neoTempo

// INFORMATION BOOKLET SERVING AS THE GENERAL TERMS & CONDITIONS

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

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

You have chosen an ASFE (Association of Services for Expatriates) international health insurance plan from Groupama Gan Vie, managed by MSH, and we are delighted to welcome you as a member.

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

MSH, the Administrator of ASFE plans under the delegated management on behalf of the insurer, is a world leader in international benefits with over 700,000 globally-mobile individuals insured worldwide. MSH provides you with the services of a dedicated team which is on hand to support and advise you day after day. MSH will be referred to throughout this document as "MSH", "the Administrator", "the Administrating Organization" whenever this term is used in the context of the administrative management of the plan.

The neoTempo plans are insured by Groupama Gan Vie – a French "société anonyme" with a capital of 1,371,100,605 euros (fully paid) - registered with the Paris Trade and Companies Register under number 340 427 616 - APE 6511 Z Head office: 8-10 rue d'Astorg - 75383 PARIS Cedex 08, France - Company governed by the French Insurance Code and subject to the French Prudential Supervision and Resolution Authority (ACPR) – 4 place de Budapest - CS 92459 - 75436 Paris Cedex 09, France, hereinafter referred to as the "Insurer".

1.2. / PURPOSE OF THE INSURANCE

The neoTempo insurance plans are a type of plan known as "open group".

They provide coverage:

- from the 1st euro or from the 1st dollar,

or

- in addition to the benefits provided by the Caisse des Français de l'Étranger (CFE) in the country of expatriation, **excluding any other healthcare insurance scheme**, subject to membership for a minimum initial period (excluding renewals) of twelve (12) months.

Their purpose, within the limit of actual costs, is the payment of Benefits, during the period of coverage, as a reimbursement of medical expenses incurred by ASFE Members living temporarily outside their Country of origin, 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.

You can enroll in one of the ASFE's neoTempo plans, based on your situation. Your membership of these plans will be referred to throughout this document as "Your membership". You and any dependents enrolled in the plan will be referred to as "Insured member".

Each plan offers three (3) levels of coverage (see paragraph 1.3/ / Various levels of coverage and options) and includes a basic HOSPITALIZATION benefit that can be supplemented by optional benefits.

The plans also include coverage zones (see section 1.4/ Coverage zones under the plan)

The neoTempo plans are numbered as follows:

neoTempo 1st € USA - BASIC package	0210/670381/10010
neoTempo 1st € USA - REGULAR package	0210/670381/10020
neoTempo 1st € USA - PLUS package	0210/670381/10030
neoTempo 1st US$ USA - BASIC package	0210/670381/55510
neoTempo 1st US$ USA - REGULAR package	0210/670381/55520
neoTempo 1st US$ USA - PLUS package	0210/670381/55530
neoTempo CFE USA - BASIC package	0210/670381/20010
neoTempo CFE USA - REGULAR package	0210/670381/20030
neoTempo CFE USA - PLUS package	0210/670381/20040
neoTempo 1st € outside the USA - BASIC package	0210/672462/10010
neoTempo 1st € outside the USA - REGULAR package	0210/672462/10020
neoTempo 1st € outside the USA - PLUS package	0210/672462/10030
neoTempo 1st US$ outside the USA - BASIC package	0210/672462/55510
neoTempo 1st US$ outside the USA - REGULAR package	0210/672462/55520
neoTempo 1st US$ outside the USA - PLUS package	0210/672462/55530
neoTempo CFE outside the USA - BASIC package	0210/672462/20010
neoTempo CFE outside the USA - REGULAR package	0210/672462/20030
neoTempo CFE outside the USA - PLUS package	0210/672462/20040
neoTempo 1st € FRANCE - BASIC package	0329/672462/14010
neoTempo 1st € FRANCE - REGULAR package	0329/672462/14020
neoTempo 1st € FRANCE - PLUS package	0329/672462/14030

As part of your membership, your Healthcare benefits are supplemented as standard by medical assistance benefits.

Chubb, a company governed by the French insurance code, insures the Assistance Services and Europ Assistance, a company governed by the French insurance code, implements them.

The plans provide a very comprehensive and flexible offer tailored to individual needs.

1.3. / VARIOUS LEVELS OF COVERAGE AND OPTIONS

Within each plan, three (3) levels of coverage are available (BASIC, REGULAR and PLUS), providing increasing levels of benefits. The level of coverage you choose applies to all of your dependents enrolled in your plan and to all the benefits listed below:

- one (1) basic HOSPITALIZATION benefit covering hospitalization expenses,
- one (1) optional ROUTINE HEALTHCARE benefit, covering routine medical services (including medical services on an outpatient basis, pharmacy items, and medical devices and prostheses),
- one (1) optional VISION AND DENTAL benefit covering vision and dental care, and dentures,
- one (1) optional PREVENTION benefit covering the cost of vaccinations and preventive anti-malaria treatment.

Details:

- The three (3) optional benefits are independent of each other and can be purchased together or separately, in addition to the basic HOSPITALIZATION benefit.
- The Member must always choose the same package (either BASIC, REGULAR or PLUS) for all benefits (HOSPITALIZATION AND OPTIONAL BENEFITS).
- Optional benefits, when selected by the Member, also apply to all of their Dependents listed on the Certificate of enrollment.
- Members who have purchased one or more optional benefits will only be able to terminate them if they have had the coverage for a minimum of twelve (12) months.

1.4. / COVERAGE ZONES UNDER THE PLAN

The geographical coverage zone is determined by the Member's main country of residence abroad. The benefits can be claimed in the main country of residence and in the associated geographical coverage zone.

Subject to payment of the corresponding 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.

It should be noted that the benefits can also be claimed in the member's country of origin if this is within the geographical coverage zone. **However, this provision is not applicable if the country of origin is the USA or a territory under U.S. jurisdiction, as listed below.**

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

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

1.5. / COVERAGE EXCLUSION ZONES (RED ZONE)

It should be noted that, depending on the classification of at-risk countries by the French Ministry of Foreign Affairs, coverage is granted or maintained subject to the following provisions:

- **At the time of enrollment in the plan, membership will be denied if travel to the country or zone is classed as highly inadvisable (red zone) by the French Ministry of Foreign Affairs.**
- **During the period of membership, if travel to a country or zone is classified as strongly inadvisable (red zone) by the French Ministry of Foreign Affairs, coverage will continue to be provided, unless the country or zone classified as a "red zone" by the Ministry is neither the member's country of expatriation nor their country of origin. In this case, membership is suspended for the entire duration of the trip to the red zone, including for hospitalization and emergency treatment.**

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

2. / DEFINITIONS OF HEALTHCARE BENEFITS

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

Abroad: Any country in the world except for the member's Country of origin.

Accident: Any bodily injury not intended by the person who suffered it, resulting from sudden, unpredictable action with an external cause. The cause and symptoms must be medically and objectively definable, and be diagnosed and require treatment. The accident must be recorded by a competent authority (medical authorities, police force, firefighters, etc.) who has issued a certificate specifying the circumstances and nature of the injury, as well as the date of the accident.
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.

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

Age: Age is calculated based on the difference in years.

Anniversary date - annual renewal date: On each anniversary date of the plan, at the end of 365 continuous days of insurance from the effective date of enrollment (shown on the Certificate of enrollment).

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

Benefits schedule: Document indicating, in respect of the level of healthcare coverage selected by the Member for themselves and any Dependents, details of the benefits provided under the plan, showing the upper limits, limits on the number of treatments or procedures, consultations and/or days covered for a given period of time and the Waiting periods.

