FIRST' EXPAT+ // RELAIS' EXPAT+
MEMBERS' GUIDE

// INFORMATION BOOKLET AND GENERAL TERMS & CONDITIONS

MSH INTERNATIONAL on behalf of asfe
SIACI SAINT HONORE GROUP

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SUMMARY

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

1.1 / PRESENTATION OF ASFE AND ITS ADMINISTRATOR MSH INTERNATIONAL

You have chosen an ASFE international insurance plan from Groupama Gan Vie, managed by MSH INTERNATIONAL, and we are delighted to welcome you as a member.
ASFE, the Association of Services For Expatriates, was created in 1992 and is governed by the French law of 1901 on associations. Its purpose is to provide expatriates all over the world with solutions in the fields of healthcare coverage, life & disability, medical assistance / repatriation and third-party liability. Throughout this document AFSE will be referred to as "**ASFE**" or the "**Contracting association**".
MSH INTERNATIONAL, the designer and **Administrator** of ASFE plans, is a world leader in international benefits with over 400,000 globally-mobile individuals insured worldwide. **MSH INTERNATIONAL** provides you with the services of a dedicated team which is on hand to support and advise you day after day. **MSH INTERNATIONAL**, an organization mandated by the **Insurer** and the **Contracting Association** to administer the plan will be referred to throughout this document as "**MSH INTERNATIONAL**", "the **Administrator**", "the **Administrating Organization**" or "the **Insurer**" whenever this term is used in the context of the administrative management of the plan.
The plan is insured by **Groupama Gan Vie** – a French société anonyme with a capital of 1,371,100,605 euros (fully paid) - RCS Paris 340 427 616 - APE 6511 Z Head office: 8-10 rue d'Astorg - 75383 PARIS Cedex 08 - Company regulated by the French Insurance Code and subject to the Prudential Supervision Authority (ACP) - 61 rue Taitbout - 75009 Paris hereinafter referred to as "the **Insurer**".

1.2 / PURPOSE OF THE INSURANCE

The **ASFE Insurance plans** Nos. 210 / 863689 00010, 210 / 863689 00020, 210 / 863689 00030, 210 / 863689 00040, 210 / 863689 00010 / D, 210 / 863689 00020 / D, 210 / 863689 00030 / D, 210 / 863689 00040 / D, 210 / 863690 00010, 210 / 863690 00020, 210 / 863690 00030, 210 / 863690 00040, 210 / 863691 00020, 210 / 863691 00030, 210 / 863691 00040, 210 / 863691 00020 / D, 210 / 863691 00030 / D, 210 / 863691 00040 / D, 210 / 863692 00020, 210 / 863692 00030, 210 / 863692 00040 in which you are enrolled are a type of plan known as "**open group**". They provide coverage from the 1st euro / 1st dollar / in addition to benefits provided by the **CFE** (Caisse des Français de l'Etranger), to the exclusion of any other healthcare insurance scheme.
Their purpose, within the limit of actual costs, is the payment of **Benefits**, from the 1st euro / 1st dollar / in addition to benefits paid by the **CFE**, as a reimbursement of medical expenses incurred by **ASFE Members** living outside their **Country of nationality**, in a private or professional capacity as well as any **Dependents** as defined below, whether or not they are residing in the same foreign country, if they are enrolled in the plan.
Your membership of these plans will be referred to throughout this document as "**Your membership**". Each plan provides basic healthcare coverage which can be supplemented by optional benefits and 4 levels of coverage within these options (see section entitled "COVERAGE OPTIONS").
Each plan also includes 5 coverage zones (see section entitled "SPECIFIC COUNTRY OF RESIDENCE AND COVERAGE ZONE UNDER THE PLAN").
As part of your membership, your healthcare benefits are supplemented as standard by **Medical Evacuation** benefits. Europ Assistance, a company regulated by the French Insurance Code, insures and operates the **Assistance Services**.
The plans provide a very comprehensive and flexible offer tailored to individual needs. You can also purchase life & disability benefits to protect you in the event of death or sick leave from work.

2 / PROCEDURES FOR ACCESSING HEALTHCARE, BENEFITS AND USEFUL SERVICES AS WELL AS HOW TO CONTACT US AND ACCESS THE MEMBERS' AREA

2.1 / ACCESSING HEALTHCARE AND BENEFITS

CLAIMING REIMBURSEMENT OF YOUR ROUTINE MEDICAL EXPENSES

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

1 **Consult a healthcare practitioner and pay the fees.**
Details of our global **Medical network** of healthcare practitioners and hospital facilities are available at:
http://www.asfe-expat.com, Members' Area, Your Healthcare / Find a facility.

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

If you are claiming a reimbursement of less than € / $500 (only for FIRST'EXPAT+ plans), please use the members' area:
scan and upload all the supporting documentation (medical prescriptions, practitioners' fees and bills) directly to the secure members' area, for claims of up to € / $500 of medical expenses (or equivalent amount in the currency of payment). This method is simple, fast and reliable and will allow you to benefit from reduced claims processing times (4 days on average).

IMPORTANT

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

If you are claiming a reimbursement of more than €/$ 500:
once you have filled out your claim form online, print it out and sign it, then send it to your claims department (SECTION '2.4 / CONTACTING US') enclosing the originals of your medical prescriptions (see section entitled IMPORTANT below), practitioners' fees and bills, as well as the pharmacy price labels for drugs purchased in France.
The documents to be enclosed with your claim must show the first and last name(s) of the patient, the date, amount and details of the treatment together with the name, address and telephone number of the practitioner, hospital, laboratory or pharmacist.
If you have not supplied all the required information or documents, you will be notified by the  icon (click on it to open the message) which will be displayed in the reimbursement statement available online in the **Members'** Area.
We recommend that you group your claims together to avoid receiving reimbursements of very small amounts and include several treatments and / or different **Dependents** on the same claim form.

2 **You will receive your reimbursement by check or by wire transfer in the currency of your bank account.**
If the currency of your bank account is not the same as the one you used to pay for your healthcare, the exchange rate used to calculate your reimbursements will be the one issued by the United Nations on the last day of the month preceding the date of your treatment.

IMPORTANT

If you are sending original documents, remember to keep photocopies for your records.
To qualify for Benefits, claims for the reimbursement of medical expenses must be received no later than 24 months following the date of treatment. If there is a disagreement over the amount reimbursed, the Member must notify us within 6 months of the date shown on the reimbursement statement.
It is specified that Benefits will be paid directly to Members or, if Prior approval has been obtained, to the healthcare provider. Direct payments are never made for dental and vision care.

FREQUENTLY ASKED QUESTIONS ABOUT THE REIMBURSEMENT OF YOUR ROUTINE MEDICAL EXPENSES

• WHAT SUPPORTING DOCUMENTS DO I NEED TO PROVIDE AND WHAT IS THE PROCEDURE TO FOLLOW WHEN MAKING A CLAIM FOR REIMBURSEMENT?

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

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

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

• ARE THERE ANY SPECIAL PROCEDURES FOR HEALTHCARE RECEIVED IN FRANCE?

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

• HOW CAN I CHECK MY BENEFITS ONLINE?

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

• WHERE CAN I FIND THE NAMES OF QUALIFIED DOCTORS, CLINICS AND HOSPITALS WORLDWIDE?

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

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

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

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

• I AM UNSURE ABOUT THE DIAGNOSIS OR TREATMENT I GOT FROM MY DOCTOR / HOSPITAL FACILITY. HOW DO I GET A SECOND OPINION?

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

• WHAT IS THE PROCEDURE IF I REQUIRE EMERGENCY HOSPITALIZATION IN MY COUNTRY OF EXPATRIATION OR IF I'M TRAVELING OR ON VACATION OUTSIDE MY COUNTRY OF EXPATRIATION?

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

• WHAT IS THE DEADLINE FOR SUBMITTING A CLAIM FOR REIMBURSEMENT?

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

• DO I NEED TO TRANSLATE MY DOCUMENTS INTO ENGLISH / FRENCH OR CONVERT THE CURRENCY FOR MY CLAIM TO BE PROCESSED?

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

• IF I SUBMIT A CLAIM FOR REIMBURSEMENT IN A CURRENCY OTHER THAN THE CURRENCY OF MY BANK ACCOUNT, WHAT EXCHANGE RATE IS APPLIED?

The exchange rate used to calculate your reimbursements is the one issued by the United Nations on the last day of the month preceding the date of your treatment.

• HOW DO I KNOW WHEN I'VE BEEN REIMBURSED?

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

• I DON'T UNDERSTAND OR I DON'T AGREE WITH THE REIMBURSEMENT I'VE RECEIVED. WHAT SHOULD I DO?

Go to: http://www.asfe-expat.com, Members' Area, Contact us / Submit an inquiry or contact your claims department (SECTION '2.4 / CONTACTING US') to clear up any misunderstanding.
In the event of a disagreement over the amount of the payment, the **Member** must notify us within 6 months of the date of issue of the reimbursement statement.

REQUESTING PRIOR APPROVAL FOR COSTLY, SERIAL OR LONG-TERM TREATMENTS OR PROCEDURES

• WHAT DO WE MEAN BY A REQUEST FOR PRIOR APPROVAL?

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

• IN WHAT CIRCUMSTANCES DO I NEED TO REQUEST PRIOR APPROVAL?

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

1. **Hospitalization**: the patient should send the **Request for prior approval**, completed and signed by the practitioner to the **Administrator** (MSH INTERNATIONAL) at least 10 DAYS before admission to hospital. If the costs are incurred in France, **Members** who have French nationality should use the **Request for prior approval** from French Social Security. In an obvious **Emergency** situation, the **Request for prior approval** should be sent to the **Administrator** (MSH INTERNATIONAL) within 2 DAYS of admission to **Hospital**, indicating the urgent nature of the hospitalization. If the hospital stay is extended beyond 30 DAYS, the **Request for prior approval** must be renewed within the FIRST 10 DAYS following expiration of that period.

2. **Routine healthcare dispensed as a series of treatments or which is costly**: Medical treatments or consultations dispensed as a series of treatments if the number of sessions exceeds 10, are subject to the prior approval procedure, particularly in respect of paramedical practitioners (physical therapy, nursing care, **Orthoptics**, **Speech therapy**, childbirth preparation classes, etc.) or **Alternative medicine** (**Acupuncture, Osteopathy, Chiropractic, Homeopathy and** nutrition) and **Specialist** treatments and procedures.
   You should also send your **Request for prior approval** to your claims department for the following costly treatments:
   - dentures - crowns - bridges, bone grafts, Periodontics and Dental surgery involving more than 3 teeth,
   - dental implants and Orthodontics,
   - refractive laser surgery,
   - medical Prostheses other than dentures (orthopedics, hearing aids, etc.),
   - attempts at Medically assisted reproduction,
   - diagnosis of chromosomal abnormalities,
   - stays in a medical center,
   - surgical procedures on an outpatient basis.
   The Member should send the **Request for prior approval**, completed and signed by the practitioner to the **Administrator** (MSH INTERNATIONAL) at least 10 DAYS before commencing the treatment or undergoing the procedure. If the treatment or procedure is to be carried out by a paramedical practitioner, the prescription from the prescribing **Doctor** should be sent along with the **Request for prior approval**. This approval is only valid for treatment commencing in the month following approval and within the limits set out in the approval.

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

• WHAT IS THE REQUEST FOR PRIOR APPROVAL USED FOR?

This document is essential in order to:
. approve the proposed treatment with respect to the condition,
. provide you with information regarding the amount that will be reimbursed,
. issue the appropriate **Precertification agreement** so that no cash advance is required.
It also allows us to negotiate rates with hospitals or healthcare practitioners.
If you have any questions regarding the **Request for prior approval**, you should first contact your claims department (SECTION '2.4 / CONTACTING US').

• HOW DO I OBTAIN PRIOR APPROVAL?

1. Send us your treatment plan by email (precert@msh-intl.com), mail or fax including the prescription from the prescribing doctor, or the medical report, x-rays if required and / or an itemized estimate of costs.
2. On receipt of your complete request, we will inform you of the terms of your reimbursement within 72 hours.

• FOR INSURED MEMBERS IN THE UNITED STATES, WHAT HAPPENS IF PRIOR APPROVAL IS OBTAINED BUT THE INSURED MEMBER THEN DECIDES TO BE TREATED IN A HOSPITAL, BY A DOCTOR OR IN A CLINIC WHICH IS NOT PART OF THE UNITEDHEALTHCARE INTERNATIONAL MEDICAL NETWORK?

We will reduce the amount covered under your open group Insurance plan by 20% . A list of the **Hospitals**, clinics and **Doctors** belonging to the UnitedHealthcare International **Medical network** is available online. For more information, please refer to the section entitled "Important information regarding care received in the USA".
In some cases, it may reasonably be impossible to get treatment in a **Hospital**, from a **Doctor** or in a clinic belonging to the UnitedHealthcare International **Medical network**. In these circumstances, we will not apply any reduction to the covered costs. For example:
if there is no **Hospital**, **Doctor** or clinic belonging to the UnitedHealthcare International **Medical network** within a 50 kilometer radius of the **Insured member's** home; and
where the treatment required by the **Insured member** is not available in **Hospitals**, from **Doctors** or in a clinic belonging to the local UnitedHealthcare International **Medical network**.

IMPORTANT

If you fail to submit a Request for prior approval, or if it has been denied, the reimbursement of healthcare services provided under the open group plan will be reduced. For all claims for reimbursement which are subject to prior approval but for which this procedure has not been followed, the Administrator (MSH INTERNATIONAL) will apply a penalty of between 40% and 100% to the amount of the Benefit.
This penalty is in addition to any others which may be applicable if treatment is received in Zone 5 outside the UnitedHealthcare International Medical network.
You should therefore be sure always to request prior approval before incurring any expenses. We will reply within 72 hours of receipt of your complete request.

REQUESTING A PRECERTIFICATION AGREEMENT FOR COSTLY TREATMENTS OR PROCEDURES

• WHAT DO WE MEAN BY PRECERTIFICATION?

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

• IN WHAT CIRCUMSTANCES CAN I REQUEST A PRECERTIFICATION AGREEMENT?

- For Maternity

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

- For hospitalization

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

- For other types of healthcare (except dental and vision)

MSH INTERNATIONAL may extend its system of **Precertification** to a wider range of medical treatments and procedures. Please contact us to find out if the treatment or procedure you are having qualifies for direct payment (SECTION '2.4 / CONTACTING US').

• WHAT IS THE PROCEDURE TO FOLLOW FOR HOSPITAL PRECERTIFICATION?

For scheduled hospitalization or maternity:

1. Contact your claims department by telephone, email (precert@msh-intl.com) or fax at least 10 days before your admission to **Hospital**, specifying the name of the **Hospital** / practitioner and their address and telephone number.
2. Go to http://www.asfe-expat.com and fill out your **Precertification request** directly at: http://www.asfe-expat.com, Members' Area, Your reimbursements / Precertification and Direct Payment Request. Send all the documents to your claims department (SECTION '2.4 / CONTACTING US').
3. We will then contact the **Hospital** directly and issue you with confirmation of your hospital **Pre- certification** agreement. MSH INTERNATIONAL will then make a payment to the healthcare provider subject to medical approval.

In an emergency:

1. Go directly to the **Hospital**
2. Present your ASFE - MSH-INTERNATIONAL card to the admissions department at the Hospital
3. Ask them to contact us no later than 48 hours following your admission. We will issue them with confirmation of the hospital **Precertification**.

IMPORTANT

On arrival at the Hospital, please present your ASFE - MSH INTERNATIONAL card: it will help facilitate administrative procedures.
Whatever country you are in, try to seek treatment within the public or state-approved sector where possible or contact us for details of medical facilities whose prices meet our criteria for "Usual, customary and reasonable costs".

IMPORTANT INFORMATION REGARDING CARE RECEIVED IN THE USA

• FOR MEMBERS WHO SELECTED THE USA COVERAGE ZONE
If you have opted for the USA coverage zone and require treatment or hospitalization there, or need to see a local **Doctor**, your plan enables you to benefit from specific agreements set up by MSH INTERNATIONAL with 2 local partners: **UnitedHealthcare** and **Optum RX.**
These agreements mean you can:
- access a selection of top-quality **Hospitals** and healthcare practitioners with UnitedHealthcare and well-known pharmacies with **Optum RX**,
- avoid having to make a cash advance to medical practitioners of the UnitedHealthcare **Medical network**, by presenting your card before commencing any medical treatment or undergoing a procedure,
- have your medical prescriptions covered directly by the insurance when you take them to a pharmacy belonging to the Optum RX **Medical network** by presenting your card before your prescription is delivered.

• THE UNITEDHEALTHCARE / OPTUM RX / MSH INTERNATIONAL CARD FOR YOUR HEALTHCARE IN THE UNITED STATES
In the weeks following your enrollment, you will receive a UnitedHealthcare / Optum RX card. This card will be in the name of the primary **Member** but will also cover all the **Dependents**. Be sure to present your card to practitioners within the UnitedHealthcare International and Optum RX **Medical network** to avoid having to make an advance payment for your medical expenses.

Find a practitioner belonging to the UnitedHealthcare International **Medical network**:
- Click on the following link: http://us1.welcometouhc.com/
- Enter your location criteria

IMPORTANT

Your coverage in the USA always gives you the freedom to choose which Hospital is best suited to your treatment (including those outside the UnitedHealthcare International Medical network). However, if you choose to be treated in the United States in a Hospital or by a Doctor or clinic that is not part of the UnitedHealthcare International Medical network, any payments we make will be reduced by 20% .
However, if it is physically impossible for you to be treated by a member of the UnitedHealthcare International Medical network, for geographical reasons or in an Emergency, the 20% reduction in the level of reimbursement specified in the plan will not be applied.
This penalty is in addition to any others that may be applicable if treatment was received without a Request for prior approval being submitted or if it was denied.
These exceptions include cases where:
- **there is no Hospital, Doctor or clinic belonging to the UnitedHealthcare International Medical network within a 50 kilometer radius of the Insured member's home; and**
- **the treatment required by the Insured member is not available in Hospitals or from Doctors or clinics belonging to the local UnitedHealthcare International Medical network.**

Find a pharmacy belonging to the Optum RX **Medical network**:
- Click on the following link to find the pharmacy nearest to you: https://chp.optumrx.com/RxSolWeb/mvc/pharmacySearch/searchByZipOrStateCity.do?type=PDPClientPharmacy&/
- Enter your location criteria

IMPORTANT

Your coverage in the United States always gives you the freedom to choose which pharmacy is most convenient for the purchase of your Prescription drugs (including those outside the Optum RX Medical network). However, if you decide to buy your Prescription drugs in the United States at a pharmacy that is not part of the Optum RX Medical network, any payments we make will be reduced by 20% .
However, if it is physically impossible for you to use a pharmacy belonging to the Optum RX Medical network, for geographical reasons or in an Emergency, the 20% reduction in the level of reimbursement specified in the plan will not be applied.
These exceptions include cases where:
- **there is no pharmacy belonging to the Optum RX Medical network within a 50 kilometer radius of the Insured member's home; and**
- **the drugs required by the Insured member are not available in pharmacies belonging to the local Optum RX Medical network. This penalty is in addition to any others that may be applicable if treatment was received without a Request for prior approval being submitted or if it was denied**

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

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

IMPORTANT

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

METHODS OF REIMBURSEMENT AND ANY BANK CHARGES WHICH MAY APPLY

You will receive your reimbursement either:
- 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.

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.

