural, or social identity of that natural person.

Personal Data breach: any breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorized disclosure of, or access to, Personal Data transmitted, stored or otherwise processed.

Processing: any operation or set of operations which is performed on Personal Data or on sets of personal data, whether or not by automated means, such as collection, recording, organization, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure, or destruction.

B. PROCESSING AND ROLE OF THE PARTIES

The Policyholder and the Broker operate as insurance intermediaries and, in order to provide the Services, are required to process Personal Data relating to the Insurer's clients and insured members, on behalf of the Insurer.
In this capacity and within the framework of the Agreement, the Insurer is the Data Controller and the Policyholder and the Broker are Data Processors.

The Parties shall comply with the GDPR and the French Data Protection Act.

The types of authorized Processing are: [Collection, Recording, Organization, Structuring, Storage, Adaptation, Alteration, Retrieval, Consultation, Use, Disclosure, or otherwise making available, Restriction, Erasure, and Destruction].

The purpose of the processing is: [claims management and the processing of complaints under the conditions described in the Agreement]

The duration of the Processing is [_____24 months____]

The categories of data subject are: the insured members/beneficiaries of the Programs____ purchased by ASFE_____

The Types of Personal Data are (check):

National/Official/Social Identity	X	Qualification and Performance		Trade union membership	
Racial or ethnic origin		Identity issued by the company	X	Billing and payment data/accounts	X
Criminal offenses or convictions		Political views		Medical and health-related data	X
Authorizations and powers	X	Contractual data		Economic situation	
Religious or philosophical beliefs		Personal contact data - physical identifiers online		Biometric data	
Sex life or sexual orientation		Vehicle identification		Genetic data	
Data on operated vehicles		Location/movement data	X	Image or voice recordings	X
Other:		Banking data (credit or debit card numbers, account numbers, etc.)	X	Contact data including addresses, phone numbers, etc.	X

All of the Insurer's Personal Data constitute confidential information which remains the property of the Insurer and is covered by professional secrecy (Article 226-13 of the French Penal Code).

In accordance with the French Data Protection Act and the GDPR, the Policyholder and the Broker agree to act on the Insurer's Personal Data only on documented instruction from the Insurer acting as Data Processor processing these data on behalf of the Data Controller. However, the Policyholder and the Broker agree to inform the Insurer without delay if, in their opinion, an instruction from the Insurer constitutes a breach of the GDPR or the French Data Protection Act or any other provision of European Union law or French law in respect of Personal Data.

The Policyholder and the Broker are, however, solely responsible for the processing of Personal Data that they carry out on their own behalf.

C. Obligations of the Insurer

It is the responsibility of the Data Controller, with respect to the Personal Data subject to Processing within the framework of the Agreement, to:

- comply with the provisions of the French Data Protection Act and the GDPR and, in particular, to process Personal Data in a lawful manner, including by obtaining the consent of the data subjects when necessary;
- provide the Data Subjects with the information required by the French Data Protection Act and the GDPR;
- allow the Data Subjects to exercise their rights under the French Data Protection Act and the GDPR and to follow up on these requests;
- keep a register of Processing activities in accordance with the French Data Protection Act and the GDPR.

D. Obligations of the Policyholder and the Broker

The Policyholder and the Broker agree to take all appropriate technical and organizational measures to preserve the security of the Insurer's Personal Data and to guarantee their confidentiality, and in particular to prevent them from being destroyed, lost, altered, or communicated to unauthorized persons.

The Policyholder and the Broker also agree to comply with the following obligations, and to ensure their agents and Data Processors comply with them:

a) Take all appropriate measures to ensure that any person acting under their authority and having access to the Insurer's Personal Data, processes such data only in accordance with the Insurer's instructions, and ensure that persons authorized to process the Insurer's Personal Data: (i) receive the necessary training in the protection of Personal Data, (ii) undertake to respect the confidentiality of such data, in particular by means of an appropriate clause in their contract, and (iii) are bound by an obligation of professional secrecy.

b) Take all appropriate security measures, including physical measures, to ensure the confidentiality, integrity, and availability of the Insurer's Personal Data and to prevent any misappropriation or fraudulent use of the Insurer's Personal Data.

c) Return all of the Insurer’s Personal Data to the Insurer free of charge and at any time within eight (8) days of the Insurer's initial request.

d) On expiration of the Agreement, at the latest within eight (8) days following this expiration, as decided by the Insurer: return all of the Insurer’s Personal Data to the Insurer free of charge and retain no copies, records or reproductions thereof or, at the express written request of the Insurer, destroy all of the Insurer’s Personal

Data in its entirety, no later than 30 days following this expiration, and retain no copies, records or reproductions thereof, and in all cases, provide the Insurer with written evidence of the destruction of the data.