Cancellation period: A Cancellation 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 6.2 / Life of your plan p.21 in the chapter CANCELING YOUR MEMBERSHIP BEFORE IT TAKES EFFECT: THE CANCELATION PERIOD).

Certificate of enrollment: Single document, issued only at the time of enrollment, attached to this Information notice, 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 Selected coverage zone, 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 names of the Dependents enrolled in the plan, Effective date of enrollment and benefits, number and type of enrollment selected, Duration of membership, Insurer of the plan, benefits and Selected coverage zone.

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.

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 sixty-six (66) on the date of enrollment, who is living in a Common-law marriage with the Member, whether or not they are in paid employment, if and only if the Member and their Common-law spouse share the same home and are free from any other ties of a similar nature (i.e. both partners are single, widowed or divorced and are not bound by a civil partnership). **If there are several common-law spouses, only the eldest will be recognized.**
To facilitate the reading of this information booklet serving as the general terms and conditions, the term 'Spouse' will refer generically to the Spouse, partner or Common-law spouse of the Member.

Contracting association: ASFE. Legal entity having purchased the plan for the benefit of its Members and which agrees to fulfill the corresponding obligations.

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

Country of nationality: Any country for which the Insured member holds a valid passport and of which they are a citizen, national or subject, as specified in the Application for coverage.

Country of origin: Country in which the Member had their main residence before leaving and/or to which they would wish to be repatriated if necessary.

Coverage and insured risks: coverage applies:

- **In the Selected coverage zone,**

and

- for all **medical care** and **treatment following an Accident, Illness, a sudden, Unexpected and unforeseen illness or a Medical emergency,**

as well as:

- **in higher coverage zones** than the selected Coverage zone, during trips for business or leisure (excluding trips for medical reasons, i.e. for the purpose of receiving specific medical care) of a maximum duration of thirty (30) days,

and

- **only for emergency treatments following an accident, the onset of a sudden, unexpected and unforeseen Illness or a Medical emergency**, 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 affected person.
  The medical treatment must begin within twenty-four (24) hours of the event that triggered the claim.

Only one trip outside the selected coverage zone, of a maximum duration of thirty (30) days, will be taken into consideration by the insurer per year and per insured person.

Date of termination: Date on which the benefits provided under the insurance plan come to an end (end date of the enrollment specified on the certificate of enrollment or termination on the initiative of the Member, the Insurer or the Contracting association [see section 6.2 / LIFE OF YOUR PLAN in the chapter CESSATION OF MEMBERSHIP AND END OF COVERAGE (right of withdrawal and termination)]).

Day hospitalization (outpatient hospitalization): Treatment administered following admission of less than twenty-four (24) hours to a Hospital or medical center on an outpatient basis, including the use of a Hospital room and nursing care, but which does not require an overnight stay and where the patient is discharged the same day.

Dental care: This term refers to the oral and dental services provided by a dental surgeon, orthodontist or stomatologist: all dental care including an annual dental check-up, root canal work, scaling, sealing of fissures, treatment of tooth decay (amalgam), application of fluoride, dental x-rays, **excluding tooth whitening treatments**, dentures, orthodontics, periodontics, implants, etc. **Only routine dental treatment is covered under the optional "Vision and Dental" benefits.**

Dental surgery: Dental surgical procedure with anesthesia, including extractions and bone or gum grafts, performed in a hospital by a dental surgeon or stomatologist. **Dental surgery is covered under the optional "Vision and Dental" benefits.**

Dependent(s): 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: The following are classed as dependents: the child(ren) of the Member, their Spouse, Partner or Cohabitant **located in the same foreign country or the same geographical zone as the member**:

- *For members of a 1st Euro/Dollar plan*: under the age of twenty-six (26) if they are in full-time education and enrolled in the plan,
- *For members of a plan supplementing a basic scheme*: under the age of twenty (20), if they are in full-time education and enrolled in the plan.

In all cases, for children aged eighteen (18) and over who are in full-time education and are covered under the plan as Dependents, a school certificate or a valid student card for the corresponding year is required at the time of enrollment and subsequently at the beginning of each school or academic year.

Doctor: Health professional holding a valid 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 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 twenty-four (24) hours of onset, without which there would be a risk of endangering the health of the affected person.

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. Treatment must be administered within twenty-four (24) hours of the Accident or infection.

The following are classed as emergency dental treatments:

- Pulpitis (persistent toothache)
- Dental abscess and/or edema
- Broken or lost tooth
- Dental hemorrhage
- Alveolitis (inflammation of the dental alveolus)
- Acute periodontitis.

This benefit does not cover dental check-ups, conservative care such as scaling or cavity treatments, root canal work, Routine dental surgery and routine dental care, routine vision care and replacement glasses or contact lenses (these are only covered under the optional "Vision and Dental" benefit).

Emergency hospitalization: Medical care delivered following hospitalization and beginning within twenty-four (24) hours of an accident or unexpected illness, resulting in a sudden and unforeseen health problem requiring emergency medical assistance in a Hospital or medical center.

Emergency treatment outside the coverage zone: Refers to Emergency care received in a higher Coverage zone than the one selected, **excluding the USA or a territory under U.S. jurisdiction**, during trips for either business or leisure, **excluding trips for medical reasons** (i.e. for the purpose of receiving specific medical care).
Coverage is acquired for a maximum of thirty (30) days per trip within the limit of one trip per year, and is also limited to the Aggregate limit for the selected coverage zone and only covers emergency treatment and care resulting from an Accident or the onset of a sudden, unexpected and unforeseen Illness or a medical emergency, 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. The treatment must begin within twenty-four (24) hours of the event triggering 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.
It is recommended that Members and any Dependents contact the Administrator, MSH, if trips of more than thirty (30) days are planned outside the Selected coverage zone.

Expatriation: An expatriate is a globally-mobile person outside their country of origin.

Fees: This is the remuneration of a private health professional. Fees may be charged in a hospital or an office (including teleconsultations). Medical fees (charged by doctors and midwives) are distinct from paramedical fees (charged by paramedical professionals).

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 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 Health questionnaire may result in an additional Premium being

applied to the Member and/or one of their Dependents, an exclusion from one or more of the benefits or a total refusal of the Application for coverage under the plan. The Health questionnaire is valid for six (6) months.

Hearing aids: Devices to improve hearing for people with hearing loss. **Only replacement hearing aids are covered under the plan.**

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

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 treatment or is under the supervision of a Doctor or a qualified nurse. **The following facilities are not classed as Hospitals: medical offices, health resorts, fitness centers, spa or thalassotherapy centers, rest homes, retirement homes, convalescent homes, hospices and facilities caring for the elderly.**

(Hospital) day care: See under Outpatient hospitalization.

Hospital room: Service offered by hospitals, allowing an inpatient to be accommodated in:
- a single room (private room),
- a room for 2 persons only (semi-private room),
- or a room for 3 persons or more (shared room).

Deluxe and VIP rooms and suites are not covered.

Hospitalization (24 hours or more): Stays of twenty-four (24) hours or more, including at least one overnight stay in a Hospital for the medical or surgical treatment of an illness, accident or infection.

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

Increased health risk: Persons with an Increased health risk are those who are sick, who have been sick or are particularly susceptible to being sick and who present a risk of Illness (morbidity) or death (mortality) greater than that of the average person of the same age.

These individuals cannot therefore be insured under the standard terms and conditions.

Information booklet serving as the general terms & conditions: This document defining the benefits, exclusions and conditions of use of the insurance plan (including all information on reimbursement procedures). It should be read in conjunction with the Certificate of enrollment and the Benefits schedule.