REIMBURSEMENT OF COSTLY TREATMENTS OR PROCEDURES

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

- Some **Doctors**, **Hospitals** or clinics may agree to send the bill directly to us. If the treatment is covered, **the Doctor, Hospital** or clinic should send us the original bill and we will pay them directly.
- If the **Doctor**, **Hospital** or clinic prefers to bill the **Insured member** directly and the **Doctor**, **Hospital** or clinic is not paid, the **Insured member** must then send us the original bill and we will make a payment directly to the **Doctor**, **Hospital** or clinic under the terms of the plan.
- If the **Doctor**, **Hospital** or clinic bills the **Insured member** directly and the **Member** then pays them, the **Member** can send us the original bill and proof that payment has been made to the **Doctor**, **Hospital** or clinic. We will then reimburse the **Member** under the terms of the plan.

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

REIMBURSEMENT OF TREATMENTS OR PROCEDURES COSTING LESS THAN €/$ 500 (ONLY FOR FIRST'EXPAT+ PLANS)

Claims can be submitted electronically (see section entitled 'Claiming reimbursement of your routine medical expenses') for all bills under € / $500 (or equivalent amount in the currency of payment). **This method is simple, fast and reliable and will allow you to benefit from reduced claims processing times (4 days on average).**

IMPORTANT

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

For bills over or equal to € / $500, the original document must also be sent to us by mail. You will find the address in SECTION '2.4 / CONTACTING US'.

AMOUNT OF REIMBURSEMENTS

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

• CUMULATIVE INSURANCE

The reimbursements from any basic health insurance scheme, from the Insurer and from any other organization cannot exceed the amount of costs actually incurred. Cumulative insurance operates within the limits of each type of coverage regardless of the date of enrollment.
Within these limits, the Member can claim reimbursement from the provider of their choice.
On pain of forfeiture, the Member must declare any cumulative insurance arrangements. This obligation remains in force during the entire period of membership. The limiting of reimbursements to costs actually incurred is determined by the insurer for each service, treatment or procedure covered.

• THIRD PARTY LIABILITY - SUBROGATION

It is specified that the Insurer does not waive the rights and actions available to them under Article L 121-12 of the French Insurance Code relating to any subrogatory remedy they may seek from a responsible third party.
The primary **Member** or one of their **Dependents** must provide all the required information if they are entitled to claim compensation from a third party.

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

USUAL, CUSTOMARY AND REASONABLE COSTS AND CONTROLLED MEDICAL EXPENSES

Usual, reasonable and customary costs which will be reimbursed under the plan are defined as reasonable medical expenses commonly charged in the relevant country for the specific treatment received, in accordance with standard medical and generally accepted procedures. Medical expenses deemed to be excessive, unreasonable or unusual considering the country in which they were incurred, will not be covered or the amount of benefits paid will be limited.
In order to ensure the sustainability of your plan and to better control increases in healthcare expenditure, we strive to make our Members aware of the value of controlling medical expenses.

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

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

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

• USE THE MSH INTERNATIONAL MEDICAL NETWORK AS MUCH AS POSSIBLE (PARTICULARLY IN THE UNITED STATES)
You are free to choose your healthcare provider but, by opting for the MSH INTERNATIONAL Medical network (accessible in the Members' Area / 'Your Healthcare / Find a facility'), you can geo-locate the healthcare providers nearest to you and receive top-quality care anywhere in the world at reasonable rates. That way, you will benefit from the best quality of care possible while minimizing the risk of exceeding the limits of your coverage. For **Members** who have selected the **Coverage zone** which includes the United States, we would remind you that care provided within the **Medical network** will be reimbursed at a higher rate than care received outside the **Medical network**.

STRICT COMPLIANCE WITH PROCEDURES FOR CLAIMING REIMBURSEMENT

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

2.2 / DEDUCTIBLES, CO-PAYMENTS AND COST-SHARING

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

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

HOW DEDUCTIBLES OPERATE

The **Deductible** is the amount you must pay towards your medical expenses, per **Insurance year**, before we can begin to reimburse you. It is the amount payable by the **Member** and any **Dependents** covered under the plan which is deducted from the sum to be reimbursed, applicable **per person** and per **Insurance year**. If this option is selected, it will be specified on the **Certificate of enrollment**.
If your claim for reimbursement exceeds the total amount of your **Deductible,** or the remaining amount of your **Deductible** (if you have already submitted claims which did not reach the annual amount), we will reimburse the cost of covered treatments exceeding the amount of the selected annual Deductible.

For example:

1. In your application for coverage, you have opted for a deductible of €350.
2. You have to pay a first bill of €1,000 in a healthcare facility.
3. You receive a reimbursement of €650 from MSH INTERNATIONAL.

Once the annual amount of the **Deductible** has been reached, all healthcare expenses covered under the plan will be reimbursed within the limits of the benefits purchased.
The amount of the **Deductible** applies separately to each **Member** listed in the **Application for coverage** and for each **Insurance year**. It is the responsibility of the **Member** and any **Dependents** to pay the amount of the **Deductible** directly to the **Doctor**, **Hospital** or clinic. If necessary, we will inform you of the amount to be paid to the health practitioner.

IMPORTANT

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

REIMBURSEMENTS WITH THE APPLICATION OF THE DEDUCTIBLE

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

CHANGING THE DEDUCTIBLE

You can request a change in the level of the **Deductible** on each **Annual renewal date** of your plan**. It is possible to make a single change to increase or decrease the selected level of Deductible, or to add or waive an existing Deductible once only during the entire life of the plan.**
If you want to opt to waive or reduce your **Deductible**, we may ask you to complete a **Medical health questionnaire** and we may apply new specific restrictions or exclusions.
If you opt to add a **Deductible** or want to increase the level of the **Deductible**, this will reduce the amount of your **Premium**. Conversely, if you opt to waive a **Deductible** or want to reduce the level of the **Deductible**, this will increase the amount of your **Premium**.

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

If you selected the USA **Coverage zone** for your plan, 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 the **Member** and any **Dependents** to pay the amount of the **Co-payment** directly to the **Doctor**, **Hospital** or clinic.
For details of the treatments or procedures affected, please refer to section '4 // HEALTHCARE BENEFITS IN DETAIL: HEALTHCARE BENEFITS SCHEDULE' of this **Members' Guide**.

COST-SHARING AND ANNUAL OUT-OF-POCKET MAXIMUM

If you selected the USA Coverage zone for your plan, 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 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.

PEARL Package (no deductible)	
Hospital bill:	**$15,000**
Co-payment (in-network):	$400
Cost-sharing (in-network):	**20% (80% is reimbursed by your plan)**
Out-of-pocket maximum:	$4,000
Reminder: your out-of-pocket maximum is the annual maximum amount that you will have to pay in respect of cost-sharing (excluding co-payment that you will have to pay for each hospitalization).	
Your co-payment amounts to $400. Calculation of your cost-sharing will be based on $14,600.	
Cost-sharing (20%):	**$2,920 (i.e. 0.2 X $14,600)**
In this case, the cost-sharing that you have to pay does not exceed the out-of-pocket maximum.	
For a bill of $15,000:	
You have to pay:	$3,320 (co-payment of $400 + cost-sharing of $2,920)
We reimburse:	$11,680 ($15,000 - $3,320)

SAPPHIRE Package (no deductible)	
Hospital bill:	**$40,000**
Co-payment (in-network):	$200
Cost-sharing (in-network):	**10% (90% is reimbursed by your plan)**
Out-of-pocket maximum:	$2,000
Reminder: your out-of-pocket maximum is the annual maximum amount that you will have to pay in respect of cost-sharing (excluding co-payment that you will have to pay for each hospitalization)	
Your co-payment amounts to $200. Calculation of your cost-sharing will be based on $39,800.	
Cost-sharing (10%):	**$3,980 (i.e. 0.1 X $39,800)**
You will not pay more than the amount of the out-of-pocket maximum	
For a bill of $40,000:	
You have to pay:	$2,200 (co-payment of $200 + out-of-pocket maximum of $2,000 instead of $3,980)
We reimburse:	$37,800 ($40,000 - $2,200)

If you have opted for a deductible, it will be applied after the co-payment. The deductible is not included in cost-sharing.

2.3 / ACCESSING SERVICES INCLUDED UNDER YOUR PLAN

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

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

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

• AN EFFECTIVE GLOBAL MEDICAL NETWORK
You are entirely free to choose your healthcare provider but, where possible, you should try to use healthcare practitioners and hospital facilities belonging to the MSH INTERNATIONAL **Medical network**.
Thanks to our **Medical network** of more than 850,000 healthcare providers, you can benefit from top- quality care all around the world at reasonable and customary or preferential rates. You can find their contact details at: http://www.asfe-expat.com, Members' Area, Your healthcare / Find a facility.

• A MULTICULTURAL MEDICAL TEAM
The MSH INTERNATIONAL medical team includes 20 **Medical advisors** who speak fluent English and at least one other language (Spanish, Chinese, French, Arabic, etc.), making it easier for you to communicate with the **Hospitals**.
Our **Doctors** are on hand to:
- give you an explanation of the treatment recommended by your practitioner,
- provide you with a second medical opinion if you are unsure of the diagnosis you have been given,
- provide you with an opinion on usual, customary and reasonable healthcare costs charged in your Main country of residence,
- help you choose practitioners or medical facilities where the fees charged are below or close to our upper reimbursement limits.

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

IMPORTANT

Any information you send us will be handled with strict confidentiality. Only our medical teams have access to this dedicated email inbox. Communication materials to help with your administrative procedures and keep you up to date.

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

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

IMPORTANT

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

2.4 / CONTACTING US

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

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

• EUROPE
ASFE / 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
ASFE / 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
ASFE / 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

USEFUL TIP
To find out where your nearest claims department is located, go to:
http://www.asfe-expat.com, Members' Area, Contact us / Our Contact Details.
Here you can also access our contact details worldwide in the event of hospital precertification outside your usual coverage zone.

IMPORTANT

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

2.5 / ACCESSING THE MEMBERS' AREA

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

• FEATURES AVAILABLE ONLINE
In the **Members'** Area, at http://www.asfe-expat.com, in just a few clicks you can:
- view and download details of your benefits, the **Members' Guide** and your insurance card;
- submit a claim for reimbursement and request hospital precertification;
- check the progress of your claims in real time:
  • get an email alert when we receive your claim and when your reimbursement statement is available online,
  • view your reimbursement statements from the last 24 months;
- wherever you are in the world, find:
  • **Doctor** and / or healthcare facility near your home,
  • detailed health information and essential vaccinations for a particular country;
- update your personal details (mailing address, email address, password, etc.);
- get the latest health information from our newsletters;
- submit an inquiry.

• UPDATING YOUR EMAIL ADDRESS
Remember to provide or update your email address in the 'Your Details' section to sign up for reimbursement alerts by email.

• GET YOUR LOGIN DETAILS IN JUST 3 CLICKS

1. Go to http://www.asfe-expat.com, **Members'** Area.
2. On the authentication page, click on 'Get your login details'.
3. Enter the required information and click on 'Send'. You will receive your login and password directly by email.

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

IMPORTANT

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

FREQUENTLY ASKED QUESTIONS ABOUT USING THE MEMBERS' AREA

• HOW DO I CHANGE MY PERSONAL CONTACT DETAILS (EMAIL ADDRESS, PASSWORD ETC.)?
You can change your contact details online at: http://www.asfe-expat.com, Members' Area, Your Enrollment, Your Details.

• HOW DO I CHANGE MY PASSWORD?
Once you are logged into the **Members' Area**, click on the 'Your Details' section to change your password.

• I'VE LOST MY ASFE - MSH INTERNATIONAL CARD. HOW DO I GET A NEW ONE?
- Go to: http://www.asfe-expat.com, Members' Area, Insurance ID card.
- Print out your personalized e-card. Or
- Contact your claims department to get a new card (SECTION '2.4 / CONTACTING US').

3 / DEFINITIONS OF HEALTHCARE BENEFITS

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

Accident: Any bodily injury not intended by the person who suffered it, resulting from sudden action by an external cause. It is the Insured member's responsibility to provide proof of the Accident and the direct cause-and- effect relationship between it and the costs incurred.

Acupuncture: Branch of traditional Chinese medicine which consists of inserting needles into specific points on the patient's body to relieve various illnesses or to create an analgesic effect.

Administrator of the plan (administrating organization): Refers to MSH INTERNATIONAL, a French insurance broker registered with ORIAS under number 07 002 751, who manages the ASFE plans.

Aggregate limit (on healthcare benefits): The Benefits schedule for the plan stipulates 2 types of benefit limits:
the Aggregate limit for healthcare benefits refers to the Maximum amount the Administrator will pay in respect of all healthcare benefits (hospitalization & Routine healthcare as well as the dental and vision options and Maternity, if selected), per recipient of the healthcare per Insurance year, for the selected level of healthcare coverage;
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 renewal date: Each anniversary of the effective date of enrollment in the plan.

Application for coverage: Refers to the physical document confirming the Member's application for coverage under the plan, and any other statement made by the primary member for themselves or for any Dependents listed on the Application for coverage.

Benefits schedule: Document indicating, in respect of the level of healthcare coverage selected by the Member for themselves and any Dependents, details of the benefits provided under the plan, showing the upper limits, limits on the number of treatments or procedures, consultations and / or days covered for a given period of time and the Waiting periods, Deductibles, Cost-shares, OOPM and 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 entitled 'Canceling your membership before it takes effect: the Cancelation period').

Certificate of enrollment: Single document, issued only at the time of enrollment confirming the Member's enrollment in the plan and specifying, as well as the name and address of the Member, and those of any insured Dependents, the Effective date of enrollment, the benefits selected, the Selected coverage zone, the chosen Deductible and the corresponding Premium. The Certificate of Enrollment corresponds to the special conditions of enrollment in the plan.

Certificate of insurance: Document whose purpose is to serve as proof of insurance cover for the person presenting it. It contains the following information: name of the Member and any Dependents, Effective date of enrollment in the plan, number and type of enrollment selected, Insurer of the plan, benefits, Selected coverage zone and chosen Deductible.

Certificate of termination: Document provided to confirm the end of membership of the plan. This certificate is usually required by the Member's new health insurer if they switch to another health insurance plan.

CFE: 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.

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.

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 regardless of their status 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 which provides the plan to its Members and agrees to fulfill the corresponding obligations.

Co-payment: Fixed amount specified in the plan per treatment, procedure or visit which is payable by the Member and their Dependents. It is applicable per person.

Cost-share: Percentage of each claim that will not be reimbursed by your 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 entitled 'Cessation of membership and end of coverage' (right of Withdrawal and termination)').

Deductible: Refers to the amount payable by the Member and any Dependents which is deducted from the reimbursable amount. It is applicable per person and per Insurance year. If this option is selected it will be specified on the Certificate of enrollment.

Dental surgery: Refers to any Dental surgical procedure with anesthesia including dental extraction and bone or gum grafts.

Dentures and dental implants: Refers to appliances used for fixed reconstruction or repair, bridges, crowns, dentures and implants, inlays, onlays, inlay cores and any auxiliary treatment required.

Dependent: The following are classed as dependents if they are enrolled in the plan: the Member's Spouse, Civil partner or Common-law spouse and Dependent children as defined in this section.

Dependent children: Children of the Member, their Spouse, Partner or Common-law spouse:
- under the age of 20,
- under the age of 26* if they are in full-time education and are covered under a 1st euro plan,

** if the child is covered by the plan in addition to CFE benefits, they will be considered dependent until the day before their 20th birthday. For children in full-time education over the age of 20 (and until their 26th birthday) under a 1st euro plan, a school certificate is required at the time of enrollment and subsequently at the beginning of each academic year.*

Doctor: Health professional holding a degree of Doctor of Medicine who is authorized to practice medicine under the laws of the country where the treatment is administered, within the limits of the license they have been granted and who is not a family member of the person covered under this plan.

Effective date of benefits: Date specified on the Certificate of enrollment on which the benefits provided under the plan take effect, after application of the Waiting periods.

Effective date of enrollment: Date specified on the Certificate of enrollment on which the benefits provided under the plan take effect.

Emergency: Refers to the medical condition or symptoms resulting from an Illness or injury occurring suddenly and which clearly requires immediate treatment, usually within 24 hours of onset, without which there would be a risk of endangering the health of the affected person.

Emergency dental and vision care with hospitalization: Term referring to extremely urgent dental and vision care dispensed following a serious Accident or the sudden onset of an infection requiring hospitalization. Treatment must be administered within 24 hours of the Accident or infection. This benefit does not cover routine Dental surgery, routine dental care, Dentures, routine vision care, vision correction, laser vision correction and Orthodontics and Periodontics. These treatments are covered under the optional Dental / Vision benefits.

Emergency dental and vision care without hospitalization: Term referring to extremely urgent dental and vision care not requiring hospitalization but which must be administered as an emergency to relieve pain which is hard to tolerate. This benefit does not cover routine Dental surgery, routine dental care, Dentures, routine vision care, vision correction, laser vision correction and Orthodontics and Periodontics. These treatments are covered under the optional Dental / Vision benefits.

Emergency hospitalization: Treatments received through an admission in an hospital or a day-care facility, following the occurence of a sudden and unexpected health problem, due to an illness, an accident, an infection...

Emergency treatment outside the coverage zone: Refers to Emergency treatment received outside 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 a Maximum of 90 days per Insurance year and is also limited to the Aggregate limit and only covers treatment required in the event of an Accident or the onset of a sudden, unexpected and unforeseen Illness, requiring surgery or Medical treatment that cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness representing an immediate and serious danger to the health of the Member and / or their Dependents.
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.

Fertility treatment: Fertility treatment means all methods of Medically assisted reproduction (MAR), also known as medically assisted procreation (MAP), enabling a couple diagnosed as infertile to have a child. The methods covered under the plan are: in vitro fertilization (IVF), artificial insemination, hormone treatments and tubal surgery.

General practitioner: A General practitioner is responsible for the long-term monitoring, well- being and primary general medical care of a community. The care provided is not limited to groups of Illnesses related to a single organ, age group or gender. The General practitioner is often consulted to diagnose symptoms before treating the condition or referring the patient to a Specialist.

Health check-ups: Health check-ups, examinations or Laboratory tests carried out at any time in life in the absence of any apparent clinical symptoms (please refer to the healthcare benefits schedule to find the list of examinations covered under this benefit).

Home country: Country for which the Insured member has a valid passport and / or to which they would wish to be repatriated if necessary.

Home hospitalization:
Home hospitalization is an alternative to conventional hospitalization and allows the patient to be cared for in their own home.

Homeopathy: Therapeutic method consisting of prescribing a highly diluted and energized form of a substance capable of producing similar complaints to those experienced by the patient.

Hospital: Refers to a care facility or a medical institution which is registered or approved as a medical or surgical Hospital under local regulations in the country in which it is located and where the Insured member receives daily treatment or is under the supervision of a Doctor or a qualified nurse.
The following are not classed as Hospitals: wellness and fitness centers, spas, nursing homes, retirement homes and convalescent homes.

(Hospital) day care: See under Outpatient hospitalization.

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

Immediate care of newborns: Refers to all tests and examinations carried out immediately following birth to assess the functional integrity of the newborn (organs and bone structure). All other complementary preventive diagnostic procedures (including swabs, determination of blood group and hearing tests) are not covered by the mother's insurance, unless, of course, the child has been added to the plan as an eligible Dependent. All of these other Medically required examinations or treatments are covered under the conditions of the benefits purchased in respect of the newborn.

Increased health risk: Persons with an Increased health risk are those who are sick, who have
been sick or are particularly susceptible to being sick and who present a risk of Illness (morbidity) or death (mortality) greater than that of the average person of the same age. These individuals cannot therefore be insured under the standard terms and conditions.

Insured member or dependent: Refers generically to the Member and other persons covered under their plan. They receive the Benefits provided by the Insurer in respect of claims made and covered under the plan. In this plan, insured members/ dependents are also referred to as "You".

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

Insurance year: The Insurance year covers the period from the Effective date of enrollment in the plan until the 365th day following this date, with automatic renewal on each anniversary date.