Notwithstanding the foregoing, the Policyholder and the Broker may at all times retain copies of the data necessary for them to comply with their legal and regulatory obligations and defend their interests, until such time as these obligations are time-barred.

e) Take all appropriate measures and guarantees to ensure that the Insurer's Personal Data cannot be stored or be subject to Processing in a form that allows the identification of the Data Subjects beyond the time necessary for the purposes for which they were sent or made accessible to the Policyholder and the Broker by the Insurer, as defined in the appendix "**Instructions relating to the processing of personal data**" of the Appendices to the Programs.

f) Not to transfer or allow access to the Insurer's Personal Data outside the European Union without the Insurer's prior written agreement, both with respect to the country or countries to which the Personal Data are to be transferred, and the recipients of such data, including in the case of outsourcing of processing as provided for below.

g) Process the Insurer's Personal Data only in accordance with the Insurer's written instructions and refrain from:
- any personal use, including commercial use, and any other operation or utilization without prior written authorization from the Insurer;

and
- allowing or facilitating their use by third parties, Data Processors or any person acting under the authority of or on behalf of the Policyholder and the Broker, for purposes other than the performance of the Services, without prior written authorization from the Insurer.

h) In the event of the discovery of a Breach of the Insurer's Personal Data, the Policyholder and the Broker agree to:
- inform the Insurer, without delay, and at the latest within forty-eight (48) hours of the discovery of this breach;
- provide the Insurer with all the required information, without delay;
- actively cooperate with the Insurer to enable it or the Data Controller, in particular, to fulfil its obligations to notify the supervisory authority and the Data Subjects;
- implement without delay, at their own expense, all measures required to stop the Insurer's Personal Data being breached with respect to the Processing being carried out by them and inform the Insurer of this.

i) Assist the Insurer, through appropriate technical and organizational measures, as far as possible, in fulfilling its obligation to respond to requests made by Data Subjects with a view to exercising their rights, and in particular in the event of a request for right of access, in order to enable the Insurer to send the Data Subject his or her Personal Data processed by the Policyholder or the Broker and to inform the Insurer without delay of any request from Data Subjects or from a data protection authority or any other regulatory or supervisory authority, without however responding directly to it, unless authorized by the Insurer, in order to enable the Insurer to assess the action to be taken.

j) Inform the Insurer of any request for access or direct disclosure from a third party who is authorized to do so by the application of binding legal or regulatory provisions or by a court decision, or judicial or administrative proceeding or investigation, and, before any access or disclosure, make the necessary checks as to the validity of the request for disclosure, and request the Insurer's agreement.

k) Inform the Insurer without delay in the event of an inspection by the French Data Protection Authority, CNIL or any other supervisory authority to which the Policyholder or the Broker is subject in connection with the Services provided.

l) Provide the Insurer with all necessary information without delay, and in particular all documentation and procedures, as well as their updates, demonstrating the Policyholder's and the Broker's compliance with their obligations relating to the protection of the Insurer's Personal Data, as well as all necessary information, and in particular all documentation and procedures, relating to the Processing carried out by the Policyholder and the Broker within the framework of the Agreement, enabling the Insurer to demonstrate compliance with its obligations provided for in the GDPR and the French Data Protection Act.

m) Maintain a written record of all categories of Processing activities performed on behalf of the Insurer, including the information required by the GDPR and the French Data Protection Act.

The Policyholder and the Broker agree to inform the Insurer of any difficulties they may encounter in the implementation of their obligations relating to the protection of the Insurer's Personal Data.

E. DURATION OF VALIDITY

The expiration of the Agreement shall not relieve the Policyholder and the Broker of their obligation to comply with the provisions of this Appendix with respect to the use and protection of the Insurer's Personal Data, and the obligations contained in the provisions of this Appendix shall remain in force for five (5) years after the date of termination or expiration of the Agreement.

F. OUTSOURCING

The Policyholder and the Broker may not use the services of a Data Processor, within the meaning of the French Data Protection Act and the GDPR, to carry out the Processing of all or part of the Insurer's Personal Data without the prior specific written agreement of the Insurer. The Policyholder and the Broker shall contact the Insurer by letter at least 60 (sixty) days before the date of implementation of the planned outsourcing of processing, indicating as a minimum the name and contact details of the chosen Data Processor, the Processing involved and the technical and organizational measures put in place to guarantee the compliance of the said Processing. In no case shall the absence of a response from the Insurer be considered as tacit agreement.
The Policyholder and the Broker also agree to inform the Insurer in the event of termination of a Data Processor.
The list of Data Processors authorized by the Insurer is shown below and/or, if applicable, in the "Personal Data Protection" Appendix of the Appendices to the Programs. This list will be updated if a Data Processor is added or removed.
No outsourcing of the processing of the Insurer's Personal Data shall take place without the signature of a written contract between the Policyholder, the Broker and the Data Processor, subjecting the Data Processor to conditions of protection of the Insurer's Personal Data identical to those of this Appendix, in order to guarantee a level of protection equivalent to that of this Appendix; the said contract shall define as a minimum the purpose and nature of the Processing, the type of Personal Data being processed and the categories of Data Subjects, as well as the rights of the Data Processor. In addition, the Policyholder and the Broker shall ensure that the chosen Data Processor provides sufficient guarantees as to the implementation of appropriate technical and organizational measures so that the Processing meets the requirements of the French Data Protection Act and the GDPR and shall be able to provide evidence of this to the Insurer.