Insurance year: Depending on the total duration of the membership, including any renewals (see Definition of Total period of membership/insurance), the Insurance year covers the period from the Effective date of Enrollment (shown on the certificate of enrollment) until:

- the end of any renewal period(s), if the total duration of membership/insurance is less than or equal to twelve (12) months.
- 365th day following this date (anniversary date), if the total duration of membership/insurance exceeds twelve (12) months.

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

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

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

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

Joint residence: Usual place of residence in the country of expatriation.
For the Member's spouse, partner or cohabitant, the insurer must be provided with all documents proving joint residence. Proof of joint residence is provided by producing all documents in the name of the Member or their spouse, partner or cohabitant, of a contractual nature or issued by an administrative body, dated within the last three (3) months and mentioning the place of residence, such as property leases, bills, bank statements and tax notices.

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.

Limits (on healthcare benefits): The Benefits schedule for the plan stipulates several types of benefit limits:

- the Aggregate limit on healthcare benefits refers to the maximum amount the Insurer will pay in respect of all healthcare benefits (Hospitalization as well as Routine healthcare, Dental and Vision, and Prevention options, if selected), for the selected level of healthcare coverage;
- specific sub-limits in terms of value and/or number of days or treatments or procedures/sessions, which are applied either per Insurance year, or for the entire life of the plan, or per medical service or consultation, or per day, for the Routine healthcare option and for certain types of medical care in particular (consultations, vaccinations, lenses and frames, etc.). These sub-limits are included in the aggregate ceiling.

All upper limits apply per recipient of the healthcare and per Insurance year, unless otherwise stated in the Benefits schedule.

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

Main country of residence / Country of expatriation: Country of residence indicated by the member in their Application for coverage and shown on their Certificate of enrollment, or confirmed in writing to the Insurer during the life of the plan, in which the primary Member and any Dependents reside for at least six (6) 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. **Maternity is not covered under the plan** (this includes maternity-related expenses such as hospitalization, anesthesia, pre- and postnatal care, childbirth preparation sessions, diagnostic tests for chromosomal disorders, routine care of the newborn, etc.).

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

Medical authority: Any person holding a valid medical or surgical degree who is authorized to practice in their specialist field in the country where the insured member is located.

Medical equipment and devices: Any prescribed medical appliance, equipment or device that supports the life, function or ability of the insured person or is required for certain treatments, such as artificial limbs, crutches, wheelchairs or orthotics. This definition does not include dentures, orthodontic appliances, and visual or hearing aids.

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

Medical network: Means all Hospitals or associated care facilities and healthcare practitioners officially listed by your plan Administrator (MSH) 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 screening and laboratory tests: All the medical services (sampling, analysis, etc.) generally performed by a biomedical laboratory.

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 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 or surgical point of view as **appropriate and necessary**.

Member: Natural person under the age of sixty-six (66) on the date of enrollment, regardless of their status, who is a member of ASFE and has submitted an Application for coverage under the plan which has been accepted in writing as defined in section 6.2 / LIFE OF YOUR PLAN in the chapter YOUR ENROLLMENT IN THE PLAN AND PERSONS INSURED, and who has agreed to fulfill the corresponding obligations, including payment of the Premium specified at the time of enrollment in the plan.
The member enrolls in the plan for themselves or for themselves and their dependents. Where applicable, the member may act as the legal representative of an insured person (minor child aged from 10 to under 18).

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.

Organ transplant: Surgical procedure involving the transplant of tissues or organs (in whole or in part): heart, lung, liver, pancreas, kidney, bone marrow, thyroid, parathyroid, bone, muscle, and cornea. **The benefit does not cover the cost of acquiring the organ.**

Outpatient surgery: Surgery performed in a hospital where the patient is admitted and discharged on the same day.

Palliative care: With respect to a progressive and incurable Illness, this refers to a treatment which does not significantly improve or cure the condition but aims to relieve the physical and psychological suffering related to the symptoms of the Illness and maintain relative 'quality of life'.
Outpatient and inpatient care administered following a diagnosis which confirms the terminal and incurable nature of the Illness is covered under this benefit, as is the reimbursement of physical care, the cost of a room in a Hospital or hospice, nursing care and prescription drugs.

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

Partner: Person under the age of sixty-six (66) at the time of enrollment bound to the Member by a civil partnership agreement and sharing the same home as the Member. 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).
To facilitate the reading of this information booklet serving as the general terms and conditions, the term 'Spouse' will refer generically to the Spouse, partner or Common-law spouse of the Member.

Period of benefits / Period of coverage: Period of membership of the plan (including any renewal(s) at the request of the Member), with a minimum duration of three (3) months and a maximum of thirty-six (36) months, during which the Member and any Dependents are covered under the plan. It starts on the effective date of enrollment (shown on the certificate of enrollment) and ends on the date of termination of membership as set out under section 6.2 / LIFE OF YOUR PLAN in the chapter CESSATION OF MEMBERSHIP AND END OF COVERAGE (right of withdrawal and termination).

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

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

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

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

Precertification: Precertification agreement formalized in writing and issued to the Insured member by the Insurer or the Administrator before incurring certain types of medical expenses or accessing services such as hospitalization, medical treatments provided as a series of treatments, costly treatments, or prostheses of any kind (on presentation of an appropriate detailed and circumstantial medical report and a fully costed estimate).

Pre-existing medical condition: Pre-existing conditions: any Illness, disorder, infection 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 at the time of enrollment in the plan. **Pre-existing conditions are not covered**.

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.

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.

Prior approval: Coverage by the insurer of certain types of expenses, medical care or Services, such as hospitalization, series of treatment (e.g. physical therapy sessions), costly treatments or Prostheses of any kind, is subject to the prior approval of the insurer's medical advisor.
Before starting any treatment, the insured person must ask the practitioner prescribing the treatment to complete a request for prior approval, which must be sent together with an itemized estimate, in order to request and obtain prior approval from the insurer or the Administrator before the treatment is actually covered. The expenses to which this applies are listed in the Benefits schedule.

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.

Rehabilitation immediately following hospitalization: Rehabilitation as a direct continuation of hospitalization, beginning no later than a maximum of thirty (30) days following the end of the hospitalization.

Renewal date: Membership may be renewed on each of the termination dates shown on the Certificate of enrollment **for a minimum of one (1) month and up to a total of thirty-six (36) months.**

Request for prior approval: Form completed by the insured member's doctor or detailed medical report, as appropriate, which is sent together with an itemized and costed estimate in order to obtain the insurer's or administrator's prior approval before incurring certain types of expenses, or starting certain types of medical treatment or services as shown in the Benefits schedule.

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

Routine healthcare: Treatments, excluding Routine dental care, performed by a General practitioner or Specialist holding a valid degree of Doctor of Medicine and is licensed to practice medicine under the laws of the country where the treatment is administered in their medical or surgical office and which do not require the patient to be admitted to Hospital.

Routine medicine (Primary care): 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.

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.

The plan provides for five (5) coverage zones (see paragraph "Specific country of residence and Coverage zone under the plan").

Specialist: Refers to a Doctor holding a valid degree of Doctor of Medicine 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.

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

Spouse: Person married to the Member and not legally separated or divorced, whether or not they are in paid employment, sharing the same home as the Member, and under the age of sixty-six (66) on the date of enrollment.
To facilitate the reading of this information booklet serving as the general terms and conditions, the term 'Spouse' will refer generically to the Spouse, partner or Common-law spouse of the Member.

Subrogation: Refers to the rights which the Administrator (MSH) can exercise on behalf of the Insurer to recover any expenses or costs from another insurance company, national health insurance scheme or any source linked to the reimbursement of treatment insured under this plan.