Intensive care: Refers to a specialized hospital department the purpose of which is to care for patients in a critical condition, that is, who are presenting with failure of one or more of their vital functions, or who are at risk of developing severe complications. The service has highly specialized technical resources. These are in continuous use by a multidisciplinary team in order to identify, prevent and correct acute and presumably reversible imbalances related to the underlying condition (Illness, surgery, trauma and intoxication). This type of facility includes Intensive care units, critical care units, intensive therapeutic services units or intensive treatment units.

Internal and external surgical and medical prostheses and devices: Refers to any appliance, prosthesis or device required or used during surgery or considered to be Medically required for the treatment.

Laboratory tests: Examinations, including x-rays and blood tests, carried out to determine the origin of the symptoms presented or to monitor the status of the condition.

Local transfer by ambulance: Refers to transportation by ambulance of a patient, required in cases of Medical necessity or Emergency, to the Hospital or the nearest licensed medical facility best suited to the situation. This Service is provided by the Assistance company.

Main country of residence / country of expatriation: Country of residence indicated by the Insured member in their Application for coverage and shown on their Certificate of enrollment, or confirmed in writing to the Insurer during the life of the plan, in which the primary Member resides for at least six months of the year. The country specified in this way must correspond to the Main country of residence recognized by the authorities of that country (in particular, the tax authorities). The Main country of residence is used to determine the minimum Coverage zone which needs to be selected on enrollment in the plan.

Maternity: Non-pathological Pregnancy, childbirth and its consequences. Maternity is classed neither as an Illness nor an Accident.

Medical advisor: Doctor working for a public or private organization (insurance company, Healthcare insurance provider, etc.) who is responsible for providing a medical opinion on the cases submitted to them.

Medical (health) questionnaire: In the context of an Application for coverage under the insurance plan, a set of questions on the health of the Member and any Dependents which enables the Insurer's Medical advisor to assess their state of health and set the terms of the insurance. In case of increased risk for the Insurer, the completion of the Medical health questionnaire may result in an additional Premium being applied to the member or one of their dependents, an exclusion from one or more of the benefits or a total refusal of the Application for coverage under the plan. The Medical Questionnaire is valid for 4 months.

Medical imaging: MRI, radiology, scans, tomography etc. Medical imaging is used for clinical purposes in order to provide a diagnosis or propose a treatment. There are several medical imaging techniques: radiology, ultrasound, magnetic resonance imaging (MRI), endoscopy, scanner, laser, tomography, etc.

Medical network: Means all Hospitals or associated care facilities and healthcare practitioners officially listed by your plan Administrator (MSH INTERNATIONAL) or by the service partners selected by them (such as UnitedHealthcare and 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 the section 'Your enrollment in the plan and persons insured' for themselves and any Dependents and who has agreed to fulfill the corresponding obligations, including payment of the Premium specified at the time of enrollment in the plan.

Members' guide (information booklet and general terms & conditions): Document defining the benefits, exclusions and conditions of use of the insurance plan (including all information on reimbursement procedures). It should be read in conjunction with the Certificate of enrollment and the Benefits schedule. For ease of use, it will here be referred to as the Members' Guide.

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.

Out-of-pocket maximum: Out-of-pocket maximum is the annual maximum Cost-share you will have to pay for your inpatient expenditures within each insurance year.

Outpatient hospitalization: Treatment received through an admission in an hospital or a day-case facility, including a hospital room and nursing, that does not require the patient to stay overnight and where a discharge note is issued.

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 profession. Paramedical practitioners are physical therapists, nurses, chiropodists/podiatrists, speech therapists and orthoptists.

Partner: Person under the age of 71 at the time of enrollment regardless of their status bound to the Member by a civil partnership agreement. A civil partnership is a contract signed by two adult persons of the opposite or same sex in order to share their life together (Article 515-1 of the French Civil Code).

Period of benefits / period of coverage: Continuous period of 365 days during which the Member and any Dependents are covered by virtue of enrollment in the plan. It starts from the effective date of enrollment in the plan as specified on the Certificate of insurance (other than in cases of early termination under the rules of the plan).

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

Physical therapy with a prescription: All treatment dispensed by a licensed physical therapist for which a Doctor's prescription is issued before the start of treatment. Coverage is limited to the number of sessions and the specific reimbursement limit applicable to this type of treatment, as specified in the Benefits schedule. If more sessions are required, a report justifying the need the extent the treatment should be produced. Physical therapy excludes certain treatments including mud therapy, Pilates, relaxation massage, Rolfing, MILTA therapy and all other methods which are not recognized by the scientific medical community.

Physical therapy without a prescription: All treatment dispensed by a licensed physical therapist for which a Doctor's prescription is not issued before the start of treatment. Coverage is limited to the number of sessions and the specific reimbursement limit applicable to this type of treatment, as specified in the Benefits schedule.
Physical therapy excludes certain treatments including mud therapy, Pilates, relaxation massage, Rolfing, MILTA therapy and all other methods which are not recognized by the scientific medical
community.

Physiotherapy: Physiotherapy, for the purposes of the plan, is all treatment which can be dispensed by a licensed physical therapist. This excludes, for the purposes of the plan, certain treatments such as mud therapy, Pilates, massage, Rolfing and MILTA therapy.

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 organisation (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 or Prostheses of any kind (on presentation of an appropriate detailed and circumstantial medical report and a fully costed estimate).

Pre-existing medical condition: Pre-existing conditions: any Illness, disorder or injury or associated symptoms which developed before the date of enrollment in the plan, of which the Member or their Dependents were aware, or of which they could reasonably have been aware and which we have not expressly agreed to cover.

Pregnancy: Period between the date of conception and the date of delivery.

Premium: Amount paid by the Member in return for benefits provided by the Insurer.

Premium notice: A Premium notice (sometimes also called a renewal notice) is a document which specifies the amount of your insurance Premiums and the period covered. The payment of the insurance Premium is made on the date specified in the Premium notice.

Prenatal care: Refers to all standard, customary screening and follow-up examinations
during Pregnancy. For women over the age of 35, Prenatal care may include:
- 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.

Prescription drugs for chronic diseases:
List of chronic diseases:
- 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

Primary care / routine healthcare: All healthcare Services provided by healthcare professionals excluding hospitalization or stays in healthcare or socio-medical facilities. It includes, for example, consultations in a private medical practice or health center, laboratory tests, x-rays taken in the doctor's office etc. Consultations carried out in Hospitals but not involving hospitalization (also known as 'outpatient' consultations) are generally classed as Primary care.

Private room: Service offered by healthcare facilities, allowing an inpatient to be accommodated in a single room. Deluxe and VIP rooms and suites are not covered.

Psychiatric treatment and care: Management and care of a person who is suffering from a severe mental health problem, requiring hospitalization in a specialized unit.

Psychiatry: Psychiatry is the medical treatment of mental Illness, whatever the cause: psychological, neurological or psychosocial. The psychiatrist is not a psychoanalyst, psychologist or psychotherapist (unless they have had additional training), but their medical degree enables them to prescribe medication or decide on psychiatric hospitalization. Consultations with and prescriptions from a Psychiatrist are covered under this plan (subject to a Waiting period of 12 months).

Rehabilitation immediately following hospitalization: Rehabilitation directly following hospitalization, commenced within a Maximum of 30 days of the end of the stay in hospital, dispensed as a combination of therapies, which may include occupational therapy, physical therapy and Speech therapy in order to restore function and / or normal shape after an injury or serious Illness.

Request for prior approval: Before incurring certain medical expenses or commencing some types of treatment or Services such as hospitalization, medical treatments provided as a series of treatments or Prostheses of any kind, the Insured member must first request and obtain the agreement of the Insurer or the Administrator to obtain a Precertification agreement (on presentation of a detailed and circumstantial medical report as appropriate and a fully costed estimate).

Routine dental care: All Routine dental care including an annual dental check-up, root canal work, scaling, sealing of fissures, treatment of tooth decay (amalgam), application of fluoride and dental x-rays, excluding tooth whitening treatments.

Routine healthcare: Treatments, excluding Routine dental care and vision care (except under certain packages, see Benefits schedule) performed by a General practitioner or Specialist who is a qualified doctor of medicine and is licensed to practice medicine under the laws the country where the treatment is administered in their medical or surgical office and which do not require the patient to be admitted to Hospital.

Selected coverage zone: Refers to the Coverage zone selected by the Member for themselves and their Dependents, and for which the appropriate Premium has been fixed by the Insurer based on Usual, customary and reasonable healthcare costs charged in this group of countries. Subject to payment of the appropriate Premium, the member may opt for a Selected coverage zone for themselves and their Dependents which is higher than that corresponding to their Main country of residence. They cannot, however, opt for a Selected coverage zone lower than that corresponding to their Main country of residence. The plan offers 5 coverage zones (see section entitled 'Specific country of residence and Coverage zone under the plan').

Semi-private room: Service offered by healthcare facilities, allowing an inpatient to be accommodated in a double room. Deluxe and VIP rooms and suites are not covered.

Service: All Services specified in the Benefits schedule of the plan.

Specialist: Refers to a qualified Doctor who is officially licensed, trained and approved in the country where the treatment is administered and where they practice and who has the additional experience and qualifications required to practice a recognized medical specialty: techniques for diagnosis, treatment and prevention specific to a particular field of medicine.

Speech therapy: Speech therapy is a paramedical discipline which treats persons presenting with disorders related to communication and the spoken or written language by means of speech rehabilitation.

Spouse: Spouse who is not legally separated or divorced, whether or not they are in paid employment, and under the age of 71 on the date of enrollment. To facilitate the reading of this Members' Guide, 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 to recover any expenses or costs from another insurance company, national health insurance scheme or any source linked to the reimbursement of treatment insured under this plan.

Termination: Termination is the formal process by which the Insurer, the Contracting association or the Member puts an end to the plan or enrollment in the plan which binds them.

Traditional chinese medicine: Asian therapeutic method which does not strictly differentiate between the mind and body and is based on a holistic approach to the person. The treatment is based on five main pillars: Acupuncture, diet, drug therapy with vegetable, mineral and animal substances, massage and movement.

Treatment of cancer: (Oncology): Refers to fees payable to Specialists, examinations, radiotherapy costs, chemotherapy and hospital charges incurred in connection with the treatment of a malignant tumor, tissue or cells, characterized by the uncontrolled growth and spread of malignant cells invading the tissues.

UCR: Abbreviation of 'Usual, Customary, and Reasonable', see definition of Usual, Customary and Reasonable Costs.

Unforeseen illness: Any deterioration in the state of health certified by a competent medical authority which is sudden, unexpected and requires the intervention of a Doctor in less than 48 hours.

Usual, customary and reasonable costs: Usual, customary and reasonable costs which will be reimbursed under the plan are defined as reasonable medical expenses commonly charged in the relevant country for the specific treatment received, in accordance with standard and generally accepted medical procedures.
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 Members' Guide for ease of reference.

Vaccinations: Refers to all vaccines and boosters required by the health authorities of the country in which the Vaccination is administered and any medically required Vaccinations for travel to a foreign country as well as malaria prevention treatment. The cost of the consultation and the purchase of the vaccine are included.

Waiting period: Period specified in the plan and shown in the Benefits schedule, during which membership is active but the benefits are not yet accessible.
The Waiting periods apply from the Effective date of enrollment of each person insured under the plan.

4 / HEALTHCARE BENEFITS IN DETAIL: HEALTHCARE BENEFITS SCHEDULE

4.1 / FOR MEMBERS WHO DID NOT SELECT THE USA COVERAGE ZONE

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

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
AGGREGATE LIMIT ON HEALTHCARE BENEFITS (€)	€400,000	€800,000	€1,600,000	€2,400,000
AGGREGATE LIMIT ON HEALTHCARE BENEFITS ($)	$500,000	$1,000,000	$2,000,000	$3,000,000
HOSPITALIZATION	**Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year**			

No Waiting period for Hospitalization benefit with the exception of Psychiatric treatment and care (12 months)

AGGREGATE COVERAGE OF HOSPITAL EXPENSES				
Hospitalization	**We will cover hospital expenses if:** **- One or more Members 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 expenses 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.**			
Hospital room covered	**Semi-private room (and lower standard) 100% UCR up to €100 / $125 per day**	**Private room (and lower standard) 100% UCR up to €150 / $190 per day**	**Private room (and lower standard) 100% UCR up to €250 / $310 per day**	**Private room (and lower standard), up to 100% UCR**
	The type of room and the amount per night that we will cover under each package is shown in this Benefits schedule.			
Room and board fees for a parent staying in Hospital with a dependent child under the age of 18	**100% UCR up to €300 / $375 per year**	**100% UCR up to €400 / $500 per year**	**100% UCR up to €700 / $875 per year**	**100% UCR**
	We will cover reasonable room and board fees for a parent staying in the same Hospital as their Dependent child under the age of 18, in the event of hospitalization lasting more than one day and up to the Maximum amount specified in this Benefits Schedule.			
Outpatient hospitalization (including Outpatient surgery)	**100% UCR**	**100% UCR**	**100% UCR**	**100% UCR**
	We will pay all covered hospital expenses for hospitalization which does not require the person receiving the treatment to stay overnight.			

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
	100% UCR	100% UCR	100% UCR	100% UCR
Emergency hospitalization within the **Selected coverage** zone and in lower **Coverage zones**	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.			
	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
Emergency hospitalization within a higher **Coverage zone** than the **Selected coverage zone**, for trips of less than 60 consecutive days	We will cover all Emergency hospital expenses (only if they are the result of an Accident or a sudden, unexpected and unforeseen Illness requiring surgery or Medical treatment that cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness representing an immediate and serious danger to the health of the Insured member) in a country located in a Coverage zone higher than the Selected coverage zone during trips of less than 60 consecutive days and an aggregate limit of 90 days per insurance year. Travel for medical reasons, and consequently all scheduled treatment in a Coverage zone higher than the Selected coverage zone, is also excluded (unless the Medical advisor rules otherwise). It is recommended that Members and any Dependents contact the Administrator, MSH INTERNATIONAL, if trips of more than 60 days are planned in a higher Coverage zone than the Selected coverage zone so that the level of coverage under your plan can be adjusted.			
HEALTHCARE COVERED UNDER YOUR HOSPITALIZATION BENEFITS				
	100% UCR	100% UCR	100% UCR	100% UCR
Intensive care	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.			
	100% UCR	100% UCR	100% UCR	100% UCR
Surgical procedures including fees, operating room and anesthesia	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.			
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.			
	100% UCR	100% UCR	100% UCR	100% UCR
Emergency dental and vision care with hospitalization	We will cover Emergency dental and vision care received in Hospital if it is Medically required following an Accident requiring hospitalization. This care must be administered within 24 hours of the Accident. This benefit does not cover routine Dental surgery, routine dental care, Dentures, implantology, routine vision care, vision correction, laser vision correction, Orthodontics or Periodontics. (These treatments are only covered under the optional benefit Health+).			
	100% UCR	100% UCR	100% UCR	100% UCR
Laboratory tests, MRI, x-rays, scans and tomography performed during 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.			
	100% UCR	100% UCR	100% UCR	100% UCR
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.			
	100% UCR	100% UCR	100% UCR	100% UCR
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.			
	100% UCR	100% UCR	100% UCR	100% UCR
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'.			

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Treatment of AIDS	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover any costs related to the treatment of HIV.			
Internal surgical and medical prostheses and devices	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover costs related to Prostheses, devices or appliances fitted during a surgical procedure.			
External surgical and medical prostheses and devices (for each **Prosthesis** and limited to 2 **Prostheses**)	100% UCR up to €1,200 / $1,500	100% UCR up to €1,800 / $2,250	100% UCR up to €2,500 / $3,100	100% UCR
	We will cover: - 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.			
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 (even if palliative home care is also covered - nursing costs - Prescribed drugs			
Organ transplant (room, care and hospitalization fees)	100% UCR	100% UCR	100% UCR	100% UCR
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 'anti-rejection' drugs.			
Physiotherapy / physical therapy, **Chiropractic** and **Osteopathy**	100% UCR up to €1,000 / $1,250	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.			
Psychiatric treatment and care **Waiting period of 12 months**	Not covered	100% UCR up to €3,500 / $4,400 (limited to 10 days per year)	100% UCR up to €7,000 / $8,750 (limited to 20 days per year)	100% UCR (limited to 30 days per year)
	After expiration of the 12-month Waiting period, we will cover Psychiatric treatments and care in Hospital (on an inpatient or outpatient basis), including room and board fees (within the limits specified in the section 'Hospital Room coverage') to treat the covered event. By covered event, we mean any treatment of mental Illnesses and disorders with respect to this benefit.			
Care of newborns (the **Member** has 30 days to enroll their newborn child in the plan without being asked to complete a **Health questionnaire**. After this period, a **Health questionnaire** will be required). The limits listed on the right apply from the 1st to the 90th day of the child's life in respect of medical expenses if he or she has been enrolled in the plan.	100% UCR up to €30,000 / $38,000 per year	100% UCR up to €60,000 / $75,000 per year	100% UCR up to €125,000 / $155,000 per year	100% UCR
	We will cover the care of newborns: - For all care required for the newborn within 90 days of birth. This replaces all other coverage under the plan (routine care during the first 7 days will be covered under the Maternity option (Health+Child) if selected) - Only if the children covered under this plan have been enrolled as Dependents within 30 days of their birth.			

A CHOICE OF 4 LEVELS OF COVERAGE	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 per year	100% UCR up to 20 days per year	100% UCR up to 30 days per year	100% UCR up to 30 days per year
	We will cover any rehabilitation, including room and board fees and treatments such as physical therapy, occupational therapy or Speech therapy following a covered event such as a cardiovascular Accident. We do not cover rehabilitation expenses or treatment which do not follow hospitalization covered under the plan. We will cover rehabilitation: - if you obtained 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.			
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.			
ROUTINE HEALTHCARE	**Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year**			
AGGREGATE LIMIT ON ROUTINE HEALTHCARE BENEFITS IN € / $	€15,000 $19,000	€30,000 $38,000	€50,000 $62,000	$3,000,000
Consultations with **General practitioners** and **Specialists** (other than dentists, ophthalmologists and psychiatrists) and **Specialist** procedures	100% UCR up to €80 / $100 per treatment, procedure or consultation	100% UCR up to €130 / $160 per treatment, procedure or consultation	100% UCR up to €180 / $225 per treatment, procedure or consultation	100% UCR
	We will cover consultations with General practitioners and Specialists (other than dentists, psychiatrists and ophthalmologists) and Specialist treatments or procedures. We will cover these consultations under Routine healthcare, whether carried out in a medical office, in the home or in hospital (excluding during periods of hospitalization).			
Emergency vision care without hospitalization	Not covered	Not covered	100% UCR up to €500 / $625 per year	100% UCR up to €750 / $950 per year
	We will cover under this benefit Emergency vision consultations related to disorders of the eye such as cataracts, retinal detachment, etc. which do not require hospitalization. Any vision care expenses which can be classed as Routine healthcare will be covered under the Health+ option if selected, and will not be covered if you have not purchased this option.			
Emergency dental care without hospitalization	Not covered	Not covered	Levels of coverage and limit shared with 'Emergency Vision care without hospitalization'	Levels of coverage and limit shared with 'Emergency Vision care without hospitalization'
	We will cover consultations for Emergency dental care, such as sudden toothache that does not require hospitalization. Any dental expenses which can be classed as Routine healthcare will be covered under the Health+ option if selected, and will not be covered if you have not purchased this option. Dental care performed during a consultation with a stomatologist will be covered only under the Health+ option.			