In all cases, the Policyholder and the Broker shall assume full responsibility for the actions or omissions of their Data Processors and shall ensure that the obligations of confidentiality and protection of the Insurer's Personal Data are duly observed by them.

List of data processors authorized by the Insurer:

- Sendinblue, 7 rue de Madrid, 75008 Paris, France

G. INSPECTION

In the event of an inspection of the Insurer by a regulatory or supervisory authority, in accordance with the terms and conditions defined by this authority, the Policyholder and the Broker agree to cooperate with the Insurer and make available to any person authorized by the Insurer, subject to an obligation of confidentiality, any information necessary to demonstrate the compliance of the Policyholder and the Broker with the obligations set out in this Appendix.

In the event of an audit, in accordance with the provisions relating to the audit of the Agreement, the Policyholder and the Broker agree to make available to the Insurer and to any person authorized by the Insurer, bound by an obligation of confidentiality, any information necessary to demonstrate the compliance of the Policyholder and the Broker with the obligations set out in this Appendix.

H. LIABILITY

Compliance with the provisions of the Appendix "Personal Data Protection Agreement" with regard to the Insurer's Personal Data is an essential condition of the Agreement without which the Insurer would not have entered into the contract.

In the event of non-compliance with the provisions of this Appendix on the protection of the Insurer's Personal Data and the confidentiality of these data, the Policyholder and the Broker may be held liable on the basis of the provisions of Articles 226-17 and 226-22 of the French Penal Code. In addition, in the event of a breach by the Policyholder and the Broker of professional secrecy or non-compliance by the Policyholder or the Broker with any of the aforementioned stipulations, the Insurer may terminate the Agreement through the exclusive fault of the Policyholder or the Broker, in accordance with the termination stipulations provided for in the Agreement, without indemnity in favor of the Policyholder or the Broker. In addition, they shall pay damages to the Insurer to compensate for the resulting loss.

Notwithstanding any stipulations to the contrary in the Agreement, the liability of the Policyholder and the Broker shall not be limited with respect to direct damages suffered by the Insurer under, or in connection with, the Agreement resulting from a failure by the Policyholder or the Broker to fulfill its confidentiality obligations or its obligations relating to the protection of the Insurer's Personal Data under the Agreement.

The Policyholder and the Broker shall not be held liable for damage caused by the Insurer's failure to fulfill its own obligations as a Data Processor.

Each Party agrees to indemnify the other against any claim for compensation from a third party to the Agreement, and in particular against any claim from a Data Subject who has suffered damage, whether material or moral, as a result of a breach by a Party of the provisions of this Appendix or a breach of the provisions of the GDPR or the French Data Protection Act. The accused Party shall be exonerated from liability if it proves that the occurrence having caused the damage is in no way attributable to it.

I. CONTACT

For any questions relating to this Appendix on the protection of the Insurer's Personal Data, in particular for any questions regarding the outsourcing of processing, the Policyholder and the Broker shall approach the Insurer's point of contact.
The Insurer may also approach the dedicated point of contact of the Policyholder or the Broker, whose names and contact details are provided in the same appendix, for any requests relating to the protection of the Insurer's Personal Data.

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.

MSH, the designer and administrator of ASFE plans, is a world leader in international benefits with over 500,000 globally-mobile individuals insured worldwide.
MSH provides you with the services of a dedicated team which is on hand to support and advise you day after day.

YOUR CONTACTS

MSH

For further information or to apply for coverage, you can reach us using the contact details below:

- Tel: +33 (0)1 44 20 48 77
- Email: sales@msh-intl.com
- Website: www.msh-intl.com

01/2023

MSH DIOTSIACI GROUP on behalf of asfe

MSH a French insurance broker and simplified joint stock company (société par actions simplifiée) with a capital of €2,500,000 whose registered office is located at 39 rue Mstislav Rostropovitch 75815 Paris Cedex 17 France. It is registered with the Paris Trade and Companies Register under number 352 807 549 and with ORIAS under number 07 002 751- intra-Community VAT identification number FR 78 352 807 549. MSH is regulated by the French Prudential Supervision and Resolution Authority (ACPR).

Groupama Gan Vie, a French limited company (société anonyme) with a capital of €1,371,100,605- registered with the Paris Trade and Companies Register under number 340 427 616 - APE 6511 Z Head office: 8-10 rue d'Astorg - 75383 Paris Cedex 08 France - Tel: +33 (0)1.44.56.77.77, Company governed by the French Insurance Code and subject to the French Prudential Supervision and Resolution Authority (ACPR) - 4 place de Budapest - CS 92459 - 75436 Paris Cedex 09, France.
The insurance products distributed by brokers under the Gan Eurocourtage brand are Groupama Gan Vie products.www.gan-eurocourtage.fr - contact-collectives@gan.fr

Europ Assistance, a company governed by the French Insurance Code, a French limited company (société anonyme) with a capital of €35,402,786, registered with the Nanterre Trade and Companies Register under number 451 366 405. Its registered office is located at 1 Promenade de la Bonnette - 92230 GENNEVILLIERS, France.