Termination: Termination is the formal process by which the Insurer, the Contracting association or the Member puts an end to the plan or enrollment in the plan which binds them, see chapter 6.2.9 Cessation of membership and end of coverage (right of withdrawal and termination) p.24.

Total duration of membership/insurance: Period of total coverage under the plan (including any renewals at the request of the Member), with a minimum duration of three (3) months and a maximum duration of thirty-six (36) months.
This period of coverage starts on the effective date of enrollment (shown on the certificate of enrollment) and ends on the date of termination of membership as set out under section 6.2 / LIFE OF YOUR PLAN in the chapter CESSATION OF MEMBERSHIP AND END OF COVERAGE (right of withdrawal and termination).

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.

Unexpected (or sudden) illness: Any deterioration in health certified by a competent medical authority which is sudden, unforeseeable, and requires the intervention of a doctor within forty-eight (48) hours.
The sudden and unforeseeable nature of the event must be recognized by the insurer's medical advisor.

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.

In this definition, the term "appropriate" takes into account the patient's health and the cost of treatment.

Medically required hospitalization means that the treatments and diagnostic tests cannot be carried out prudently and effectively on an outpatient basis.

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

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

Important: **Some hospitals, including the American Hospital in Paris, France, the Mount Elizabeth Hospital, the Mount Elizabeth Novena and the Gleneagles Hospital in Singapore, the Bumrungrad International Hospital in Thailand, QuironSalud and HM Sanchinarro in Spain, the Acibadem International Hospital in Turkey, the Clémenceau Medical Center in Lebanon, the Aspetar Hospital in Qatar and the Albert Einstein Hospital in Brazil, the Hospital ABC Observatorio, the Hospital ABC Santa Fe and the Angeles Metropolitano Hospital in Mexico City, the North Shore University Hospital in Manhasset (NY), the Mount Sinai Hospital in New York, the Cedars-Sinai Medical Center in Los Angeles (CA) and the Northwestern Memorial Hospital in Chicago (IL) charge fees that are generally well in excess of Usual, customary and reasonable costs.**
If you are hospitalized or receive treatment in this type of facility, the insurer draws your attention to the fact that you will be reimbursed based on reasonable and customary costs as determined by the insurer.
This means you are likely to be responsible for a significant portion of the expenses.

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.

Vision care: Consultations and examinations by a qualified optometrist or ophthalmologist, glasses (1 frame + 2 lenses) and corrective contact lenses. Refractive surgery can also correct certain visual disorders. **Only consultations, examinations and replacement glasses or contact lenses are covered under the plan.**

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. **No benefits will be paid during this period.**

Year (per year): The term "per year" used in the benefits schedules means "per insurance year".

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

Prior approval: In all of the cases listed in the benefits schedules below where the insurer requires prior approval, **the coverage of any medical care requiring prior approval that has been delivered without prior approval (request for prior approval not submitted or denied by the insurer) will be denied.**
However, if the insurer's medical advisor, having reviewed the medical report, recognizes that the medical care was medically necessary and covered under the plan, a penalty will be applied to the coverage.
This includes:
- **Hospitalization, including on an outpatient basis,**
- **Medical or surgical prostheses,**
- **Stays in medical centers,**
- **Series of treatment (e.g. sessions of physical therapy).**

Upper limit of coverage: The cumulative amount of reimbursements from the insurer is capped, per insurance year and per insured person. Where applicable, any compensation or benefits of the same nature paid by the benefits scheme to which the member belongs is deducted from this amount.
The amount of this upper limit is shown in the table of benefits below. It is based on the level of coverage and the benefit options purchased.

3.1. / BENEFITS SCHEDULE (EXCLUDING HOSPITALIZATION AND MEDICAL CARE IN THE USA AND TERRITORIES UNDER U.S. JURISDICTION

When you enroll in the plan, you can choose between three (3) levels of coverage.

You can also choose the currency in which you want to pay your insurance premium and receive your medical expenses reimbursements.

The benefits below are expressed with the CFE portion included.

A CHOICE OF 3 LEVELS OF COVERAGE	BASIC	REGULAR	PLUS
AGGREGATE LIMIT ON HEALTHCARE BENEFITS	€/$250,000	€/$400,000	€/$600,000

3.1.1. HOSPITALIZATION BENEFIT (EXCLUDING HOSPITALIZATION IN THE USA AND TERRITORIES UNDER U.S. JURISDICTION)

The HOSPITALIZATION BENEFIT, i.e. excluding OPTIONAL BENEFITS, covers hospitalization costs only in a hospital.

The schedules below detail the benefits and the levels of coverage for this category of costs qualifying for reimbursement.

	BASIC	REGULAR	PLUS
HOSPITALIZATION	**Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year**		
Waiting period for Hospitalization benefits: 3 months (except in the event of a medical Emergency, Accident or Unexpected illness) **Subject to prior approval, except in the event of a medical Emergency, Accident or Unexpected illness**			
Provided you have requested and obtained our prior approval, except in the event of an accident or medical emergency, we will cover hospital expenses when: - The member of the plan is in Hospital, whether on an Outpatient basis or for several consecutive days, - The need for hospitalization was established by a General practitioner or Specialist, - The duration of your stay is medically appropriate and approved following a Request for prior approval, - Your treatment is administered or monitored by a General practitioner and/or Specialist. If you need to stay in Hospital longer than the period specified in the prior approval agreement, or if changes are made to your treatment, your General practitioner or Specialist must send us a medical report as soon as possible. This medical report must include: - The diagnosis, - The treatment you have already received, - The treatment you require, - The additional length of time you will need to stay in Hospital. **We do not cover hospital expenses if hospitalization is due to one or more of the following reasons:** **- Maternity,** **- Convalescence,** **- Psychiatry – Mental or nervous disorders – Psychology,** **- 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 care.**			
Hospital room	€/$50 per night	€/$80 per night	€/$120 per night
Outpatient hospitalization (including Outpatient surgery) in a hospital	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.		