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
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
	We will cover prescribed sessions of Speech therapy, Orthoptics, occupational therapy and nursing care. We will cover these sessions under Routine healthcare, whether carried out in a medical office, in the home or in hospital (excluding during periods of hospitalization).			
Physical therapy, Osteopathy and **Chiropractic** on prescription	100% UCR up to €1,000 / $1,250 per year limited to 10 sessions per year	100% UCR up to €2,000 / $2,500 per year limited to 15 sessions per year	100% UCR up to €3,500 / $4,400 per year limited to 20 sessions per year	100% UCR limited to 30 sessions per year
	We will cover consultations in physical therapy, Osteopathy and Chiropractic prescribed as Routine healthcare. The limit on the number of sessions includes all specialties combined.			
Physical therapy, Osteopathy and **Chiropractic** without a prescription	100% UCR up to 5 sessions, with a Maximum of €50 / $60 per session	100% UCR up to 10 sessions, with a Maximum of €100 / $125 per session	100% UCR up to 20 sessions, with a Maximum of €150 / $190 per session	100% UCR up to 30 sessions
	We will cover consultations in physical therapy, Osteopathy and Chiropractic for which you do not have a prescription. The limit on the number of sessions includes all specialties combined.			
Homeopathy, Acupuncture and Traditional Chinese medicine	100% UCR up to 3 sessions per year, with a Maximum of €50 / $60 per session	100% UCR up to 5 sessions per year, with a Maximum of €100 / $125 per session	100% UCR up to 7 sessions per year, with a Maximum of €150 / $190 per session	100% UCR up to 10 sessions per year
	We will cover consultations in Acupuncture, Homeopathy and Traditional Chinese medicine. The limit on the number of sessions includes all specialties combined.			
Laboratory tests, MRI, x-rays, scans, tomography and physical diagnostic examinations on an outpatient basis	100% UCR up to €2,000 / $2,500 per year	100% UCR up to €3,500 / $4,400 per year	100% UCR up to €7,500 / $9,400 per year	100% UCR
	We will cover all types of Laboratory tests and medical examinations recognized by the medical scientific community, such as x-rays, scans, MRI, blood tests, etc. which are prescribed by a General practitioner or Specialist for diagnostic purposes or as part of your medical care.			
Prescription drugs	100% UCR up to €1,500 / $1,900 per year	100% UCR up to €4,500 / $5,600 per year	100% UCR up to €7,500 / $9,400 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.			
Prescription drugs for chronic diseases	100% up to €5,000/$6,300 per year, limited to €35,000/$44,000 for the entire life of the plan	100% up to €7,500/$9,400 per year, limited to €50,000/$63,000 for the entire life of the plan	100% up to €10,000/$12,500 per year, limited to €75,000/$94,000 for the entire life of the plan	100% UCR
	We will cover prescription drugs for chronic diseases subject to the following conditions: - 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 disease 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.			
Psychiatry Waiting period of 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.			

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
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, within the limits specified in the Benefits schedule, the cost of equipment and medical, orthopedic and hearing Prostheses. This would include, for example, the purchase of a hearing aid if a hearing problem is diagnosed by a General practitioner or Specialist. It does not include any consumables (batteries, repairs, etc.) related to the covered equipment.			
WELLBEING & WELLNESS				
Health check-up	**Not covered**	**100% UCR up to €150 / $190 every 3 years**	**100% UCR up to €500 / $625 every 3 years**	**100% UCR up to €1,000 / $1,250 every 3 years**
	We will cover one Health check-up for every Member over the age of 20. The purpose of this Health check-up is to review the state of health and focus on prevention. It is limited to the following tests: **- 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.**			
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 cover, within the limits specified in the Benefits schedule, consultations with a dietitian with a recognized qualification in the country in which they are practicing. **We will only cover the consultation itself and will not cover any weight loss treatments or, for example, costs related to food supplements.**			
Nicotine replacement	**Not covered**	**100% UCR up to €50 / $60 per year**	**100% UCR up to €75 / $90 per year**	**100% UCR up to €100 / $125 per year**
	We will cover the following costs related to smoking cessation support: **- Nicotine patches** **- Nicotine gum** **- Nicotine tablets**			

OPTIONAL BENEFIT HEALTH+: DENTAL + VISION

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
DENTAL	**Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year**			
Waiting period: **- 3 months for dental care and Periodontics,** **- 6 months for Dentures, dental implants, bone grafts and dental surgery** **- 12 months for Orthodontics**				
Annual aggregate limit on dental benefits in € / $ for the procedures listed below (excluding Orthodontics which has its own limit)	100% UCR up to €250 / $310 per tooth and €1,000 / $1,250 per year	100% UCR up to €400 / $500 per tooth and €1,500 / $1,900 per year	100% UCR up to €500 / $625 per tooth and €2,000 / $2,500 per year	100% UCR up to €600 / $750 per tooth and €3,500 / $4,400 per year
Routine dental care (up to the annual aggregate limit above)	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover, after expiration of the 3-month Waiting period, consultations with a qualified dentist who is authorized to practice in the country where they are located, as well as all treatments or procedures carried out during these consultations and listed below: - 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)	100% UCR	100% UCR	100% UCR	100% UCR
	After expiration of the 6-months Waiting period, we will cover inlay cores, posts, bridges, crowns, dentures and implant supports. Facets are not covered.			
Dental surgery (up to the annual aggregate limit above)	100% UCR	100% UCR	100% UCR	100% UCR
	After expiration of the 6-months Waiting period, we will cover any surgical procedures, with or without anesthesia, including tooth extraction, bone or gum grafts and the fitting of implants.			
Periodontics (up to the annual aggregate limit above)	Not covered	100% UCR	100% UCR	100% UCR
	After expiration of the 3-month Waiting period, we will cover all treatments of disorders of the retaining tissue of the tooth, including the gum.			
Orthodontics up to age 16	Not covered	100% UCR up to €800 / $1,000 per year for 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
	After expiration of the 12-month Waiting period, for any treatment started before the age of 16, we will cover Orthodontics for a maximum period of 3 years.			
VISION	**Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year**			
Waiting period: 6 months				
Lenses and frames, limited to one pair every 2 years	100% UCR up to €100 / $125	100% UCR up to €250 / $310	100% UCR up to €400 / $500	100% UCR up to €600 / $750
	We will cover, after expiration of the Waiting period, the cost of prescription lenses and frames with vision correction, limited to one pair every 2 years. Protective glasses (sunglasses or other types) without vision correction are not covered.			
Cost of surgical treatments for visual corrections (myopia, hyperopia, astigmatism and keratoconus)	Not covered	Not covered	Level of coverage and limit shared with 'Lenses and frames' benefit	Level of coverage and limit shared with 'Lenses and frames' benefit
	We will cover, after expiration of the Waiting period, the cost of the surgical treatment of myopia, hyperopia, astigmatism and keratoconus. This benefit can be used only once per eye for the duration of the plan.			
Corrective contact lenses including disposable lenses	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.			

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Consultations with ophthalmologists or optometrists	100% UCR Maximum 1 per year, limited to €80 / $100	100% UCR Maximum 1 per year, limited to €130 / $160	100% UCR Maximum 1 per year, limited to €180 / $225 per year	100% UCR Maximum 1 per year
	We will cover, after expiration of the Waiting period, an annual vision test with an ophthalmologist or optometrist. Disorders of the eye such as cataracts, retinal detachment, glaucoma, AMD, etc. are covered under Routine healthcare or hospitalization if necessary.			

OPTIONAL BENEFIT HEALTH+ CHILD: MATERNITY
AVAILABLE IF THE OPTIONAL BENEFIT HEALTH+ (DENTAL + VISION) HAS BEEN PURCHASED

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
MATERNITY	Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year			
Waiting period: **- 10 months for Maternity** **- 12 months for Fertility treatment**				
Maternity and childbirth preparation classes, prenatal and postnatal care received by the mother and **Immediate care of newborns**	100% UCR up to €3,500 / $4,400 per year	100% UCR up to €5,000 / $6,250 per year	100% UCR up to €8,000 / $10,000 per year	100% UCR up to €11,000 / $13,800 per year
	We will cover the cost of Maternity and childbirth after expiration of the 10-month Waiting period. This includes: - 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)	Level of coverage and limit shared with the benefit above	Level of coverage and limit shared with the benefit above	Level of coverage and limit shared with the benefit above	Level of coverage and limit shared with the benefit above
	We will cover the cost of midwives or other Specialists for home births or in a birth center after expiration of the 10-month Waiting period.			
Childbirth complications (C-sections are only covered if they represent an **Absolute necessity**)	Annual limit for Maternity benefit doubled	Annual limit for Maternity benefit doubled	Annual limit for Maternity benefit doubled	Annual limit for Maternity benefit doubled
	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	Not covered	100% UCR €900 / $1,100 per attempt (limited to €3,600 / $4,400 for the entire life of the plan)	100% UCR €1,200 / $1,500 per attempt (limited to €4,800 / $6,000 for the entire life of the plan)	100% UCR €1,500 / $1,900 per attempt (limited to €6,000 / $7,600 for the entire life of the plan)
	We will cover, after expiration of the 12-month Waiting period, the cost of pharmacy items, Laboratory tests, follow-up examinations and fertilization involved in Fertility treatment. For the purposes of this plan, fertility treatment means all of the following methods of Medically Assisted Reproduction: - In vitro fertilization (IVF), - Artificial insemination, - Hormone treatments, - Tubal surgery.			

4.2 / FOR MEMBERS WHO SELECTED THE USA COVERAGE ZONE

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

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

HOSPITALIZATION

No Waiting period for Hospitalization benefit with the exception of Psychiatric treatment and care (12 months)

AGGREGATE COVERAGE OF HOSPITAL EXPENSES

Hospitalization	We will cover hospital charges if: - One or more **Members** 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.**					
Hospital room covered	**Private Room** (and lower standard), 80% UCR	**Private Room** (and lower standard), 60% UCR	**Private Room** (and lower standard), 90% UCR	**Private Room** (and lower standard), 70% UCR	**Private Room** (and lower standard), 100% UCR	**Private Room** (and lower standard), 80% UCR
	The type of room and the amount per night that we will cover under each package is shown in this **Benefits schedule.**					
Room and board fees for a parent staying in **Hospital** with a Dependent child under the age of 18	80% UCR up to $500 per year	60% UCR up to $500 per year	90% UCR up to $875 per year	70% UCR up to $875 per year	100% UCR	80% UCR
	We will cover reasonable room and board fees for a parent staying in the same **Hospital** as their **Dependent** child under the age of 18, in the event of hospitalization lasting more than one day and up to the Maximum amount specified in this **Benefits Schedule.**					
Outpatient hospitalization (including Outpatient surgery)	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will pay all covered hospital expenses for hospitalization which does not require the person receiving the treatment to stay overnight.					
Emergency hospitalization within the **Selected coverage zone and in lower Coverage zones**	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover treatment administered following admission to a **Hospital** or medical day center, following the onset of a sudden and unforeseen medical condition requiring immediate treatment within 24 hours for the sole purpose of preventing a life-threatening risk. 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.					

A CHOICE OF 3 LEVELS OF COVERAGE	PEARL		SAPPHIRE		DIAMOND	
HEALTHCARE COVERED UNDER YOUR HOSPITALIZATION BENEFITS						
Intensive care	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover hospital expenses in case of treatment in a general or cardiac **Intensive care** unit (including a Critical care unit) for patients presenting with organ failure or who are at risk of severe complications.					
Surgical procedures including fees, operating room and anesthesia	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover the following costs in the event of hospitalization: - 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.					
Consultations with **General practitioners** and **Specialists** as part of hospitalization covered under this plan (excluding **Physiotherapy** and **Alternative medicine**) and including **Specialist** treatments and procedures.	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover consultations with **General practitioners** or **Specialists** during your stay in **Hospital** following a covered Event.					
Emergency dental and vision care with hospitalization *	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover **Emergency** dental and vision care received in **Hospital** if it is **Medically required** following an **Accident** requiring hospitalization. This care must be administered within 24 hours of the **Accident**. This benefit does not cover routine **Dental surgery**, routine dental care, **Dentures**, implantology, routine vision care, vision correction, laser vision correction, **Orthodontics** or **Periodontics. (**These treatments are only covered under the optional benefit Health+).					
Laboratory tests, MRI, x-rays, scans and tomography carried out as part of your hospitalization covered under this plan	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover all expenses related to: - **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.					
Prescription drugs	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover the cost of any drugs prescribed by the **General practitioner** or **Specialist** in charge of your treatment during your hospitalization.					
Renal dialysis	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover the cost of renal dialysis, with the exception of transportation costs to and from the care facility where the dialysis is carried out.					
Oncology (treatment of cancer)	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover the cost of any medically justified treatment you receive in the **Treatment of cancer**, including chemotherapy, radiotherapy, **Oncology**, diagnostic tests and drugs, as part of hospitalization (on both an inpatient and outpatient basis). Remote follow-up examinations will be covered under '**Routine healthcare**'.					
Treatment of AIDS	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover any costs related to the treatment of HIV.					
Internal surgical and medical prostheses and devices	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover costs related to **Prostheses, devices or appliances** fitted during a surgical procedure.					
External surgical and medical prostheses and devices (for each **Prosthesis** and limited to 2 **Prostheses**)	80% UCR up to $2,250	60% UCR up to $2,250	90% UCR up to $3,100	70% UCR up to $3,100	100% UCR	80% UCR
	We will cover: - **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.					

** No co-payments apply on those benefits*

A CHOICE OF 3 LEVELS OF COVERAGE	PEARL		SAPPHIRE		DIAMOND	
Palliative care*	80% UCR up to $19,000	60% UCR up to $19,000	90% UCR up to $31,000	70% UCR up to $31,000	100% UCR	80% UCR
	If a **Member** is diagnosed with a terminal **Illness** and can no longer be treated with a view to being cured, we will cover: - the cost of a room in a **Hospital** or hospice (even if palliative home care is also covered) - nursing costs - **Prescribed drugs**					
Organ transplant (room, care and hospitalization fees)	80 % UCR	60 % UCR	90 % UCR	70 % UCR	100 % UCR	80 % UCR
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 trans-plant	60% UCR up to $3,800 per trans-plant	90% UCR up to $5,600 per trans-plant	70% UCR up to $5,600 per trans-plant	100% UCR up to $7,500 per trans-plant	80% UCR up to $7,500 per trans-plant
	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 'anti-rejection' drugs.**					
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 of 12 months	80% UCR up to $4,400 (limited to 10 days per year)	60% UCR up to $4,400 (limited to 10 days per year)	90% UCR up to $8,750 (limited to 20 days per year)	70% UCR up to $8,750 (limited to 20 days per year)	100% UCR (limited to 30 days per year)	80% UCR (limited to 30 days per year)
	After expiration of the 12-month **Waiting period**, we will cover **Psychiatric treatments and care** in **Hospital** (on an inpatient or outpatient basis), including room and board fees (within the limits specified in the section '**Hospital** Room coverage') to treat the covered event. By covered event, we mean any treatment of mental **Illnesses** and disorders with respect to this benefit.					
Care of newborns (the **Member** has 30 days to enroll their newborn child in the plan without being asked to complete a **Health questionnaire**. After this period, a **Health questionnaire** will be required). The limits listed on the right apply from the 1st to the 90th day of the child's life in respect of medical expenses if he or she has been enrolled in the plan*	80% UCR up to $75,000	60% UCR up to $75,000	90% UCR up to $155,000	70% UCR up to $155,000	100% UCR	80% UCR
	We will cover care of newborns: - For all care required for the newborn within 90 days of birth. This replaces all other coverage under the plan (routine care during the first 7 days will be covered under the **Maternity** option (**Health+Child**) if selected) - Only if the children covered under this plan have been enrolled as Dependents within 30 days of their birth.					
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 (limited 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.					

** No co-payments apply on those benefits*

A CHOICE OF 3 LEVELS OF COVERAGE	PEARL		SAPPHIRE		DIAMOND	
Immediate rehabilitation following a stay in hospital and commenced within 30 days of hospitalization*	80% UCR up to 20 days per year	60% UCR up to 20 days per year	90% UCR up to 30 days per year	70% UCR up to 30 days per year	100% UCR up to 30 days per year	80% UCR up to 30 days per year
	We will cover any rehabilitation, including room and board fees and treatments such as physical therapy, occupational therapy or **Speech therapy** following a covered event such as a cardiovascular **Accident**. **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.					
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.**					
ROUTINE HEALTHCARE	Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year					
AGGREGATE LIMIT ON ROUTINE HEALTHCARE IN $	$38,000		$62,000		$3,000,000	
	In network	Out of network	In network	Out of network	In network	Out of network
Co-payment, per consultation only	$35	$45	$25	$35	$15	$25
Consultations with **General practitioners** and **Specialists** (other than dentists, ophthalmologists and psychiatrists) and **Specialist** procedures	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover consultations with **General practitioners** and **Specialists** (other than dentists, psychiatrists and ophthalmologists) and **Specialist** treatments or procedures. We will cover these consultations under **Routine healthcare**, whether carried out in a medical office, in the home or in hospital (excluding during periods of hospitalization).					
Emergency vision care without hospitalization*	Not covered	Not covered	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover under this benefit **Emergency** Vision consultations related to disorders of the eye such as cataracts, retinal detachment, etc. which do not require hospitalization. Any vision care expenses which can be classed as **Routine healthcare** will be covered under the Health+ option, if selected, and will not be covered if you have not purchased this option.					
Emergency dental care without hospitalization*	Not covered	Not covered	Levels of coverage and limit shared with 'Emergency Vision care without hospitalization'	Levels of coverage and limit shared with 'Emergency Vision care without hospitalization'	Levels of coverage and limit shared with 'Emergency Vision care without hospitalization'	Levels of coverage and limit shared with 'Emergency Vision care without hospitalization'
	We will cover consultations for **Emergency** dental care, such as sudden toothache that does not require hospitalization. Any dental expenses which can be classed as **Routine healthcare** will be covered under the Health+ option if selected, and will not be covered if you have not purchased this option. Dental care carried out during a consultation with a stomatologist will be covered only under the Health+ option.					
Prescribed sessions of **Speech therapy**, **Orthoptics**, occupational therapy and nursing care*	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover prescribed sessions of **Speech therapy**, **Orthoptics**, occupational therapy and nursing care. We will cover these sessions under **Routine healthcare**, whether carried out in a medical office, in the home or in hospital (excluding during periods of hospitalization).					
Physical therapy, osteopathy and chiropractic on prescription*	80% UCR limited to 15 sessions per year	60% UCR limited to 15 sessions per year	90% UCR limited to 25 sessions per year	70% UCR limited to 25 sessions per year	100% UCR limited to 30 sessions per year	80% UCR limited to 30 sessions per year
	We will cover consultations in physical therapy, **Osteopathy** and **Chiropractic** for which you do not have a prescription, under routine health care. The limit on the number of sessions includes all specialties combined.					

** No co-payments apply on those benefits*

A CHOICE OF 3 LEVELS OF COVERAGE	PEARL		SAPPHIRE		DIAMOND	
Physical therapy, osteopathy and chiropractic without a prescription*	80% UCR up to 10 sessions	60% UCR up to 10 sessions	90% UCR up to 20 sessions	70% UCR up to 20 sessions	100% UCR up to 30 sessions	80% UCR up to 30 sessions
	We will cover consultations in physical therapy, **Osteopathy** and **Chiropractic** for which you do not have a prescription. The limit on the number of sessions includes all specialties combined.					
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.					
Psychiatry Waiting period of 12 months	80% UCR Maximum of 10 consultations per year	60% UCR Maximum of 10 consultations per year	90% UCR Maximum of 15 consultations per year	70% UCR Maximum of 15 consultations per year	100% UCR Maximum of 20 consultations per year	80% UCR, Maximum of 20 consultations 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						
	In network	Out of network	In network	Out of network	In network	Out of network
Co-payment, per consultation only	$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) - 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.'					

** No co-payments apply on those benefits*

A CHOICE OF 3 LEVELS OF COVERAGE	PEARL		SAPPHIRE		DIAMOND	
Prostate cancer screening, for men aged 45 and over (every year)	We will cover an annual screening for prostate cancer for men aged 45 and over.					
Screening for oral cancer (every 5 years)	We will cover screening for oral cancer every 5 years, for all **Members**.					
Screening for skin cancer (every 5 years)	We will cover screening for skin cancer every 5 years, for all **Members**.					
Colonoscopy, from age 50 (every 5 years)	We will cover colonoscopy every 5 years, for all **Members** aged 50 and over.					
Annual screening for fecal occult blood	We will cover an annual screening for fecal occult blood, for all **Members**.					
Bone density test, for women aged 45 and over (every 5 years)	We will cover a **Bone density test** every 5 years for all **Members** aged 45 and over.					
Dietitian	Not covered	Not covered	90% UCR, max 2 sessions per year	70% UCR, max 2 sessions per year	100% UCR, 3 sessions per year	80% UCR, 3 sessions per year
	We will cover, within the limits specified in the **Benefits schedule**, consultations with a dietitian holding a recognized qualification in the country in which they are practicing. We will only cover the consultation itself, and will not cover any weight loss treatments or, for example, costs related to food supplements.					
Nicotine replacement	80% UCR up to $60 per year	60% UCR up to $60 per year	90% UCR up to $90 per year	70% UCR up to $90 per year	100% UCR up to $125 per year	80% UCR up to $125 per year
	We will cover the following costs related to smoking cessation support: - Nicotine patches - Nicotine gum - Nicotine tablets					

OPTIONAL BENEFIT HEALTH+: DENTAL + VISION

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

Waiting period:
- 3 months for dental care and Periodontics,
- 6 months for Dentures, dental implants, bone grafts and dental surgery,
- 12 months for Orthodontics

ANNUAL AGGREGATE LIMIT ON DENTAL BENEFITS FOR THE PROCEDURES LISTED BELOW (EXCLUDING ORTHODONTICS WHICH HAS ITS OWN LIMIT)	80% UCR up to $500 per tooth and $1,900 per year	60% UCR up to $500 per tooth and $1,900 per year	90% UCR up to $625 per tooth and $2,500 per year	70% UCR up to $625 per tooth and $2,500 per year	100% UCR up to $750 per tooth and $4,400 per year	100% UCR up to $750 per tooth and $4,400 per year
	In network	Out of network	In network	Out of network	In network	Out of network
Co-payment, per consultation only	$35	$45	$25	$35	$15	$25
Routine dental care (up to the annual aggregate limit above)	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover, after expiration of the **3-month Waiting period**, consultations with a qualified dentist who is authorized to practice in the country where they are located, as well as all treatments or procedures carried out during these consultations and listed below: - 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)	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	After expiration of the 6-month **Waiting period**, we will cover inlay cores, posts, bridges, crowns, dentures and implant supports. **Facets are not covered.**					
Dental surgery (up to the annual aggregate limit above)	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	After expiration the 6-month **Waiting period**, we will cover any surgical procedures, with or without anesthesia, including tooth extraction, bone or gum grafts and the fitting of implants.					

A CHOICE OF 3 LEVELS OF COVERAGE	PEARL		SAPPHIRE		DIAMOND	
Periodontics (up to the annual aggregate limit above)	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	After expiration of the 3-month **Waiting period**, we will cover all treatments of disorders of the retaining tissue of the tooth, including the gum.					
Orthodontics up to age 16	80% UCR up to $1,000 per year for 3 years	60% UCR up to $1,000 per year for 3 years	90% UCR up to $1,500 per year for 3 years	90% 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**, after expiration of the 12-month **Waiting period** 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

Waiting period: 6 months

	In network	Out of network	In network	Out of network	In network	Out of network
Co-payment, per consultation only	$35	$45	$25	$35	$15	$25
Lenses and frames, limited to one pair every 2 years	80% UCR up to $310 per year	60% UCR up to $310 per year	90% UCR up to $500 per year	70% UCR up to $500 per year	100% UCR up to $750 per year	80% UCR up to $750 per year
	We will cover, after expiration of the **Waiting period**, the cost of prescription lenses and frames with vision correction, limited to one pair every 2 years. Protective glasses (sunglasses or other types) without vision correction are not covered.					
Cost of surgical treatments for visual corrections (myopia, hyperopia, astigmatism and keratoconus)	Not covered	Not covered	Level of coverage and limit shared with 'Lenses and frames' benefit	Level of coverage and limit shared with 'Lenses and frames' benefit	Level of coverage and limit shared with 'Lenses and frames' benefit	Level of coverage and limit shared with 'Lenses and frames' benefit
	We will cover, after expiration of the **Waiting period**, the cost of the surgical treatment of myopia, hyperopia, astigmatism and keratoconus. This benefit can be used only once per eye for the duration of the plan.					
Corrective contact lenses including disposable lenses	80% UCR up to $250 per year	60% UCR up to $250 per year	90% UCR up to $375 per year	70% UCR up to $375 per year	100% UCR up to $500 per year	80% UCR up to $500 per year
	We will cover, after expiration of the **Waiting period**, the cost of corrective contact lenses on prescription.					
Consultations with ophthalmologists or optometrists	80% UCR, limited to one consultation per year	60% UCR, limited to one consultation per year	90% UCR, limited to one consultation per year	70% UCR, limited to one consultation per year	100% UCR, limited to one consultation per year	80% UCR, limited to one consultation per year
	We will cover, after expiration of the **Waiting period**, an annual vision test with an ophthalmologist or optometrist. Disorders of the eye such as cataracts, retinal detachment, glaucoma, AMD, etc. are covered under **Routine healthcare** or hospitalization if necessary.					

OPTIONAL BENEFIT HEALTH+CHILD: MATERNITY
AVAILABLE IF THE OPTIONAL BENEFIT HEALTH+ (DENTAL + VISION) HAS BEEN PURCHASED

A CHOICE OF 3 LEVELS OF COVERAGE	PEARL		SAPPHIRE		DIAMOND	
MATERNITY	Based on usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year					

Waiting period:
- 10 months for Maternity
- 12 months for Fertility treatment

	In network	Out of network	In network	Out of network	In network	Out of network
Co-payment, per consultation only	$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**	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)	Level of coverage and limit shared with the benefit above					
	We will cover the cost of midwives or other **Specialists** for home births or in a birth center after expiration of the 10-month **Waiting period**.					
Childbirth complications (C-sections are only covered if they represent an **Absolute necessity)**	Annual limit for Maternity benefit doubled					
	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 per attempt (limited to $6,000 for the entire life of the plan)	70% UCR up to $1,500 per attempt (limited to $6,000 for the entire life of the plan)	100% UCR up to $1,900 per attempt (limited to $7,600 for the entire life of the plan)	80% UCR up to $1,900 per attempt (limited to $7,600 for the entire life of the plan)
	We will cover, after expiration of the 12-month **Waiting period**, the cost of pharmacy items, **Laboratory tests**, follow-up examinations and fertilization involved in **Fertility treatment**. For the purposes of this plan, **Fertility treatment** means all of the following methods of **Medically Assisted Reproduction**: - In vitro fertilization (IVF), - Artificial insemination, - Hormone treatments, - Tubal surgery.					

5 / DETAILS OF EXCLUSIONS FROM HEALTHCARE BENEFITS (WHAT IS NOT COVERED)

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

The following are excluded from the insurance:

- costs incurred before the effective date of the plan and after coverage has ceased;
- travel and accommodation expenses related to healthcare;
- any medical or surgical expenditure not prescribed by a qualified medical authority (practitioners, therapists, clinics, Hospitals and medical centers) who / which are not recognized:
  - by the authorities in force in the country where the treatment takes place as having particular expertise in the treatment of the relevant Accident or Illness,
  - by the Medical advisor as being properly qualified, competent and authorized to prescribe treatment and who have been notified in writing by him or her;
- non-prescription drugs;
- treatments, consultations and Drugs prescribed by the Member, their Dependents or any member of their family;
- costs deemed unnecessary and / or inappropriate by the Insurer's Medical advisor;
- in the event of hospitalization, additional expenses with no direct medical purpose such as charges for telephone, television, internet access, newspapers, taxi fares, meals for visitors etc.;
- costs deemed to be excessive, unreasonable or unusual considering the country in which they were incurred. Therefore, only Usual, Customary and Reasonable costs will be covered and reimbursed under the plan, i.e. reasonable medical expenses which are commonly charged in the relevant country for the specific treatment received, according to standard medical and generally accepted procedures;
- the cost of hospitalization in a deluxe or VIP room or other suites;
- experimental treatments or drugs, namely all forms of treatment or medication which, in the opinion of the Medical advisors, are not conventional or whose effectiveness has not been proven;
- in respect of pharmacy items, products which are not recognized as drugs such as sunscreen, makeup, over-the-counter products, etc.,
- the cost of cosmetic, esthetic or reconstruction treatments performed by a plastic surgeon to improve or transform the appearance - even for psychological reasons - unless this treatment is linked to the restoration of a physical feature or function following a disfiguring Accident or surgery related to the Treatment of cancer occurring during the Period of insurance coverage;
- treatments and stays in health resorts, fitness centers, convalescent homes or nursing homes, spas and thermal treatment centers, ... and other similar establishments which are not recognized as Hospitals;
- all tests and treatments for obesity / anorexia, or which are required as a result of obesity or anorexia, including, in particular, programs and fees for weight loss / weight gain and medicinal support and drugs prescribed for obesity / anorexia. In some clinical cases, with the approval of the Medical advisor, surgical procedures for morbid obesity (BMI = Body Mass Index> 40) may be covered;
- products classified as vitamins or minerals and dietary supplements (except in the treatment of a serious vitamin deficiency), over-the-counter products and cosmetics;
- all types of care, treatment and consultations for Mental illnesses or disorders (excluding stays in a psychiatric hospital and excluding consultations with Psychiatrists, if covered under the plan and limited to the number of days / sessions specified in the and excluding psychiatric medication after the 12th month waving period) or behavioral disorders (chapter V of the WHO International Classification of Diseases, version 10). These treatments can be medicinal, based on consultations or dialogues or administered using equipment;
- the care, treatment and all consequences of attempted suicide or self-inflicted injuries or Illnesses, or the use of narcotics without a medical prescription;
- consultations in psychology, psychotherapy and / or psychoanalysis with a therapist or family counselor (even if such consultations are conducted by a Psychiatrist);
- cognitive developmental delay, except for a child under 20 who has not attained the level of cognitive development expected for a child of their age. Treatments are not covered if the development of the child is only slightly or temporarily delayed. The cognitive developmental delay must have been quantitatively measured by qualified personnel;
- speech therapy will only be covered in the native language of the person receiving the treatment, unless the Medical advisor rules otherwise;
- expenditure arising when receiving an organ donation or purchasing an organ, namely:
  - mechanical or animal organs, except in cases where a mechanical device is used temporarily for the sole purpose of maintaining vital functions while awaiting a transplant;
  - any purchase of an organ from a donor regardless of origin;
  - the cultivation and storage of stem cells, for prevention purposes, for hypothetical future use in the event of a possible Illness;

- costs generated by complications caused directly by an injury or Illness which is not covered or only partially covered under the plan;
- pre-existing conditions: any Illness, condition or injury, or related symptoms, which developed before the date of enrollment in the plan of which the Member or their Dependents were aware, or of which they could reasonably have been aware and which we have not expressly agreed to cover;
- the cost of transportation and evacuation. Some of these costs will be covered under the terms and conditions of 'Medical Evacuation and Medical Transportation' benefits and under the 'Repatriation' option if selected;
- all costs of Medical evacuation from a ship to a medical center on land;
- the cost of medical hospitalization or stays in sanatoriums or preventoriums if the establishments where the Insured member was treated are not approved by the competent public authority;
- foot care from a podiatrist or chiropodist, such as treatments for corns / calluses, thickened and / or deformed nails, except in cases of Medical necessity approved by the Medical advisor;
- fetal surgery, i.e. treatment or surgery carried out in the womb before birth, unless it is the result of complications reported during Pregnancy;
- the cost of voluntary termination of Pregnancy;
- the cost of gestational surrogacy, namely all treatments directly related to the use of a surrogate mother (gestational surrogacy) whether the Insured member is the surrogate mother or the intended parent;
- all devices, operations and treatments for the purpose of preventing birth: contraception, sterilization, vasectomy, termination of Pregnancy (unless there is a threat to the health of the mother), family planning consultations, etc.;
- all devices, operations and treatments for sexual dysfunction (sexual deficiencies such as impotence, regardless of cause) or disorders related to gender (disorders related to sex changes or gender reassignment);
- the cost of Infertility treatments (and, in particular, Medically assisted reproduction) unless the optional benefit Health+Child (Maternity) was purchased by the Member and / or their Dependents;
- Infertility treatment costs other than those specified in chapter '4) Healthcare Benefits in detail: Healthcare Benefits Schedule' if the optional benefit Health+Child (Maternity) has been selected;
- sleep disorders, including insomnia, unless the Insured member is diagnosed as suffering from severe sleep apnea;
- Pre and postnatal care costs if the 'Maternity' benefit has not been purchased;
- the consequences of breaking the laws of the country where the Insured member is staying;
- the cost of psychomotor therapy;
- disorders of the temporomandibular joint (TMJ), except in cases of Medical necessity approved by the Medical advisor;
- costs for which a Request for prior approval was not submitted or where it was denied by the Insurer;
- ife-sustaining treatments, unless the Medical advisor rules otherwise;
- treatments administered for more than 90 consecutive days to an Insured member who has permanent neurological damage and / or is in a persistent vegetative state (PVS) unless the Medical advisor rules otherwise;
- administrative costs;
- Doctors' fees for purely administrative purposes (for example, to obtain a visa, complete a claim form, etc.);
- care provided in a nursing facility or retirement home and the costs resulting from personal assistance with daily activities, even if that person has been declared as being in a state of temporary or permanent disability. Such services are classed as home care even if they are prescribed by a Doctor and delivered by providers with medical or paramedical status;
- non-medical admissions or hospital stays which include:
  - treatment which could be administered in day care or on an outpatient basis,
  - treatment which is not medically justified in the opinion of the Medical advisor,
  - convalescence.
- treatment of a condition which is subject to a specific exclusion. Specific exclusions are listed on your Certificate of enrollment;
- costs which were paid by another insurance provider, person, organization or state program;
- any loss, damage, Illness and / or injury which may occur as a result of Medical treatment administered in a Hospital or performed by a Doctor, even if the treatment was approved as being covered;
- all care, treatment and consultations outside the selected geographical Coverage zone, if in a Coverage zone higher than one selected, other than in an Emergency following an Accident or sudden, unexpected and unforeseen Illness requiring surgery or Medical treatment which cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness which poses an immediate and serious threat to the health of the Insured member or if we have authorized its treatment by way of an exception with the approval of the Medical advisor;
- all care, treatment and consultations provided under HEALTH+ (Dental / Vision) and / or HEALTH+CHILD (Maternity) benefits if the Member and any Dependents did not purchase these options;
- all care, treatment and consultations received within a Coverage zone which is higher than the selected Coverage zone, particularly in the United States, in the following cases:
  - If the Member (and any Dependents) did not opt for the higher Coverage zone where the care was received, we will not cover the care, treatment and consultations received in this zone, except in cases of medical Emergency as defined in the plan (Emergencies following an Accident or sudden, unexpected and unforeseen Illness requiring surgery or Medical treatment which cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness which poses an immediate and serious threat to the health of the Insured member).
  - If the Member (and any Dependents) opted for the 'United States' Coverage Zone, we will not cover care, treatment and consultations received in the United States if it is established that the Member (and any Dependents) enrolled in the plan for the sole purpose of traveling to the United States to receive care, treatment and consultations, and if the symptoms of the condition were known to them prior to their enrollment in the plan.

As well as the consequences of:
- intentional acts committed by the Member or the Dependent;
- civil or foreign war, insurrection, rebellion (with or without declaration of war), riots, military coups or any usurping of power, martial law or acts committed by any illegally constituted authority, regardless of the location and the protagonists of the events, except in cases of legitimate self-defense;
- the direct or indirect effects of changes in the structure of the atomic nucleus, chemical contamination, radioactivity or any nuclear material, explosions or Illnesses which have been declared an epidemic and placed under the control of the public health authorities and any other conflict or disaster, if the Insured member has endangered themselves by entering a conflict zone recognized by the Government of their home country, has actively taken part in the conflict or has shown a blatant disregard for their own safety;
- harmful, dangerous or addictive use of alcohol, narcotics and / or drugs and any treatment arising from the harmful, dangerous or addictive use of these substances;
- alcoholism or drunkenness on the part of the Member or Dependent;
- participation in any sporting competitions and training for these competitions as well as the practice of any sports in a club or federation;
- the practice of sports for professional purposes;
- the practice of the sports listed below:
    - extreme sports: bungee jumping, caving, extreme canoeing and kayaking (in rapids greater than Class V, rivers greater than Class II, on seas and oceans more than two nautical miles from land), sailing (transoceanic and single-handed navigation more than 20 nautical miles from shelter) and base jumping,
    - mountain sports: mountaineering, climbing (excluding artificial holds without a safety rope), rock climbing, hiking and trekking requiring special gear (ropes, ice axes or 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.

6 / GENERAL OPERATING PROCEDURES

6.1 / YOUR PLAN

COVERAGE OPTIONS

The plan provides:
- a range of BASIC BENEFITS (commercialized as '**HEALTH'**) covering costs related to hospitalization, **Routine healthcare** on an outpatient basis, **Preventive** and alternative **medicine**, pharmacy items, equipment and medical **Prostheses**,
- two OPTIONAL BENEFITS available in addition to the BASIC BENEFITS (HEALTH), chosen by each **Member**, covering the following costs:
  - LEVEL 1 OPTIONAL BENEFITS (commercialized as '**HEALTH+')**: Vision and Dental.
  - LEVEL 2 OPTIONAL BENEFITS (commercialized as '**HEALTH+CHILD'**): Maternity. Level 2 optional benefits can only be selected if level 1 optional benefits have themselves been selected.

Within each of these benefits, four packages are offered to each **Member** on enrollment: Quartz, Pearl, Sapphire and Diamond, providing increasing levels of benefits and services.
The plan also offers, in respect of Basic benefits and Level 1 Optional benefits (excluding Level 2 optional Maternity benefits), the possibility for the **Member** to choose a **Deductible** as defined in chapter '3 // DEFINITIONS OF HEALTHCARE BENEFITS'.
Four levels of **Deductible** are available as well as the option of having no **Deductible**.
For Zone 5 (USA), the plan also offers various levels of co-payment.
The plan is therefore a highly flexible offering suited to the needs of each of the **Members**.
It is specified that:
- the optional benefits, if they are selected by the **Member**, also apply to all of their **Dependents** listed on the **Certificate of enrollment**,
- **a Member who has purchased optional benefits will only be able to withdraw from these optional benefits once for the entire duration of the plan in order to retain only the basic benefits.**

ELIGIBILITY FOR THE INSURANCE

Primary Member
Each member of the **Contracting association** may be enrolled in the insurance, for a specific
Coverage zone corresponding at least to their **Country of expatriation**, on condition that:
- they are of a different nationality from that of their **Main country of residence** for the duration of their membership of the plan,
- they have duly completed and signed the **Application for coverage** and the **Medical questionnaire**,
- they are under the age of 71 at the time of enrollment.