	BASIC	REGULAR	PLUS
	100% UCR	100% UCR	100% UCR

	BASIC	REGULAR	PLUS
Emergency hospitalization within the selected coverage zone	We will cover treatment administered following admission to a Hospital 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. We must be notified of any **emergency hospitalization** within 48 hours of admission. All **services** provided in the Emergency room which are not followed by admission to hospital will only be covered under the **"Routine healthcare"** optional benefit. **If this option has not been purchased as part of the plan, the services will not be covered.** We will also cover the local transportation by ambulance of a patient, required in cases of medical necessity or emergency, to the nearest Hospital best suited to the situation.		
Emergency hospitalization in a higher coverage zone (excluding the USA and territories under U.S. jurisdiction) than the selected coverage zone. **Trip of 30 consecutive days maximum and a maximum of one trip per year**	100% UCR up to 30 days per year	100% UCR up to 30 days per year	100% UCR up to 30 days per year
	We will cover all **Emergency hospital expenses (only if they are the result of an Accident or a sudden, unexpected and unforeseen illness requiring surgery or medical treatment that cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness representing an immediate and serious danger to the health of the insured member)** in a country located in a **higher coverage zone**. **Travel for medical reasons, and consequently all scheduled treatment in a coverage zone higher than the selected coverage zone, is also excluded.** It is recommended that Members and any **Dependents** contact the **administrator** MSH if trips of more than 30 days or multiple trips are planned in a **higher coverage zone than the selected coverage zone**, so that the level of coverage under your plan can be adjusted. We will also cover the local transportation by ambulance of a patient, required in cases of medical necessity or emergency, to the nearest Hospital best suited to the situation.		
Hospitalization - Intensive care	100% UCR	100% UCR	100% UCR
	We will cover hospital expenses in case of treatment in a general or cardiac **intensive care** unit (including a Critical care unit) for patients presenting with organ failure or who are at risk of severe complications.		
Hospitalization - Surgical procedures including fees, operating room and anesthesia	100% UCR	100% UCR	100% UCR
	We will cover the following costs in the event of hospitalization: - operating room - recovery room - drugs and dressings used in the operating room and the recovery room - drugs and dressings used during your stay in **hospital.** We will cover the fees for surgeons and anesthetists and the care required immediately before and after the operation (on the same day). This also includes operations performed on an **outpatient** basis.		
Hospitalization - Consultations with general practitioners and specialists during hospitalization covered under this plan (excluding alternative medicine) and including specialist treatments and procedures	100% UCR	100% UCR	100% UCR
	We will cover consultations with **general practitioners** or **specialists** during your stay in **hospital** following a covered Event.		
Hospitalization - Laboratory tests, MRI, x-rays, scans, tomography	100% UCR	100% UCR	100% UCR
	For your hospitalization covered under the plan, we will cover all expenses related to: - **Medical imaging**, such as x-rays, scans, MRI, etc., - tests such as blood tests or urine samples, - diagnostic tests such as electrocardiograms, if these examinations are prescribed by your **general practitioner** or **specialist** to help diagnose or assess your health during your stay in hospital.		
Hospitalization - Prescription drugs	100% UCR	100% UCR	100% UCR
	We will cover the cost of any **drugs prescribed** by the **general practitioner or specialist** in charge of your treatment during your hospitalization.		
Hospitalization - Renal dialysis	100% UCR	100% UCR	100% UCR
	We will cover the cost of renal dialysis, with the exception of transportation costs to and from the care facility where the dialysis is carried out.		
Hospitalization - Oncology (Treatment of cancer)	100% UCR	100% UCR	100% UCR
	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'** if the option has been selected.		

	BASIC	REGULAR	PLUS
Hospitalization - Treatment of AIDS	100% UCR	100% UCR	100% UCR
	We will cover any costs related to the treatment of conditions related to HIV.		
Hospitalization - Internal surgical and medical prostheses/devices	100% UCR	100% UCR	100% UCR
	We will cover costs related to **prostheses, devices or appliances** fitted during a surgical procedure.		
Hospitalization - External surgical and	100% UCR up to €/$600 per year	100% UCR up to €/$800 per year	100% UCR up to €/$1,000 per year

	BASIC	REGULAR	PLUS
medical prostheses/devices	Subject to the approval of the medical advisor, we will cover: - **essential prostheses or devices** immediately following surgery if medically required, - **medically required prostheses or devices** during the short-term recovery process.		
Hospitalization - Palliative care	100% UCR up to €/$5,000 per year	100% UCR up to €/$7,500 per year	100% UCR up to €/$12,500 per year
	If a **member** is diagnosed with a terminal **illness** and can no longer be treated with a view to being cured, we will cover: - hospitalization costs in a **hospital** or hospice, - the cost of **palliative care** in a hospital or hospice, - nursing costs in a hospital or hospice, - **prescribed drugs.**		
Hospitalization - Organ transplant: Medical expenses, room and board, cost of treatment and fees during an organ transplant	100% UCR up to €/$10,000 per year	100% UCR up to €/$15,000 per year	100% UCR up to €/$20,000 per year
	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 not cover:** **- the cost of transporting the organ,** **- organ acquisition costs,** **- the donor's operation and hospital costs.**		
Hospitalization for psychiatric, mental, or nervous disorders	**Not covered**	**Not covered**	**Not covered**
	We will not cover hospitalization for: **- mental or nervous disorders,** **- psychiatry or psychology.**		
Hospitalization – Physical therapy / Physiotherapy	100% UCR up to €/$500 per year	100% UCR up to €/$1,250 per year	100% UCR up to €/$2,500 per year
	We will cover consultations, treatments and procedures in **physical therapy / physiotherapy**, prescribed and carried out during your hospitalization. **We will not cover chiropractic and osteopathy.**		
HEALTHCARE FOLLOWING COVERED HOSPITALIZATION			
Home hospitalization (on prescription) - subject to prior approval	100% UCR up to 30 days per year	100% UCR up to 30 days per year	100% UCR up to 30 days per year
	If you have requested and obtained our prior approval, **we will cover home hospitalization and home nursing care following hospitalization.**		
Reconstructive surgery	**Not covered**	**Not covered**	**Not covered**
	We will not cover the cost of reconstructive surgery, even if it is medically necessary or follows an Accident or Illness covered under the plan.		
Rehabilitation immediately following hospitalization, started within 30 days of the end of hospitalization - subject to prior approval	100% UCR, up to 10 days per year	100% UCR, up to 15 days per year	100% UCR, up to 20 days per year
	We will cover any rehabilitation, including room and board fees and treatments such as **physical therapy**, physiotherapy, occupational therapy or **speech therapy** following a covered hospitalization. **We do not cover rehabilitation expenses or treatment which do not follow hospitalization covered under the plan.** We will cover these costs if you requested and obtained our prior approval before beginning the treatment, and if it begins within a maximum of 30 days following the end of the 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 processing the request for prior approval.		
Nursing care related to covered hospitalization and beginning within 30 days of the end of the hospitalization - subject to prior approval	100% UCR up to €/$750 per year	100% UCR up to €/$1,000 per year	100% UCR up to €/$1,500 per year
	We will cover the cost of prescribed nursing care following covered hospitalization. We will cover this treatment if you requested and obtained our prior approval before beginning the treatment, and if it begins within a maximum of 30 days following the end of the hospitalization, whether it is carried out in a doctor's office, at home or in a hospital.		

Good to know

Medical assistance and evacuation benefits are included in your neoTempo plan.
For more information, please refer to section "General provisions of medical evacuation benefits included as standard with your healthcare plan".