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.**

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 + Zones 1, 2, 3 and 4
- Zone 4: Bahamas, Brazil, China, Hong Kong, Jersey, St. Barthelemy, St. Martin, Singapore, Switzerland, and United Kingdom + Zones 1, 2 and 3
- Zone 3: Australia, Austria, Canada, French Polynesia, Greece, Ireland, Israel, Italy, Japan, Monaco, 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, France, Georgia, Germany, Guatemala, Hungary, Iceland, Kazakhstan, Kuwait, Latvia, Lebanon, Liechtenstein, Luxembourg, Malaysia, Mexico, 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 excluding Zones 2 to 5

It is specified that, based on events (war or civil war, insurrection, etc.) which may occur there and, in any event, in accordance with the designation of countries at risk issued by the ministry of foreign affairs of the Member's country of nationality, enrollment in the plan may be excluded for certain countries to which travel is strongly discouraged by the ministry (red zone) or subject to prior acceptance by the Insurer if travel to that country is discouraged by the ministry unless for compelling reasons (orange zone).
The benefits apply in the **Selected coverage zone** and in lower **Coverage zones** (for example, if the **Selected coverage zone** is zone 3, the benefits will apply in zones 3, 2 and 1). However, trips to the home country, if located in the selected coverage zone or in a lower coverage zone, are covered as long as the total duration does not exceed 5 months over the year.
The benefits also apply, **in respect of Emergency care only**, worldwide outside the **Selected coverage zone if in a Coverage zone higher than one selected**, during temporary stays (for professional or leisure purposes) for less than 60 consecutive days, (**only if it is required following an Accident or sudden, unexpected and unforeseen Illness requiring surgery or Medical treatment which cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness which poses an immediate and serious threat to the health of the Insured member).**

6.2 / LIFE OF YOUR PLAN

EFFECTIVE DATE AND RENEWAL OF THE PLAN

The **Open group insurance plan** arranged between the **Insurer** and the **Contracting association** takes effect on July 1, 2015.
It is purchased for an initial period ending December 31, 2015 and is **automatically renewed on January 1st of each year for successive periods of one year unless terminated by either party by registered mail sent two months before each renewal date.**
The plan may be amended by mutual agreement between the **Insurer** and the **Contracting association**. In this case the **Member** will receive prior notification, under the conditions of the paragraph entitled 'Information to Members', of the changes made to their rights and obligations under the plan.

ENROLLMENT IN THE PLAN AND PERSONS INSURED

The **Member** can choose enrollment in the plan for themselves only (Individual **Premium**) or for themselves and all or some of their **Dependents** as defined in the chapter '3 // DEFINITIONS OF HEALTHCARE BENEFITS' (with as many individual **Premiums** as **Dependents** in addition to the individual **Premium** for the primary **Member**).
The **Member** can also choose to enroll one or several dependent children under the age of 18, subject to these children being expatriated outside their **Country of nationality** and outside their parents' **Country of residence** and subject to the **Application for coverage** being duly completed and signed by the **Member**.
On enrollment, the **Member** selects a healthcare package or packages, decides whether or not to purchase optional benefits and chooses the level of benefits and the amount of the **Deductible** and **Co-payment**.
It is specified that the packages and levels of benefits for all of the **Member's Dependents**, as well as the **Deductibles** and **Co-payments,** must be the same as those selected for the **Member** themselves.
Therefore:
- if an optional benefit is selected by the **Member**, it also applies to all of their **Dependents** who are registered on enrollment,
- all of the **Member's Dependent** children must be covered by the same benefits.

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

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

• DO MY DEPENDENTS HAVE ACCESS TO THE SAME SERVICES?
Yes, your **Dependents** who are enrolled in the plan are entitled to the same services as you, for all benefits selected, excluding death & disability.

• WHAT SHOULD I DO IF MY CHILD CAN NO LONGER BE COVERED BY THE ASFE HEALTHCARE BENEFITS PROVIDED UNDER MY PLAN?
In this case your child will need to take out their own insurance. Please feel free to contact one of our advisors for details of a suitable solution: contact@asfe-expat.com.

ADDING ONE OR MORE DEPENDENTS TO THE PLAN

You can request the addition of a **Dependent** family member during the life of the plan by filling out the **Application for coverage** provided for this purpose.
Newborns can be covered from birth without a **Medical health questionnaire** (except in cases of multiple births or the adoption of a child from a care home or foster family), provided we are notified within 30 days of the child's birth.

To inform us of your intention to add a newborn to your plan, please make the request in writing within 30 days chid's birth, and send us the birth certificate issued by the hospital.

If we are informed of the addition of a newborn more than 30 days after birth, the child will be required to undergo full medical screening and will only be covered from the date of our acceptance (subject to Medical approval of the **Application for coverage**).
Please note that all children from multiple births and children adopted from a care home or foster family will be subject to full medical screening.

THE VARIOUS COMPONENTS OF YOUR PLAN

Your membership of the ASFE plan is formalized by all of the following documents which make up your plan:
- **Certificate of enrollment:** this is a single document, issued only at the time of enrollment, which confirms the **Member's** enrollment in the plan and specifies, in addition to the name and address of the **Member**, those of any insured **Dependents**, the **Effective date of enrollment**, the selected benefits and packages, the **Selected coverage zone**, the **Deductible(s)** and **Co-payment(s)** if applicable and the corresponding **Premium**. The **Certificate of enrollment** corresponds to the special conditions of your plan.
- **Certificate of insurance:** this is a document which can be reissued, the purpose of which is to serve as proof of insurance coverage for the person presenting it. It contains the following information: name of the **Member** and any of their **Dependents**, **Effective date of enrollment**, number and type of plan purchased, the **Insurer** of the plan, the benefits and packages selected and the **Selected coverage zone.**
- **Premium notice**: this is a document which shows the amount of your insurance **Premiums** and the **Period of coverage**. The insurance **Premiums** are paid on the date shown on the **Premium notice.**
- **Members' Guide (information booklet and general terms & conditions):** this refers to this document which defines the benefits, exclusions and conditions of use of the insurance plan (including all information relating to claims procedures), and which should be read in conjunction with the **Certificate of enrollment** and the **Benefits schedule**. For ease of use, we will refer to it here as the **Members' Guide**.

IMPORTANT

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

OBTAINING A CERTIFICATE OF ENROLLMENT FOR A NEW DEPENDENT

Upon acceptance of a new dependent, following the medical underwriting process by our Medical adviser, we will send you a new Certificate of enrollment, to take into account the acceptance of this new dependent. This certificate replaces any other pre-existing version in your possession.

CANCELING YOUR MEMBERSHIP BEFORE IT TAKES EFFECT: THE CANCELATION PERIOD

In accordance with article L.112-9 of the French Insurance Code, the Member may reverse their decision to enroll in the plan by registered mail with proof of delivery during a period of 14 calendar days from the date on which their Certificate of enrollment is sent out, without having to provide reasons or pay penalties.
This cancelation should be worded as follows:
'I, the undersigned ..... (last name - first names) declare my express wish to cancel my membership of plan no. 210 / XXXX and request the reimbursement of the Premium paid under the terms and conditions defined by article L112-9 of the French Insurance Code.'
Exercising the right to cancel within the period specified in the first paragraph results in the termination of membership of the plan from the date of receipt of the registered mail referred to in the same paragraph by the **Administrator MSH INTERNATIONAL**.
Once the **Member** becomes aware of an event that may result in a claim under the plan, they can no longer exercise their right to cancel.
In case of cancelation, the **Member** is only required to pay the portion of the **Premium** corresponding to the period during which the risk was covered, that period being calculated until the **Date of termination.**
The Administrator MSH INTERNATIONAL is required to reimburse the balance no later than 30 days following the **Date of termination**. However, the entire **Premium** remains due to the **Insurer** if the right to cancel is exercised when an event that may result in a claim under the plan, and of which the **Member** was not aware, occurred during the cancelation period.

START OF MEMBERSHIP AND EFFECTIVE DATE OF BENEFITS

For the **Member**:
The effective date of membership is subject to acceptance by the **Administrator (MSH INTERNATIONAL)** once they have received:
- the **Application for coverage** and the **Medical questionnaire(s)** duly completed and signed,
- and full payment of the first monthly, quarterly, bi-annual or annual installment of the **Premium**.

Membership takes effect on the date shown on the **Certificate of enrollment** and at the earliest on the 1st day or 15th day of the month following notification of acceptance of membership specified on the **Certificate of enrollment**.
Membership of the plan is purchased for a fixed period shown on the **Certificate of enrollment whose duration cannot be less than 6 months** or for a period ending after 365 days of coverage with automatic annual renewal on the anniversary of enrollment for successive periods of one year, subject to payment of the **Premiums** specified by the **Insurer**.
When membership of the plan is purchased by the **Member** solely on behalf of one or more **Dependent children under the age of 18**, who are expatriated outside their country of nationality and outside their parents' **Main country of residence**, membership takes effect under the conditions specified above.
When the **Member** applies for optional benefits after enrollment in the plan and, at the earliest, on the anniversary of the effective date of their enrollment under the basic version of the plan, the optional benefit(s) will take effect, subject to the outcome of the medical formalities, on expiration of the **Waiting periods** specified in the paragraph below. The waiting periods will be counted from the date of acceptance of the amendment by the **Insurer**. Until these waiting periods have passed, the **Member** will only be covered by the basic benefits.
For the **Member's Dependents**:
Subject to the outcome of the requested medical formalities, the enrollment of **Dependents** in the plan takes effect:
- on the same date as the **Members** themselves if they are registered at the time of the original enrollment,
- if there is a change in family status as a result of marriage, civil partnership, **Common-law marriage**, birth or adoption of a child, from the 1st day or 15th day of the month following the signing of the application to enroll these new **Dependents** in the plan, **subject to this change being declared to the Administrator (MSH INTERNATIONAL) within 90 days of the change. Otherwise, the Dependent's enrollment will be postponed until the anniversary date in the year following the application**.

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

Or after application of the following **Waiting periods** (depending on the benefits selected):
- **Waiting period of 3 months** in respect of the following benefits: routine 'Dental / Vision consultations and care' (excluding **Emergencies**)' and '**Periodontics**',
- **Waiting period of 6 months** in respect of the following benefits: 'Vision' and 'Dental (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**' (including **Pre and postnatal care**),
- **Waiting period of 12 months** in respect of the following benefits: '**Orthodontics**', '**Fertility treatment** (including **Medically assisted reproduction**)' and '**Psychiatric treatments and care**'.

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

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

RENEWING YOUR MEMBERSHIP OF THE PLAN

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

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

CESSATION OF MEMBERSHIP AND END OF COVERAGE (RIGHT OF WITHDRAWAL AND TERMINATION)

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

- on the **Date of termination** of the plan. In this case, the **Insurer** will offer the **Member** a plan which provides continued coverage on an individual basis subject to payment of the **Premium** specified by the **Insurer**.
- if the **Member** no longer has membership of the **Contracting association**, the association must inform the **Administrator (MSH INTERNATIONAL)** of this within a period of one month. This request may be made at any time but at the earliest after 6 months of membership of the plan.
- in accordance with the conditions specified in the section 'Procedure if I fail to pay my Premium' if the **Premiums** corresponding to the membership are no longer being paid.
- During the course of the year, termination of the plan 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[1]. Requests to terminate the plan will not be accepted unless official supporting documentation 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 termination becomes possible 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 'Your enrollment in the plan and persons insured' if they are under the age of 60 on the date of the member's death,
  - in accordance with the conditions specified in the section 'Your enrollment in the plan and persons insured' other than those relative to maximum age on enrollment if they are over the age of 60 on this date. However, no medical formalities will be required by the **Insurer**.

Membership and coverage cease in any event:

- at the end of the fixed term shown on the **Certificate of enrollment** or at the end of the period covered by the last **Premium** paid, if the **Member** requests to be removed from the plan, by mail sent to the **Administrator (MSH INTERNATIONAL) subject to a notice period of 2 months.** This request can be submitted at any time **but at the earliest after 12 months of membership of the plan.**

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.

1 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.

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

MAKING CHANGES TO THE PLAN

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

• CHANGING YOUR PLACE OF RESIDENCE, MAILING ADDRESS OR EMAIL ADDRESS:
changing your private mailing address, email address or **Main country of residence**:
please notify us in writing as soon as possible of any changes in:
- your private mailing address, even if you are staying in the same **Main country of residence**
- your email address,
- your **Main country of residence**.

IMPORTANT

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

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

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

• DEATH OF THE PRIMARY MEMBER OR A DEPENDENT
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 required minimum age) and including the other **Dependents** in their plan. Following the death of a **Dependent**, their membership will come to an end and the **Premium** for the current year for this **Dependent**, calculated on a pro rata basis, will be refunded.

• CHANGING THE PACKAGE (QUARTZ, PEARL, SAPPHIRE OR DIAMOND)
The package can only be changed on the anniversary of enrollment in the plan. **There can be only one change of package during the entire duration of membership of the plan.**

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

• CHANGING THE LEVEL OF COVERAGE (FROM THE 1ST EURO / DOLLAR OR IN ADDITION TO CFE BENEFITS (CAISSE DES FRANÇAIS DE L'ETRANGER))
Changes to the level of coverage are only possible on the anniversary of enrollment in the plan. **There can be only one change of level of coverage during the entire duration of membership of the plan.**

• CHANGING THE OPTION(S) (HEALTH, HEALTH+ OR HEALTH+CHILD)
Any change of option is only possible on the anniversary of enrollment in the plan. **There can be only one change of option during the entire duration of membership of the plan.**

• CHANGING THE CURRENCY (EURO OR DOLLAR)
Any change of currency is only possible on the anniversary of enrollment in the plan. **There can be only one change of currency during the entire duration of membership of the plan.**

• CHANGING THE COVERAGE ZONES (ZONE 1, 2, 3, 4 OR 5) AND ADDING A DEPENDENT TO THE PLAN
Contact your claims department to make any changes to the **Coverage zone** or to add a **Dependent** to the plan.

6.3 / YOUR PREMIUM

CALCULATING YOUR PREMIUM

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

It is specified that, as long as at least 3 children are covered in respect of the membership of an **Insured member**, **Premiums** will only be payable for the 2 children, the highest of the amounts, with the other children being covered without payment of a **Premium**.
The amount of the **Premium** is reviewed on each anniversary of enrollment in the plan taking into account the age of each person covered under the plan and the pricing in place on that date (taking into account the application of the Adjustment clause specified below).
Any taxes applicable to the plan, the recovery of which is not prohibited, are charged to the **Member** and payable at the same time as the **Premium**.

CHANGES IN THE LEVEL OF YOUR PREMIUM

Adjustment of the Premium for the Open group insurance plan: Premium rates may be reviewed on January 1st each year based on the results of the **Open group insurance plan** provided by the ASFE association **from Groupama Gan Vie, the Insurer**, during the previous calendar year and changes in the level of healthcare costs throughout the world. In order to do this, the amounts of the **Premiums** in euros / dollars are assigned a coefficient (K) which is calculated using the following formula:

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

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

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

WAYS OF PAYING YOUR PREMIUM AND ADDITIONAL CHARGES

Premiums are payable to ASFE monthly (in case of direct debit from a bank account in France 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 http://www.asfe-expat.com, Members' Area, Online payment.

• 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.

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**.

PROCEDURE IF YOU FAIL TO PAY YOUR PREMIUM

In accordance with the provisions of article L113-3 of the French Insurance Code, all **Premiums** due remain payable and may be recovered by any legal means.
In case of non-payment of a **Premium by the Member**, in accordance with the provisions of article L141-3 of the French Insurance Code, the **Contracting association** must, at the earliest, 10 days after the due date of the unpaid **Premium**, send the **Member** a registered letter of formal notice. By mutual agreement between the **Insurer** and the **Contracting association**, it is agreed that the Contracting association authorizes the **Insurer** to prepare and send out this letter.
The letter will state that, at the end of a period of 40 days of dispatch of this letter, the **Member** is barred from the insurance plan due to non-payment of the **Premium**. The **Member** remains liable for the full **Premium** until the date of their removal from the plan.

BANK CHARGES

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

REIMBURSEMENT OF THE PREMIUM

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

6.4 / LEGAL INFORMATION

APPLICABLE LEGISLATION AND JURISDICTION

The **Open group insurance plans** are governed by French law and the French Insurance Code and in particular by articles L.141-1 and following. They fall under section 2 (Healthcare) of article R. 321-1 of the Insurance Code.
Coverage under the plan is based on the declarations made by the **Contracting association**, the **Members** and the **Insured members**.
The Contracting association, the Insurer, the Member and the Insured member declare that they submit to the jurisdiction of the French courts and waive their right to take legal action in any other country.

INFORMATION TO MEMBERS

This **Members' Guide**, which has been prepared by the **Insurer** and serves as the general terms and conditions, is provided to each **Member** by the **Contracting association**, along with the **Certificate of enrollment** containing the special conditions.
It is the duty of the **Contracting association**:
- to inform **Members** in writing of any proposed amendments to their rights and obligations, in accordance with article L141-4 of the French Insurance Code, at least three months before the date of their entry into force,
- to alert **Members** to the termination of the plan and inform them of the conditions under which they can enroll in the individual plan made available by the **Insurer**.

It is the duty of the Contracting association to provide proof that the Members' Guide and information relating to amendments to and termination of the plan have been issued to the Member.
By mutual agreement between the **Insurer** and the **Contracting association**, it is agreed that the association authorizes the **Insurer** to prepare and send out this information.

APPLICABLE LANGUAGE

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

REGULATORY INFORMATION

• LIMITATION PERIOD

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

- **in the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only from the date on which the insurer is aware of it,**
- **in the event of a claim, only from the date the relevant parties are aware of it, if they can prove they were unaware of such facts until then.**

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

- **when the debtor acknowledges the right of the person against whom they were prescribing (article 2240 of the French Civil Code),**
- **a legal claim, even in summary proceedings, until the end of the hearing. This also applies when the legal claim is brought before a court which has no jurisdiction or where the act of referral to the court is cancelled by the effect of a procedural irregularity (Articles 2241 and 2242 of the French Civil Code). The interruption is void if the claimant withdraws his application or allows the suit to lapse, or if he is defeated in his claim (Article 2243 of the French Civil Code),**
- **an act of enforcement or precautionary measures taken in implementation of the code of civil enforcement procedures (Article 2244 of the Civil Code).**

The limitation period is also interrupted by:

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

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

PRIVACY AND DATA PROTECTION

Protection of personal data: The personal data of **Members** and **Dependents** is processed in accordance with the French law on Data Protection and Freedom of Information of January 6, 1978 amended. The processing of this data is necessary for the management of their membership and benefits. With the exception of health-related data, it is intended for the **Insurer** and / or the **Administrator** (**MSH INTERNATIONAL**) and their distributors, agents, service providers and subcontractors and for the reinsurers as well as professional and administrative bodies with respect to legal obligations.
This data can also be used for the purposes of the evaluation and acceptance of risks, internal control (portfolio monitoring) and in the context of legal provisions, notably with respect to combating money laundering and the financing of terrorism. As part of the campaign against insurance fraud, the **Member's** personal data may be passed on to professional bodies involved in combatting fraud as well as to licensed investigators.
The **Member,** having provided proof of identity, has the right to access, rectify, remove and object to this data free of charge by mailing a letter to the **Insurer**:
Groupama Gan Vie - Direction des Affaires Générales - Correspondant Informatique et Libertés 4-8 Cours Michelet - 92082 La Défense Cedex - France.
Collection and processing of health-related data: The **Member** or **Dependent** expressly accepts the collection and processing of health-related data. This data is required for the management of the benefits and is processed in compliance with medical confidentiality. It is intended for the exclusive use of the **Insurer's Medical advisor** and their medical department, or for internal or external authorized persons (including medical experts).
The **Member** and the **Dependent** have the right to access, rectify, remove and object to data relating to them by mailing a letter, together with a photocopy of ID, to the **Insurer's Medical advisor** whose contact details will be provided on request at the above address.
Recording of telephone calls: The **Member** and / or **Dependents** may be required to contact the **Insurer** and / or the **Administrator (MSH INTERNATIONAL)** by telephone for all types of inquiries.
The **Insurer** and / or the **Administrator (MSH INTERNATIONAL)** will inform them that their calls may be recorded to ensure the proper implementation of their benefits and, more generally, to improve quality of service. These recordings are intended only for the departments of the **Insurer** and / or the **Administrator (MSH INTERNATIONAL)** who handled that particular call.
If the **Member** or a **Dependent** has been recorded and wants to listen to the recording of a conversation, they can make the request by mailing a letter to the **Insurer and / or the Administrator (MSH INTERNATIONAL)** at the above address. They will be provided with copies of the recording or a transcript of the content of the conversation free of charge, within the time limits set for storage of these recordings.
Transfer of information outside the European Union: With respect to the implementation of the plan and benefits and in compliance with the stated purposes, personal data relating to **Members** and / or **Dependents** may be transferred to countries within the European Union or outside the European Union. **Members** and **Dependents** are informed of this by these provisions and expressly authorize it.