3.1.2. Optional benefits: Routine healthcare - Vision and Dental - Prevention

	BASIC	REGULAR	PLUS
ROUTINE HEALTHCARE	**Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year**		
Waiting period for Routine healthcare benefits: 3 months (except in the event of a Medical emergency, Accident or Unexpected illness)			
AGGREGATE LIMIT ON ROUTINE HEALTHCARE BENEFITS	€/$12,000	€/$24,000	€/$30,000
Consultations with general practitioners and specialists (other than dentists, ophthalmologists, optometrists and psychiatrists) and specialist procedures	100% UCR up to €/$50 per treatment, procedure or consultation	100% UCR up to €/$80 per treatment, procedure or consultation	100% UCR up to €/$120 per treatment, procedure or consultation
	We will cover consultations with **General practitioners** and **Specialists** (other than dentists, ophthalmologists and psychiatrists) and **Specialist** treatments or procedures. We will cover these consultations under **Routine healthcare**, whether carried out in a medical office, in the home or in hospital (excluding during periods of hospitalization).		
Teleconsultation	100% UCR up to €/$50 per treatment, procedure or consultation	100% UCR up to €/$80 per treatment, procedure or consultation	100% UCR up to €/$120 per treatment, procedure or consultation
	We will cover teleconsultations.		
Prescription drugs (excluding contraception)	100% UCR up to €/$2,000 per year	100% UCR up to €/$5,000 per year	100% UCR up to €/$10,000 per year
	We will cover (under **Routine healthcare**) the cost of drugs: - prescribed by your **General practitioner** or **Specialist**, - which are used only in case of illness or injury.		
Prescribed contraceptives	100% UCR up to €/$40 per year	100% UCR up to €/$50 per year	100% UCR up to €/$60 per year
	We will cover mechanical and medicinal methods of contraception prescribed by a general practitioner or specialist.		
Emergency dental care without hospitalization	100% UCR up to €/$150 per year	100% UCR up to €/$250 per year	100% UCR up to €/$350 per year
	We will cover consultations for Emergency dental care, such as sudden toothache that does not require hospitalization. Non-emergency dental expenses (e.g. dental check-ups, scaling, etc.) and dental treatment carried out during a consultation with a stomatologist are only covered under the "Vision and Dental" Option if you purchased it as part of the plan.		
Laboratory tests, MRI, x-rays, scans, tomography and physical diagnostic examinations on an outpatient basis	100% UCR up to €/$1,000 per year	100% UCR up to €/$2,000 per year	100% UCR up to €/$3,000 per year
	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.		
Physical therapy and **physiotherapy, on prescription - subject to prior approval**	100% UCR up to €/$500 per year limited to 5 sessions per year	100% UCR up to €/$1,000 per year limited to 10 sessions per year	100% UCR up to €/$1,500 per year limited to 15 sessions per year
	If you requested and obtained our prior approval before beginning the treatment, we will cover physical therapy consultations prescribed under Routine healthcare. The limit on the number of sessions includes all specialties combined.		
Emergency ophthalmic examination	100% UCR up to €/$70 per consultation	100% UCR up to €/$120 per consultation	100% UCR up to €/$170 per consultation
	We will cover consultations for Emergency vision care that does not require hospitalization. Non-emergency ophthalmic expenses are covered under the "Vision and Dental" Option if you purchased it as part of the plan. Consultations and examinations carried out by an optometrist or ophthalmologist will only be covered under the "Vision and Dental" option.		

	BASIC	REGULAR	PLUS
External appliances and medical prostheses (excluding dentures and hearing aids) - subject to prior approval	100% UCR up to €/$500 per year	100% UCR up to €/$750 per year	100% UCR up to €/$1,000 per year
	If you requested and obtained our prior approval, we will cover all expenses for appliances and **Medical, orthopedic prostheses** that are **medically necessary** and prescribed. **It does not include any consumables (batteries, repairs, etc.) related to the covered equipment.**		
Osteopathy and **chiropractic** **Homeopathy, acupuncture and traditional Chinese medicine** **Psychiatry and psychology**	**Not covered**	**Not covered**	**Not covered**
	We will not cover: **- consultations in Osteopathy and Chiropractic with or without a prescription,** **- sessions of Acupuncture and Traditional Chinese medicine and consultations with a homeopath.** **- psychiatrist and psychologist consultations.**		

	BASIC	REGULAR	PLUS

VISION AND DENTAL CARE	Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year		
	BASIC	REGULAR	PLUS
Waiting period for Vision and Dental benefits: Vision 3 months except for emergency consultations with an ophthalmologist - Dental 3 months except for emergency dental treatment			
Consultation with an ophthalmologist or optometrist	100% UCR up to €/$200 per consultation limited to 2 sessions per year	100% UCR up to €/$350 per consultation limited to 2 sessions per year	100% UCR up to €/$500 per consultation limited to 2 sessions per year
	We will cover the cost of consultations with **ophthalmologists** and **optometrists**. We will cover these consultations under "Vision and Dental care", whether carried out in a medical office, in the home or in hospital (excluding during emergency or periods of hospitalization). **Disorders of the eye such as cataracts, retinal detachment, glaucoma, AMD, etc. are covered under hospitalization if necessary or under the "Routine healthcare" option.**		
Lenses and frames / Corrective contact lenses including disposable lenses / Hearing aids	100% UCR up to €/$150 per year	100% UCR up to €/$300 per year	100% UCR up to €/$400 per year
	Once the **Waiting period** has expired, we will cover the cost of prescribed glasses (2 lenses and 1 frame) or contact lenses for vision correction. **Protective glasses (sunglasses or other types) or contact lenses without vision correction are not covered.**		
Routine dental care and dental surgery	100% UCR up to €/$700 per year	100% UCR up to €/$1,000 per year	100% UCR up to €/$1,500 per year
	We will cover consultations with a dentist as well as all treatments or procedures carried out during these consultations: Scaling / treatment of tooth decay (amalgam) / sealing of fissures / Dental x-rays / application of fluoride / All surgical procedures, with or without anesthesia. **Dentures, implants, periodontics, orthodontics and teeth whitening are not covered by the Contract.**		

PREVENTION	Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year		
	BASIC	REGULAR	PLUS
No waiting period for Prevention benefits			
Prescribed and/or mandatory vaccinations	100% UCR up to €/$175 per year	100% UCR up to €/$300 per year	100% UCR up to €/$450 per year
	We will cover vaccinations prescribed and/or mandatory for expatriates, such as anti-malaria, yellow fever and Covid-19.		
Antimalarial treatments	80% UCR up to €/$100 per year	90% UCR up to €/$100 per year	100% UCR up to €/$100 per year
	We will cover the cost of preventive anti-malarial treatments prescribed during the period of expatriation.		

Coverage in the event of an emergency

Worldwide coverage (**outside the USA and Territories under US jurisdiction**) only applies to treatments provided as an emergency during temporary stays (trips for leisure or business purposes) of up to thirty (30) consecutive days per year.
Medical emergency means emergencies following an accident or sudden, unexpected and unforeseen illness requiring surgery or medical treatment which cannot wait until repatriation to the main country of residence or the worsening of a serious illness which poses an immediate and serious threat to the health of the insured member.
In the event of a medical emergency as defined under the plan, please contact your claims department as soon as possible. If the insured member traveled to a higher coverage zone for the sole purpose of receiving treatment, if the symptoms of the disease were known to the recipient of the treatment before they enrolled in the plan or if the treatment is not subsequent to an accident or sudden, unexpected and unforeseen illness requiring surgery, treatment dispensed in this zone will not be covered, even in an emergency.

3.2.1. Benefits specific to the USA and territories under U.S. jurisdiction for insured members with zone 5 plans (worldwide including the USA and territories under the U.S. jurisdiction)

IMPORTANT INFORMATION FOR HOSPITALIZATION AND MEDICAL CARE IN THE USA AND TERRITORIES UNDER U.S. JURISDICTION

If you opted for Zone 5, you are covered worldwide, including the United States and territories under U.S. jurisdiction (Puerto Rico, U.S. Virgin Islands, Northern Mariana Islands, U.S. Minor Outlying Islands, and American Samoa).

If you require treatment or hospitalization in the USA or in a Territory under US jurisdiction, or need to see a local Doctor, your plan enables you to benefit from specific agreements set up by MSH with 2 local partners: UnitedHealthcare and Optum RX.

These agreements mean you can:

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

IMPORTANT: Your coverage in the USA and Territories under US jurisdiction always gives you the freedom to choose which hospital or pharmacy is best suited to your treatment (including those outside the networks). However, if you choose to be treated or buy drugs prescribed in the United States or in Territories under US jurisdiction from a provider that is not part of the networks, **any payments we make will be reduced by 20%**.
However, if it is physically impossible for you to be treated by a member of the networks, for geographical reasons or in an Emergency, the 20% reduction in the level of reimbursement specified in the plan will not be applied.
This penalty is in addition to any others that may be applicable if treatment was received without a Request for prior approval being submitted.
Geographical exceptions include cases where, within a fifty (50) kilometer radius of the Insured member's home:

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

Hospitalization and medical services, identical to those listed in the hospitalization benefits schedule**: HOSPITALIZATION (EXCLUDING HOSPITALIZATION IN THE USA OR TERRITORIES UNDER U.S. JURISDICTION)** and **OPTIONAL BENEFITS: ROUTINE HEALTHCARE - VISION AND DENTAL - PREVENTION (EXCLUDING THE USA OR TERRITORIES UNDER THE U.S. JURISDICTION), when they occur in the USA or a territory under U.S. jurisdiction depending on the level of coverage purchased, are covered on the basis of Usual, Customary and Reasonable costs as determined by us ("UCR"), as follows:**

BASIC		REGULAR		PLUS	
In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR

It is specified that the maximum benefit amounts in €/$ per year, per medical service or in number of days remain the same.