FORCE MAJEURE

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

FRAUD AND CONCEALMENT OF THE FACTS – MISREPRESENTATION

Irrespective of the ordinary causes of nullity and subject to the provisions of article L132-26 of the French Insurance Code, the insurance plan is null and void in the event of concealment or intentional misrepresentation on the part of the Member and their Dependents, when such concealment or misrepresentation changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the Member or the Dependent concealed or distorted has no impact on the claim. The Insurer is then entitled to retain the Premiums paid and to payment of all due Premiums by way of damages. In the event that a claim for reimbursement proves to be false, fraudulent or intentionally overstated or if the Member or one of their Dependents had resorted to fraudulent methods or means to take advantage of the insurance plan, the claim will not be paid. As a result, the **Member** or their **Dependents** would then be immediately liable for any amount paid in respect of this claim before the discovery of the fraudulent act or omission. If fraudulent methods or means have been employed, the **Premium** will not be refunded, either in whole or part, and any pending claims for reimbursement will not be honored.

PENALTIES FOR MISREPRESENTATION

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

COMPLAINTS PROCEDURES AND MEDIATION SERVICE

To make a complaint (disagreement or dissatisfaction) regarding the plan, the **Member** or **Dependent** can contact:
- the **Administrator MSH INTERNATIONAL** by writing to the following address: MSH INTERNATIONAL, Service réclamation, 23 allées de l'Europe 92 587 Clichy Cedex - France. If a potential dispute is not resolved following this initial contact, you have the option of contacting the Ombudsman of the Union of Insurance Brokers (Chambre Syndicale des Courtiers d'Assurances), who is the competent authority for handling complaints from individuals, 91 rue Saint Lazare, 75009 PARIS, or the Prudential Control Authority (Autorité de Contrôle Prudentiel), 61 rue Taitbout 75009 PARIS.

Or
- the **Insurer's** customer relationship department at the following address:
  - by mail: Service des relations avec les consommateurs Groupama Gan Vie Immeuble Michelet - 4-8 Cours Michelet - 92082 LA DEFENSE CEDEX - France Tel: +33 (0)1 70 96 62 68
  - by email: src-collectives@ggvie.fr

If the response is not satisfactory, the complaint may be submitted to the **Insurer's** Complaints department at the following address:
-by mail: Groupama Gan Vie – Service Réclamations – 160 avenue Charles de Gaulle - TSA 41269 - 91246 Morangis Cedex – France
-by email: service.reclamations@ggvie.fr
In both cases, the **Insurer** agrees to acknowledge receipt of the complaint within a period of no more than 10 working days. It will be processed within 2 months at the most. If this is not the case, the complainant will be informed. Finally, and without prejudice to their right to take legal action if necessary, the **Member** or the **Dependent** may apply to the **Insurer's** ombudsman by writing to the following address: Médiateur de Groupama Gan Vie - 5-7 rue du Centre - 93199 Noisy-le-Grand Cedex – France. Details of complaints processing procedures are available from the usual advisor and in the 'Legal notices' section of the website www.gan-eurocourtage.fr.

LIABILITY

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

COMMUNICATING WITH DEPENDENTS

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

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

7.1 / GENERAL

PURPOSE OF THE INSURANCE

Policy no. 58662558 purchased by ASFE from Europ Assistance.
These General Provisions relating to emergency medical assistance and emergency transportation / evacuation services agreed between EUROP ASSISTANCE, a company governed by the French Insurance Code and the Policyholder, are intended to provide Insured members who meet the conditions of coverage with the assistance services purchased on their behalf by the association, ASFE, the Policyholder of this plan.

DEFINITIONS

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

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

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

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

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

Deductible: The portion of costs payable by you.

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

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

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

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

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

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

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

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

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

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

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

WHAT TYPES OF TRIP ARE COVERED UNDER THE PLAN?

The assistance services provided under the plan and described in chapter II apply:
in your Country of expatriation, to trips for leisure purposes as well as business trips,
outside your Country of expatriation, during any trips for leisure or business purposes of not more than 180 consecutive days, provided the Insured member has taken out coverage for the corresponding geographical zones.

It is the Policyholder's responsibility to check that Insured members meet the conditions of enrollment set out in these General Provisions.
Business trips begin from the moment the Insured member leaves their Place of residence, or the place in which they normally conduct their business in the Country of expatriation, and end on their return to the first of these two locations.

WHAT IS THE GEOGRAPHICAL COVERAGE OF THE PLAN?

The assistance services apply worldwide.

CONDITIONS OF COVERAGE

We will use every possible means required to assist you wherever you are in the world and in accordance with the terms of these General Provisions.
However, we will be able to intervene only under the following conditions:
- if there are no restrictions on the free movement of persons and goods, whether by land, sea, or air, and for any reason whatsoever, including following a decision or recommendation by local, national or international authorities or the occurrence of a Natural disaster or a situation of war,
- if, as a minimum, the international airport nearest to your location is open,
- if the safety of the persons who will carry out the assistance services is guaranteed, it being understood that it is not within our remit to conduct military-style operations.

USING OUR SERVICES

• IF YOU REQUIRE ASSISTANCE

In an emergency, it is essential to contact the local first response services for problems falling within their remit.
Under no circumstances can our intervention replace local public services or those of any service provider which we would be obliged to use under local and / or international regulations.
To enable us to provide a response:
We recommend you prepare your call.
We will ask you for the following information:
- your surname(s) and first name(s),
- your precise location and the address and telephone number where you can be reached,
- your plan number.
You must:
- call us without delay on: 01 41 85 84 46 (from abroad call 33 1 41 85 84 46), fax: 01 41 85 85 71 (33 1 41 85 85 71 from abroad),
- obtain our prior approval before taking any initiative or incurring any expense,
- comply with the solutions we recommend,
- provide us with details of your plan,
- provide us with all original supporting documentation for the expenses you are claiming.

IMPORTANT

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

• WHAT ARE THE CONDITIONS OF IMPLEMENTATION OF THE ASSISTANCE SERVICES?

We reserve the right to request any documentation required in support of requests for assistance, proof of Home address or Place of residence, proof of expenses, tax assessment notice on which all details have been obscured other than your name, address and the persons declared as members of your household for tax purposes.
We operate on the express condition that the Event which prompts us to provide the service was uncertain at the time of enrollment in the plan and at the time of departure.
It follows therefore that the plan cannot cover an event whose origins lie in an illness and / or injury which was pre-existing, diagnosed and / or treated or which required continuous hospitalization or day hospitalization or outpatient hospitalization in the 6 months preceding the request for assistance. This applies equally to the manifestation or the deterioration of the condition.
In the event that EUROP ASSISTANCE provides a response without proper checks having been made or on the basis of insufficient or inaccurate data with respect to the information which must be provided to EUROP ASSISTANCE, the cost of the intervention by EUROP ASSISTANCE will be billed to the Insured member and will be payable on receipt of invoice.

• CUMULATIVE INSURANCE

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

• MISREPRESENTATION

When they change the purpose of the risk or decrease our risk assessment:

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

• FORFEITURE OF COVERAGE DUE TO FRAUDULENT DECLARATIONS

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

WHAT TO DO WITH YOUR TICKETS?

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

7.2 / DESCRIPTION OF OUR SERVICES AND BENEFITS

ASSISTANCE SERVICES

Scope of assistance services during your expatriation.

• DESCRIPTION OF OUR SERVICES

If you are sick or injured, our doctors will contact the local doctor you consulted following the Illness or Accident.
The information we obtain from the local doctor, and your usual doctor where required, enables us to activate and organize the following, subject to our doctors' decision and based on medical requirements:

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

In some cases, your medical condition may require preliminary transportation to a nearby care center before a return to a facility close to your Place of residence can be considered.
Only your medical condition and compliance with the health regulations in force are taken into consideration when making the decision to transfer you, the choice of means used for this transfer and the place of hospitalization where required.

IMPORTANT

In this respect, it is expressly agreed that the final decision to be implemented will be taken by our doctors to avoid any conflict between medical authorities.
Furthermore, should you refuse to follow the decision deemed the most appropriate by our doctors, you release us of all liability, in particular in the event of you returning by your own means or if your medical condition deteriorates.
If precertification has not been issued by the healthcare insurer to the hospital to which the Insured member has been admitted, the Assistance provider will be unable to deliver the repatriation assistance services unless the incurred medical expenses are settled by the Insured member themselves or by one of their relatives.
It should also be noted that the Assistance provider cannot be held responsible for delays in the fulfilment of services resulting from delays in the precertification procedure by the healthcare insurer or any third party involved in the payment of medical expenses prior to the implementation of the "Repatriation transportation" benefit.
The Assistance provider cannot be held responsible if the costs incurred following the Insured member's admission to hospital have not been paid to the hospital or if the Insured member's medical insurance is inadequate or non-existent, as payment of these costs is a precondition of repatriation transportation.

• WHAT WE EXCLUDE

We cannot under any circumstances replace local emergency services.
In addition to the general exclusions specified in chapter III, the following are excluded from coverage:

- **the consequences of infectious risk situations in an epidemic context, exposure to infectious biological agents, whether dispersed intentionally or accidentally, exposure to chemical agents such as combat gas, exposure to incapacitating agents, exposure to neurotoxic agents or those with latent neurotoxic effects,**
- **the consequences of intentional acts by you or the consequences of fraudulent acts, suicide attempts or suicide,**

- **illnesses and / or injuries which were pre-existing, diagnosed and / or treated or which required continuous hospitalization or day hospitalization or outpatient hospitalization in the 6 months preceding the request for assistance. This applies equally to the manifestation or the deterioration of the condition,**
- **expenses incurred without our approval or not expressly specified in these General Provisions of the plan,**
- **expenses not supported by original documents,**
- **losses occurring in countries excluded from coverage or outside the validity dates of the plan, and in particular beyond the duration of the trip Abroad,**
- **the consequences of incidents occurring during motor trials, races or competitions (or their test runs) subject, in accordance with current regulations, to prior authorization from the local authorities when you are taking part as a competitor or during test runs on a track which is subject to prior authorization from the local authorities even if you are using your own vehicle,**
- **trips undertaken for the purpose of medical diagnosis and / or treatment or for cosmetic surgery procedures, their consequences and the resulting costs,**
- **the organization and coverage of transportation specified in the chapter entitled "REPATRIATION TRANSPORTATION" for benign conditions which can be treated locally and do not prevent you from continuing with your journey or your stay,**
- **requests for assistance relating to medically assisted reproduction or voluntary termination of pregnancy, their consequences and the resulting costs,**
- **requests for assistance relating to reproduction or gestational surrogacy, its consequences and the resulting costs,**
- **medical equipment and prostheses (dentures, hearing aids and medical prostheses),**
- **spa cures, their consequences and the resulting costs,**
- **hospitalization costs, medical costs (consultations, pharmacy items and other treatments and procedures) and dental treatment,**
- **scheduled hospitalization, its consequences and the resulting costs,**
- **the cost of vision care (glasses and contact lenses for example),**
- **vaccines and vaccination costs,**
- **medical checks, their consequences and related costs,**
- **esthetic procedures, their consequences and the resulting costs,**
- **stays in rest homes, their consequences and the resulting costs,**
- **rehabilitation, physical therapy, chiropractic, their consequences and the resulting costs,**
- **medical or paramedical services and the purchase of products whose therapeutic value is not recognized under French legislation, and related costs,**
- **health checks for preventive screening, regular treatments or laboratory tests, their consequences and the resulting costs,**
- **search and rescue missions, particularly in the mountains and at sea,**
- **search and rescue missions in the desert and the resulting costs,**
- **costs related to excess baggage when traveling by air and the cost of forwarding the bags if they cannot travel with you,**
- **trip cancelation costs,**
- **restaurant costs,**
- **customs duties.**

7.3 / FRAMEWORK OF THE PLAN

This plan is subject to French law.

OBLIGATIONS OF THE POLICYHOLDER

• INFORMATION TO INSURED MEMBERS

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

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

LIABILITY - COMPLAINTS

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

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

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

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

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

APPLICABLE LAW AND LANGUAGES

The plan is governed by the French Insurance Code.
Pre-contractual communications and the plan itself are governed by French law. Any dispute arising from the fulfilment, non-fulfilment or interpretation of the plan will be under the jurisdiction of the French courts. The language used for the duration of the plan is French.
In the event of any difference in interpretation between the French version and the foreign language version of the documents issued to the insured member, the French language version will prevail.

EFFECTIVE DATE AND DURATION OF THE PLAN AND THE BENEFITS

• EFFECTIVE DATE OF THE PLAN
The plan arranged between the Policyholder and Europ Assistance takes effect on July 1, 2015. It is acquired for an initial period of one year from the effective date and may be terminated each year by registered mail sent 2 months before each annual renewal date. On expiration, it is automatically renewed from year to year unless terminated by the Insurer or the Policyholder.
The option of terminating the plan each year is available to both the Policyholder and the Insurer. The termination notice period runs from the date on the postmark.

• EFFECTIVE DATE OF BENEFITS
For Insured members, and subject to payment of the corresponding premium, the period of validity of the benefits corresponds to the dates of the stay Abroad, declared by the Insured to the Policyholder and specified in the application for coverage, with a maximum duration of 365 consecutive days.
The effective date of benefits cannot be earlier than the date on which the Policyholder took out the insurance.
The duration of the validity of benefits for each Insured member cannot exceed 365 consecutive days.

TERMINATION OF THE PLAN AND CESSATION OF BENEFITS

• CANCELATION OF THE GROUP PLAN BETWEEN THE INSURER AND THE POLICYHOLDER
In addition to the option of annual termination specified above (in the paragraph entitled “DURATION OF THE PLAN”), the plan may be terminated:

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

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 L326-12 of the French Insurance Code).

Termination must be carried out by registered mail or by a declaration, for which a receipt should be obtained, made at the registered office of Europ Assistance.
For our part, we must terminate the policy by registered mail sent to your last known home address.

CESSATION OF BENEFITS

Your benefits come to an end:

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

2. **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.

WHAT ARE THE RESTRICTIONS IN CASES OF FORCE MAJEURE OR OTHER SIMILAR EVENTS?

Under no circumstances can we replace local organizations in an emergency.
We cannot be held responsible for failures or delays in the fulfilment of services resulting from cases of force majeure or events such as:
- civil or foreign war, manifest political instability, civil unrest, riots, acts of terrorism and reprisals,
- recommendations from WHO or national or international authorities or restrictions on the free movement of persons and goods, irrespective of the cause but in particular for reasons of health, safety, weather or restrictions or bans on air traffic,
- strikes, explosions, natural disasters, nuclear disintegration or radiation from a source of radioactive energy,
- delays in and / or impossibility of obtaining administrative documents such as exit and entry visas, passports, etc. required for travel within or outside the country where you are located or on arrival in the country, as recommended by our doctors for hospitalization there:
- the use of local public services or those of any service provider which we are obliged to use under local and / or international regulations,
- lack or unavailability of the appropriate technical and human means to enable travel (including denial of service).

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 "REPATRIATION TRANSPORTATION") with respect to the health of the Insured member or an unborn child.

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,
- the voluntary participation of an Insured member in riots or strikes, brawls or assaults,
- 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.

SUBROGATION

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

WHAT IS THE LIMITATION PERIOD?

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

1. In the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only from the date on which the insurer became aware of it;
2. In the event of a loss, only from the date on which the relevant parties became aware of it, if they can prove they were unaware of such facts until then.

If the action taken by the insured against the insurer arises from a claim made by a third party, the limitation period shall run only from the date on which this third party brings a legal action against the insured or has received compensation from him or her."
In accordance with Article L114-2 of the French Insurance Code:
"The limitation period is interrupted by one of the ordinary causes of interruption and by the appointment of experts following an insured loss. The interruption of the limitation period may also be initiated by the dispatch of a registered letter with proof of delivery from the insurer to the insured regarding action for payment of the premium and by the insured to the insurer regarding payment of the indemnity."

The ordinary causes of interruption of the limitation period are described under Articles 2240 to 2246 of the French Civil Code: the acknowledgement by the debtor of the right of the person against whom they were seeking interruption of the period of limitation (Article 2240 of the French Civil Code), a legal claim (Articles 2241 to 2243 of the French Civil Code) or an act of enforcement (Article 2244 to 2246 of the French Civil Code).
In accordance with Article L114-3 of the French Insurance Code:
"Notwithstanding Article 2254 of the French Civil Code, the parties to the insurance contract cannot, even by mutual agreement, modify the duration of the limitation period, nor add to the motives for its suspension or interruption."

COMPLAINTS

EUROP ASSISTANCE's address for service is the address of its registered office.
In the event of a complaint or dispute, You can write to their Customer Feedback department at: Service "Remontée Clients", Europ Assistance, 1 Promenade de la Bonnette, 92633 Gennevilliers Cedex, France.
If the time required to handle the complaint or dispute is to exceed ten working days, you will be sent an acknowledgement within that period. A written response to the complaint will be sent within a maximum period of two months from the date of receipt of the initial complaint.

SUPERVISORY AUTHORITY

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

DATA PROTECTION AND FREEDOM OF INFORMATION

All the information collected by EUROP ASSISTANCE FRANCE, 1 Promenade de la Bonnette, 92633 Gennevilliers Cedex, France during the process of application for one of its services and / or during the provision of the services is required for the fulfilment of our obligations to you. If you do not respond to the request for information, EUROP ASSISTANCE FRANCE will be unable to provide you with the service you wish to purchase.
This information is reserved solely for the EUROP ASSISTANCE FRANCE departments in charge of your plan and may be passed on, for the sole purpose of fulfilment of service, to service providers or partners of EUROP ASSISTANCE FRANCE. EUROP ASSISTANCE FRANCE also has the option of using your personal data for the purposes of quality control or statistical analysis.
EUROP ASSISTANCE FRANCE may pass on some of your data to the partners providing these assistance services.
You have the right to access, amend, rectify and remove information concerning you by writing to the Customer Feedback department: EUROP ASSISTANCE FRANCE, Service "Remontée Clients", 1, Promenade de la Bonnette, 92633 Gennevilliers Cedex, France.
If, for the purposes of fulfilling the requested service, information about you is transferred outside the European Union, EUROP ASSISTANCE FRANCE will take contractual measures with the recipients to ensure this transfer is secure.
Moreover, Insured members are informed that telephone conversations with EUROP ASSISTANCE FRANCE may be recorded for the purposes of quality control and staff training. These recordings will be kept for a period of two months. Insured members may object to this by informing the agent handling the call.

8 / GENERAL PROVISIONS OF PERSONAL THIRD-PARTY LIABILITY BENEFITS INCLUDED AS STANDARD WITH YOUR HEALTHCARE PLAN

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 and General Terms & Conditions.

8.1 / DEFINITIONS

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

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 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 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 Colisée
8 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.

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.

8.2 / COVERAGE

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

ARTICLE 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 8.3/.

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 is 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 8.3/ of this plan.

ARTICLE 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 covered by mandatory local insurance.**
- **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.**
- **as 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.**

8.3 / UPPER LIMITS OF COVERAGE

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

NATURE OF BENEFITS	CEILINGS 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

8.4 / GEOGRAPHICAL SCOPE

Coverage applies Worldwide.

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.

8.5 / 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 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.

8.6 / 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.

8.7 / 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, 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.

8.8 / MISCELLANEOUS PROVISIONS

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.

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 1.114-2 of the French Insurance Code.

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.

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.

8.9 / 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 01 53 26 25 25, who has been mandated by ACE European Group Ltd, a Chubb Company, to deliver the insured services.

PURPOSE OF THE BENEFIT

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

1. To seek an out-of-court settlement, and if necessary by legal proceedings, in respect of financial compensation for Damage suffered by the Insured, 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 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.
2. 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.

INSURED SERVICES

The Insurer agrees, subject to the implementation conditions listed under paragraph “implementation of the coverage”:

1. 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;
2. 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;
3. 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.

GEOGRAPHICAL SCOPE OF THE COVERAGE

The benefit applies in the Coverage zone selected by the Insured member.

IMPLEMENTATION OF THE COVERAGE

• 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 3), 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.

• 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.

• 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 described in paragraph E 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.

• 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 or, failing that, as stated in paragraph E, 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.

• SETTLEMENTS AND SUBROGATION

GIE CIVIS will directly settle any covered fees and expenses without the Insured 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 within thirty days of the date on which they themselves received these amounts and indemnities.

For their part, the Insured 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 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 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.

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 from seeking any other legal remedies at their own expense.

8.10 / THE INSURANCE CONTRACT

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.

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 in the first paragraph of C.2. 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".

TERMINATION

• 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),

• 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 the first bullet point of C.1.b) 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.

8.11 / OBLIGATIONS OF THE INSURED MEMBER

AT THE TIME OF PURCHASING THE INSURANCE

• 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.

• 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 the premiums already paid being retained by 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.

DURING THE LIFE OF THE PLAN

• 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.

• 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.

9 / GENERAL PROVISIONS OF LEGAL ASSISTANCE BENEFITS INCLUDED AS STANDARD WITH YOUR HEALTHCARE PLAN

Policy no. 08152901Z purchased by ASFE from AREA CIVIS.

9.1 / LEGAL EXPENSES INSURANCE FOR EXPATRIATES AND IMPATRIATES

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.

LEGAL EXPENSES INSURANCE

• PURPOSE OF YOUR COVER

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

• COVERED EVENTS

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

- **Consumer law:** in the event of litigation following the purchase, hiring, financing, ownership or sale of personal estates or services intended for your private use.
- **Transportation law:** in the event of litigation resulting from the transportation of your personal estates intended for your private use and your personal effects (moving, luggage transportation, etc.).
- **Real estate law:** in the event of litigation against your landlord / lady in your capacity as a tenant, concerning your home in your State of expatriation: concerning expatriates from France to another State, in the event of litigation concerning your home in France: leasing during your expatriation, condominimum, neighbors, maintenance or repair work, insurance, etc.
- **Employment law:** in the event of litigation against your employer in your capacity as an employee, concerning the signature, implementation and termination of your employment contract.
- **Criminal law: defense in the event of criminal proceedings** (hearings, police custody, indictments or legal action brought before a criminal court), when the services of an attorney are required by the procedure in the country in question, and the provision of advances for bail bonds if necessary.
- **Administrative law: in the event of litigation against your State of expatriation concerning administrative matters** (regulations, disputes with a public body, customs disputes, etc.), **excluding disputes regarding tax matters.**

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

• EVENTS THAT ARE NOT COVERED

- **If the prejudicial event or reprehensible action causing the litigation is brought to your attention before your enrollment to the policy underwritten by ASFE, or after the termination of your membership.**
- **If your request is legally inadmissible, lapsed or if the amount at stake is less than the minimum coverage limit, set at €200 / $250.**
- **If the litigation results from your third-party liability when it is covered by an insurance policy.**
- **If the litigation results from:**
  - **your expression of political, trade-union or religious opinions,**

- **the protection of your patents, intellectual property or copyright,**
- **your capacity as endorser, guarantor or assignee of rights,**
- **criminal proceedings, investigation measures or claims filed against you within the European Economic Area for a crime or offense involving deliberate actions to do harm, or for a brawl or insult,**
- **the practice of a non-salaried professional activity, as regards your relations with the French tax department or the department in the State of expatriation,**
- **the application of book I of the French civil code (Code Civil) (divorce, filiation, citizenship, etc.) and marriage settlements, inheritance and inter vivos gifts,**
- **civil or foreign war,**
- **the application of this policy.**

• IN THE EVENT OF LITIGATION
This cover provides you with the services of legal experts who will assist you under the following conditions:

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

• MANAGEMENT OF YOUR LITIGATION:
We undertake to seek an amicable arrangement for your litigation as quickly as possible.

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

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

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

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

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

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

You have, with our assistance should you so wish, control of the directives and measures that may prove necessary during the proceedings. Under all circumstances, it is necessary to obtain our prior approval on the coverage of legal and attorney's fees related to the action or legal remedies that you intend to pursue in order to enable us to examine the cogency and appropriateness of said action, by providing us with all useful documents. The same procedure applies to the acceptance of a transaction. It is your responsibility to pay all amounts, retainers and deposits that may be required and that are not covered by this plan.
We will pay the legal fees and fees of representatives, up to the amounts shown in the following table relating to the law yer 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	
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, Administrative Court	€800 / $1000	- Any fines and amounts that you have to pay or reimburse to a third party (or third parties)
Board in Industrial Disputes (Conseil de Prud'hommes)		- Expenses and costs incurred by the third party (or third parties) and to be borne by you
- Conciliation	€305 / $380	
- Judgment Board	€580 / $725	- Attorney fees based on performance
- Deciding judge	€380 / $475	
Appeal Court (Cour d'Appel)		
- Defense (criminal matters)	€580 / $725	
- Other	€800 / $1,000	- Expenses and actions made necessary or more serious due to an action on your part
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	- Investigations to identify or locate the third party (or third parties)
- 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	- Expenses incurred without our approval
- 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.		

• ARBITRATION IN THE EVENT OF DISAGREEMENT:

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

- this difficulty may be submitted to a third-party for consideration, an arbitrator appointed of a common accord among professionals entitled to provide legal advice (notary public, attorney, professor of faculty, etc.) or, failing this, by the presiding judge of the Tribunal de Grande Instance (regional court) ruling in summary proceedings. We will cover the fees incurred to exercise this up to €800 / $1,000 incl. tax.
  However, the presiding judge of the Tribunal de Grande Instance, ruling in summary proceedings, may decide otherwise if you have exercised this right in wrongful conditions.
- **If you have launched a litigation at your own expense and you obtain a settlement that is more favorable than that proposed by ourselves or the third-party arbitrator,** we will compensate you for the expenses incurred for this action, up to the covered amount.

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.

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 launched an action.

Unrecoverable fees: Mounts 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.: 01.53.26.25.25 - Fax: 01.53.26.36.34

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.

9.2 / SERVICES AND ASSISTANCE FOR EXPATRIATES AND IMPATRIATES

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

1. Cash advance
   This cash advance will be payable within 3 hours, 7 days a week, from 10am to 5pm, French time. **The maximum amount is €800 / $1,000, and is limited to two advances per year.**
2. **The booking and / or payment in the form of an advance of nights in a hotel across the world.**
   This booking or **advance payment** of hotel stays is made through the ACCOR network, our partner for these hotel services. For other hotels, we pay the bill for the hotel after you notify us of its contact details. **The maximum amount is €800 / $1,000, and is limited to two advances per year.**
3. **The booking or payment in the form of an advance of air fares to enable the journey to continue.**

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

Under all circumstances::

4. **The delivery by international courier according to urgency of the following: (Chronopost / UPS / Federal Express / Jet Service / official courier of the GIE CIVIS):**
   - administrative documents,
   - air fares,
   - traveler's checks,
   - prescription drugs,
   - corrective lenses.

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

5. **Escort service for children under six and dependent persons traveling alone.**
   For air travel between the country of expatriation and France (expatriates), or between France and your country of origin (impatriates), we undertake to contact a network of escorts for your children under six years of age and dependent persons for tax purposes, subject to the request being made at least 72 hours before travel v a the hotline, seat availability for the selected dates and delivery times.
   As part of this service, we cover the cost of an air ticket for an escort once a year. In excess of this annual coverage, a return air ticket in economy class will be invoiced for each escort assignment.

6. **As regards air travel and in the event of overbooking,** we undertake **to find alternative solutions** with other airlines and **advance the amount of expenses incurred d**ue to overbooking (hotel, related secondary transportation, etc.) **up to a ceiling of €800 / $1,000.**

7. **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.**

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

   PURPOSE OF THE SERVICE

   We provide you with the service detailed below via telephone, in the event of maintenance and / or repair work in your private home in Metropolitan France involving the following trade(s): plastering – painting – floor coating – joinery (PVC, wood, aluminium) – locksmith – mirror – electricity – plumbing – heating:
   - discuss with you the work that you intend to perform and the trade(s) required for said work,
   - put you in contact with an appropriate building company according to the work needed by the client (or companies, if several companies are required),
   - check the estimate(s) provided by the company for each trade to inform you about our comments, if any.

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

   PROCESSING 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.

9.3 / 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.

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.

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

10 / GENERAL PROVISIONS OF MEDICAL ASSISTANCE / REPATRIATION BENEFITS AVAILABLE AS AN OPTION

Policy no. 58662558 purchased by ASFE from Europ Assistance.

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 paiement:

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 paiement:
- 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.

10.1 / SOME HELPFUL TIPS...

BEFORE YOUR LEAVE

1. Check that your plan covers you in the country you are traveling to and for the entire duration of your trip.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.

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, in particular "What are the general exclusions applicable to the plan?" p. 85.

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.

10.2 / GENERAL

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.

DEFINITIONS

• 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 Ministery 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 regulated by the French Insurance Code, a French limited company ("société anonyme") with a capital of 35,402,786 euros, registered with the French "Registre du Commerce et des Sociétés" 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.

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 total or partial damage, deterioration, destruction or loss of an object.

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.

WHAT TYPES OF TRIP ARE COVERED UNDER THE PLAN?

The assistance services and insurance coverage provided under the plan described in chapter II. 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.

WHAT IS THE GEOGRAPHICAL COVERAGE OF THE PLAN?

The assistance services and the insurance coverage apply in the Coverage zone selected by the Insured.

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.

USING OUR SERVICES

• 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:

1 We recommend you prepare your call.

2 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.

3 You must:

- call us (in France) without delay on: 01 41 85 84 46 (from abroad call +33 1 41 85 84 46)
- email: **service-medical@europ-assistance.fr**
- 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.

• 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 "ADVANCE OF HOSPITAL CHARGES" benefit, 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.

• 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
Fax: 01 41 85 85 61
Email: slv@europ-assistance.fr

Or submitted online via our website: https://sinistre.europ-assistance.fr/

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

• 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 payment of all due premiums in accordance with the French Insurance code, article L113-8,
- 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 L113-9.

• 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 provided for in these General Provisions) if you have used supporting documentation which you know to be inaccurate, or used fraudulent means, or if you have made inaccurate or incomplete 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.

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.

10.3 / DESCRIPTION OF OUR SERVICES AND BENEFITS

ARTICLE 1.A – ASSISTANCE SERVICES

• PERSONAL ASSISTANCE IN THE EVENT OF ILLNESS OR INJURY

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 euros/190 dollars per night and a total of 1,500 euros/1,900 dollars** 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 euros/190 dollars per night and a total of 1,500 euros/1,900 dollars**.
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.

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.

RETURN OF AN INSURED COMPANION

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 euros/190 dollars per night and a total of 1,500 euros/1,900 dollars**.
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.

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 euros/190 dollars per night and a total of 2 nights**.

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 admission to hospital of the Family member must be later than the effective date of your enrollment in this Plan.

RETURN TO THE PLACE OF RESIDENCE

If you have been transported under the conditions specified in the chapter "MEDICAL EVACUATION" p. 55 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.

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.

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 356 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.

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 for the "Advance of hospital charges" specified in the Appendix to this Plan.

• ASSISTANCE ON RETURNING HOME FOLLOWING REPATRIATION (FRANCE ONLY)

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.

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.

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 euros/195 dollars** 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.

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 euros/100 dollars** for the duration of your stay in hospital.

• ASSISTANCE IN THE EVENT OF DEATH

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 euros/2,500 dollars**, 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.

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.

IDENTIFICATION OF THE BODY AND DEATH FORMALITIES

If the Insured 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 euros/190 dollars per night per person and for a total of 2 nights**.

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.

• TRAVEL ASSISTANCE

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 person making the Trip is the manager of the company.

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.

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.

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.

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.

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 euros/2,880 dollars** 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 euros/190 dollars per night and a total of 1,500 euros**.

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 [2]

(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.).

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.

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.

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 euros/18,750 dollars**.

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.

2 This service is also available before you go abroad as an expatriate.

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.

ARTICLE 1.B – WHAT IS EXCLUDED

Under no circumstances can we replace local emergency rescue organizations.
In addition to the general exclusions listed p., coverage excludes:
- **the consequences of infectious risk situations in an epidemic context, exposure to infectious biological agents whether dispersed intentionally or accidentally, exposure to chemical agents such as combat gas, exposure to incapacitating agents, exposure to neurotoxic agents or those with latent neurotoxic effects,**
- **the consequences of intentional acts 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 MEDICAL EVACUATION" p. 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.**

ARTICLE 2.A – LUGGAGE AND PERSONAL EFFECTS

• 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 euros/2,500 dollars** 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).

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 euros/380 dollars** 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 euros/2,500 dollars.

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 euros/190 dollars**.

• EXCLUSIONS FROM COVERAGE

In addition to the general exclusions listed p.85, 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.**

• 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 euros (in respect of damage to luggage only: suitcases, bags, etc.) will be applied to each Claim.

• 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.

• 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.
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.

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.

• 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.

ARTICLE 2.B – TRAVEL INCIDENTS

• 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'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.

• EXCLUSIONS FROM COVERAGE
- 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

• 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.

10.4 / FRAMEWORK OF THE PLAN

This plan is subject to French law.

ARTICLE 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.

ARTICLE 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.

ARTICLE 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,
-delays in and/or impossibility of obtaining administrative documents such as exit and entry visas, passports, etc. required for travel within or outside the country where you are located or on arrival in the country, as recommended by our doctors, for hospitalization,
-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).

ARTICLE 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 MEDICAL EVACUATION" p. 55) with respect to the health of the Insured or an unborn child.

ARTICLE 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 (in respect of "EARLY RETURN IN THE EVENT OF A NATURAL DISASTER"), 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.

ARTICLE 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 will be made by the President of the Tribunal de Grande Instance under whose jurisdiction 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.

ARTICLE 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.

ARTICLE 8 – SUBROGATION

Having incurred costs in respect of our insurance coverage and/or assistance services, if this coverage has been purchased, 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 L121-12 of the French Insurance Code.
Our subrogation is limited to the amount of the costs we incurred in fulfillment of this plan.

ARTICLE 9 – WHAT ARE THE LIMITATION PERIODS?

In accordance with the provisions of article L114-1 of the French Insurance Code:
"All legal actions arising from an insurance contract are barred two years from the event that gave rise to them.
However, this time limit runs:
1. In the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only from the day on which the insurer became aware of it;
2. In the event of a loss, only from the day on which the relevant parties became aware of it, if they can prove they were unaware of such facts until then.
If the action taken by the insured against the insurer arises from a claim made by a third party, the limitation period shall run only from the day on which this third party brings a legal action against the insured or has received compensation from him or her."

In accordance with article L114-2 of the French Insurance Code:
"The limitation period is interrupted by one of the ordinary causes of interruption and by the appointment of experts following an insured loss. The interruption of the limitation period may also be initiated by the dispatch of a registered letter with proof of delivery from the insurer to the insured regarding action for payment of the premium and by the insured to the insurer regarding payment of the compensation."
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 (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."

ARTICLE 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.

ARTICLE 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) – 61, rue Taitbout – 75436 Paris Cedex 09 – France.

ARTICLE 12 – DATA PROTECTION AND FREEDOM OF INFORMATION

All the information collected by EUROP ASSISTANCE FRANCE, 1 Promenade de la Bonnette, 92633 Gennevilliers Cedex, France during the process of application for one of its services and/or during the provision of the services is required for the fulfillment of our obligations to you. If you do not respond to the request for information, EUROP ASSISTANCE FRANCE will be unable to provide you with the service you wish to purchase.
This information is reserved solely for the EUROP ASSISTANCE FRANCE departments in charge of your insurance plan and may be passed on, for the sole purpose of fulfillment of service, to service providers or partners of EUROP ASSISTANCE FRANCE.
EUROP ASSISTANCE FRANCE also has the option of using your personal data for the purposes of quality control or statistical analysis.
EUROP ASSISTANCE FRANCE may pass on some of your data to the partners providing these assistance services or insurance coverage.
You have the right to access, amend, rectify and remove information concerning you by writing to the Customer Feedback department: EUROP ASSISTANCE FRANCE, Service "Remontée Clients", 1, Promenade de la Bonnette, 92633 Gennevilliers Cedex, France.
If, for the purposes of fulfilling the requested service, information about you is transferred outside the European Union, EUROP ASSISTANCE FRANCE will take contractual measures with the recipients to ensure this transfer is secure.
Moreover, Insured members are informed that telephone conversations with EUROP ASSISTANCE FRANCE may be recorded for the purposes of quality control and staff training. These recordings will be kept for a period of two months. Insured members may object to this by informing the agent handling the call.

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

BENEFICIARY:
Any member enrolled in this plan.

THE ADMINISTRATOR:
MSH International
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

OPERATING PROCEDURE BETWEEN THE PARTIES

1/ THE BENEFICIARY

The Beneficiary contacts EUROP ASSISTANCE on + 33 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.

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.

3/ MSH INTERNATIONAL / ASFE PRISE EN CHARGE

On receipt of this information, MSH INTERNATIONAL / ASFE PEC send their agreement and the amount of coverage being granted to EUROP ASSISTANCE by faxing the completed request for prior approval to 01 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 INTERNATIONAL / ASFE Prise en charge cannot be sought given the urgency of the request, MSH INTERNATIONAL / 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.

4/ EUROP ASSISTANCE

EUROP ASSISTANCE may then settle the medical bill within the limits of the benefits set by MSH INTERNATIONAL / ASFE Prise en charge.
Medical bills settled by EUROP ASSISTANCE are re-involved and sent to MSH INTERNATIONAL/ASFE Prise en charge as follows:
- one bill per file,
- original medical bills enclosed marked «payé/paid» without the EUROP ASSISTANCE stamp.

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.

10.6 / BENEFITS SCHEDULE

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

ASSISTANCE SERVICES	MAXIMUM AMOUNTS PER PERSON (INCLUDING TAXES) FOR THE ENTIRE DURATION OF THE PLAN
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 charges
- Delivery of medication	
- 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/$1900)
- Health information	Information
- Travel information	Information
- Assistance with unplanned changes to travel plans	Organization
- Mountain, sea and desert search and rescue costs	€15,000/$18,750
- Access to "123 Classez", the Europ Assistance data vaulting service	
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

Insurer's legal information: Groupama Gan Vie, a French 'société anonyme' with a capital of 1,371,100,605 euros – RCS Paris 340 427 616 - APE 6511 Z Head office: 8-10 rue d'Astorg - 75383 PARIS Cedex 08 – France - Tel: 01.44.56.77.77. Company regulated by the French Insurance Code and subject to the French Prudential Supervision and Resolution Authority (ACPR) - 61 rue Taitbout - 75009 Paris
The insurance products distributed by brokers under the Gan Eurocourtage brand are Groupama Gan Vie products.
www.gan-eurocourtage.fr – contact-collectives@gan.fr

YOUR CONTACTS

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: contact@asfe-expat.com
- Website: www.msh-intl.com
- Linkedin: MSH INTERNATIONAL

GA-VF012017

MSH INTERNATIONAL on behalf of asfe

SIACI SAINT HONORE GROUP

18.10.2018