4. / EXCLUSIONS FROM HEALTHCARE BENEFITS (WHAT IS NOT COVERED)

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

The following are excluded from the insurance:

- **costs incurred before the effective date of the plan and after coverage has ceased;**
- **travel and accommodation expenses related to healthcare;**
- **the cost of an ambulance or the taxi fare to attend scheduled appointments or to return home following surgery with anesthesia, except in case of chemotherapy.**
- **any medical or surgical expenditure prescribed by a medical authority which is not recognized (practitioners, therapists, clinics, hospitals and medical centers who/which are not recognized):**
  - **by the authorities in force in the country where the treatment takes place as having particular expertise in the treatment of the relevant Accident or illness;**
  - **by the Medical advisor as being properly qualified, competent or authorized to prescribe treatment and who have been notified in writing by him or her;**
- **non-prescription drugs;**
- **treatments, consultations and drugs prescribed by the Member, their Dependents or any member of their family;**
- **costs deemed unnecessary and/or inappropriate by the Insurer's Medical advisor;**
- **in the event of hospitalization, additional expenses with no direct medical purpose such as charges for telephone, television, internet access, newspapers, taxi fares, meals for visitors etc.;**
- **costs deemed to be excessive, unreasonable or unusual considering the country in which they were incurred. Therefore, only Usual, Customary and Reasonable costs will be covered and reimbursed under the plan, i.e. reasonable medical expenses which are commonly charged in the relevant country for the specific treatment received, according to standard medical and generally accepted procedures;**
- **with respect to physical therapy/physiotherapy, only conventional treatments approved by the medical advisor are covered. Lymphatic drainage, massage and colonic irrigation are not covered;**
- **the cost of hospitalization in a deluxe or VIP room or other suites;**
- **experimental treatments or drugs, namely all forms of treatment or medication which, in the opinion of the Medical advisors, are not conventional or whose effectiveness has not been proven;**
- **in respect of pharmacy items, products which are not recognized as drugs such as sunscreen, makeup, over-the-counter products, formula milks, vitamins, minerals, probiotics, gluten-free products, etc.;**
- **products classified as vitamins or minerals and dietary supplements (except in the treatment of a serious vitamin deficiency), over-the-counter products and cosmetics;**
- **the cost of cosmetic, esthetic or reconstruction treatments performed by a plastic surgeon to improve or transform the appearance - even for psychological reasons - unless this treatment is linked to the restoration of a physical feature or function following a disfiguring Accident or surgery related to the Treatment of cancer occurring during the Period of insurance coverage;**
- **pre-exposure prophylactic treatment for HIV (pre-exposure);**
- **growth hormones unless supporting medical documents are provided and approved by the medical advisor;**
- **medication for and treatment of erectile dysfunction;**
- **treatments and stays in health resorts, fitness centers, convalescent homes or nursing homes, spas and thermal treatment centers and other similar establishments which are not recognized as Hospitals;**
- **all tests and treatments for obesity/anorexia, or which are required as a result of obesity or anorexia, including, in particular, programs and fees for weight loss/weight gain and medicinal support and drugs prescribed for obesity/anorexia. In some clinical cases, with the approval of the Medical advisor, surgical procedures for morbid obesity (BMI = Body Mass Index> 40) may be covered;**
- **consultations with Psychiatrists and psychologists and consultations for mental Illnesses or disorders or behavioral disorders (chapter V of the WHO's International Classification of Diseases, version 10);**
- **consultations in psychology, psychotherapy and/or psychoanalysis with a therapist or family counselor (even if such consultations are conducted by a Psychiatrist);**
- **the care, treatment and all consequences of attempted suicide or self-inflicted injuries or Illnesses, or the use of narcotics without a medical prescription;**
- **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;**
- **orthodontics, except if it follows hospitalization;**
- **orthodontics, dentures, implantology and periodontics;**
- **consultations in Osteopathy and Chiropractic with or without prescription,**
- **sessions of Acupuncture and Traditional Chinese medicine and consultations with a homeopath and any other alternative medicine**
- **surgical contraception;**
- **expenditure arising when receiving an organ donation or purchasing an organ, namely:**
  - **mechanical or animal organs, except in cases where a mechanical device is used temporarily for the sole purpose of maintaining vital functions while awaiting a transplant;**
  - **any purchase of an organ from a donor regardless of origin;**
  - **the cultivation and storage of stem cells, for prevention purposes, for hypothetical future use in the event of a possible Illness;**
- **costs generated by complications caused directly by an injury or Illness which is not covered or only partially covered under the plan;**
- **pre-existing conditions: any Illness, condition or injury, or related symptoms, which developed before the date of enrollment in the plan of which the Member or their Dependents were aware, or of which they could**

reasonably have been aware and which we have not expressly agreed to cover;

- repatriation and evacuation costs, including medical evacuation from a ship to a medical center on land. However, some of these costs will be covered by the assistance company under the terms and conditions of 'Standard assistance' benefits and under the 'Premium assistance' option, if selected;
- the cost of medical or surgical hospitalization or stays in sanatoriums or preventoriums if the establishments where the Insured member was treated are not approved by the competent public authority;
- foot care from a podiatrist or chiropodist, such as treatments for corns/calluses, thickened and/or deformed nails, except in cases of Medical necessity approved by the Medical advisor;
- maternity-related expenses and medical care such as hospitalization, anesthesia, pre- and postnatal care, childbirth preparation sessions, diagnostic tests for chromosomal disorders, routine care of the newborn, etc.).
- the cost of gestational surrogacy, namely all treatments directly related to the use of a surrogate mother (gestational surrogacy) whether the Insured member is the surrogate mother or the intended parent;
- termination of pregnancy (unless in the event of hospitalization if there is a threat to the health of the mother);
- all devices, operations and treatments for sexual dysfunction (sexual deficiencies such as impotence, regardless of cause) or disorders related to gender (disorders related to sex changes or gender reassignment);
- sleep disorders, including insomnia, unless the Insured member is diagnosed as suffering from severe sleep apnea;
- the consequences of breaking the laws of the country where the Insured member is staying;
- the cost of psychomotor therapy;
- disorders of the temporomandibular joint (TMJ), except in cases of Medical necessity approved by the Medical advisor;
- costs for which the Insured member has not submitted a Request for prior approval; the level of reimbursement of medical care provided under the plan may then be reduced. The plan administrator applies a penalty to the benefit amount of between 40% and 100%. This penalty is in addition to any others which may be applicable if treatment is received in Zone 5 outside the UnitedHealthcare International medical network.
- life-sustaining treatments,
- 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, retirement home and the costs resulting from personal assistance with daily activities, even if that person has been declared as being in a state of temporary or permanent disability. Such services are classed as home care even if they are prescribed by a Doctor and delivered by providers with medical or paramedical status;
- non-medical admissions or hospital stays which include:
  - treatment which could be administered in day care or on an outpatient basis,
  - treatment which is not medically justified in the opinion of the Medical advisor,
  - convalescence.
- treatment of a condition which is subject to a specific exclusion. Specific exclusions are listed on your Certificate of enrollment;
- costs which were paid by another insurance provider, person, organization or state program;
- all care, treatment and consultations provided under the "Routine healthcare", "Vision and Dental care" and/or "Prevention" optional benefits, if the Member and any Dependents did not select these options;
- all care, treatment and consultations outside the selected Geographical coverage zone, if in a Coverage zone higher than the one selected (excluding zone 5), other than in a Medical 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; or outside the selected coverage zone, for a trip of more than thirty (30) days, per year and per insured member.
- all care, treatment and consultations received within a Coverage zone which is higher than the selected Coverage zone, particularly in the United States, in the following cases:
  - If the Member did not opt for the higher-level Coverage zone corresponding to the one where the medical care was delivered, we will not cover medical care, treatment and consultations received in this zone.
  - If the Member opted for the 'United States' Coverage Zone, we will not cover care, treatment and consultations received in the United States if it is established that the Member (and any Dependents) enrolled in the plan for the sole purpose of traveling to the United States to receive care, treatment and consultations, and if the symptoms of the condition were known to them prior to their enrollment in the plan.

The consequences of the following are also excluded from the insurance:

- intentional acts committed by the Member or the Dependent;
- civil or foreign war, insurrection, rebellion (with or without declaration of war), riots, military coups or any usurping of power, martial law or acts committed by any illegally constituted authority, regardless of the location and the protagonists of the events, except in cases of legitimate self-defense;
- the direct or indirect effects of changes in the structure of the atomic nucleus, chemical contamination, radioactivity or any nuclear material,
- any conflict or disaster, if the Insured member has endangered themselves by entering a conflict zone recognized by the Government of the country in question, has actively taken part in the conflict or has shown a blatant disregard for their own safety;
- harmful, dangerous or addictive use of alcohol, narcotics and/or drugs and any treatment arising from the

harmful, dangerous or addictive use of these substances;

- alcoholism or drunkenness on the part of the Member or Dependent;
- participation in any sporting competitions and training for these competitions as well as the practice of any sports in a club or federation;
- the practice of sports for professional purposes;
- the practice of the sports listed below:
  - extreme sports: bungee jumping, caving, extreme canoeing and kayaking (in rapids greater than Class V, rivers greater than Class II, on seas and oceans more than two nautical miles from land), sailing (transoceanic and single-handed navigation more than 20 nautical miles from shelter) and base jumping,
  - mountain sports: mountaineering, climbing (excluding artificial holds without a safety rope), rock climbing, hiking and trekking requiring special equipment (ropes, ice axes and crampons), ski jumping, bobsleigh, Skeleton, skiing (alpine, cross-country and snowboarding) off marked trails which are open to the public and canyoning,
  - air sports: aerobatics, gliding, parachuting, microlighting, hang gliding, paragliding and skysurfing,
  - water sports: scuba diving as part of a sporting competition or for leisure purposes, riverboarding and kite surfing,
  - competitive self-defense and combat sports,
  - motor sports: motor racing, motorcycle racing or kart racing.

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

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

5. / Reimbursements

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

5.1.1. Deadline for submitting a claim for reimbursement

All claims for the reimbursement of medical expenses must be submitted in accordance with the provisions of Article "Limitation period" to MSH within twenty-four (24) months of the date on which the medical care was provided. **Claims received after this twenty-four (24) month period will not be processed.**

5.1.2. Supporting documents

In the event of an illness or accident giving rise to a claim, the insurer must be in possession of dated supporting documents showing the last name, first names, and date of birth of the patient and the local currency.

These supporting documents include:

- proof of expenses incurred and original proof of payment.
- original bills for fees or expenses, medical prescriptions, receipted prescriptions and itemized receipted invoices, dated and showing the type of illness, the nature and date of visits, and the medical care provided. The prescriptions must clearly show the name and price of the drugs and specify the local currency.
- if the medical care requires a request for prior approval: the prior approval form accepted by the insurer's medical advisor.

For medical care delivered outside the coverage zone during occasional stays, proof that the services are the result of a medical emergency, accident or unexpected illness as defined in the article "Definitions" must be provided to the insurer by any means.

The insurer reserves the right to request any other supporting documents it deems necessary. Any supporting medical documents must be sent to the insurer's medical advisor or to the insurer's consulting health professional under confidential cover.

All supporting documents can be sent in paperless format to MSH, your claims administrator. However, we reserve the right to request the original documents.

5.1.3. 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 can be made by wire transfer in the currency of your bank account.

BANK CHARGES WHICH MAY APPLY

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

5.1.4. Reimbursement following a request for prior approval

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

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

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

5.1.5. CUMULATIVE INSURANCE

The reimbursement of or compensation for costs incurred as the result of an illness or accident cannot exceed the level of costs payable by the Member or their Dependent following reimbursements of any kind to which they are entitled.

For the purpose of the above provisions, benefits of the same type purchased from several insurers operate within the limits of each individual benefit, regardless of the date of purchase. Within these limits, the member or their dependent may obtain compensation by contacting the organization of their choice.

THE MEMBER MUST DECLARE ANY CUMULATIVE INSURANCE. FAILURE TO DO SO MAY RESULT IN DENIAL OF COVERAGE. THIS OBLIGATION APPLIES FOR THE ENTIRE DURATION OF MEMBERSHIP OF THE PLAN.

Reimbursements are limited to the amount of expenses actually incurred, as determined by the insurer for each covered item or medical service.

5.1.6. DISAGREEMENT OVER A REIMBURSEMENT

In the event of disagreement over the amount of a payment, the member must notify the insurer within three (3) months of the date on which the reimbursement statement was produced.

5.1.7. FRAUD AND CONCEALMENT OF FACTS - MISREPRESENTATION

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

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

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

5.1.8. FORFEITURE OF COVERAGE

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

5.1.9. SUBROGATED CLAIMS

This refers to the insurer's right to recover the amounts of claims they have settled from the person who was responsible for a loss.

If the member and/or their insured Dependents, if applicable, are suffering from a disease or are the victims of an accident for which compensation may be paid by a liable third party, the insurer may make a subrogated claim against the person liable to pay the compensation, or their insurer.

A member and/or their insured Dependents, if applicable, who have suffered injuries caused by a third party must inform the insurer at the time of the claim for benefits.

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

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

5.1.10. MEDICAL CHECKS

The insurer reserves the right to have checks, or medical assessments, carried out by an independent health professional chosen by the insurer, whose fees are paid by the insurer for dental, vision, hospitalization and hearing aid expenses. During these checks or assessments, the insured person may be accompanied, at their own expense, by the healthcare professional of their choice, or present the conclusions of their own practitioner.

If the member or a dependent refuses to provide the supporting documents requested by the insurer, or refuses to undergo the medical assessment requested by the insurer, the insurer may deny coverage and request the reimbursement of the expenses in question.

If the conclusions of the assessment are contested, the insured person must send the insurer's medical advisor a registered letter with proof of receipt, under confidential cover, within thirty (30) days of notification. This letter must specify the decision that is being contested and include medical evidence in support of their argument. If an agreement cannot be reached, an arbitration panel will be formed including, in addition to these two (2) doctors, a third (3rd) doctor appointed by them. Each party will pay their own doctor's fees; those of the third (3rd) doctor and the costs involved in their appointment will be shared equally between the two (2) parties.

6. / GENERAL OPERATING PROCEDURES

6.1. / YOUR PLAN

Primary member
Each member of the Contracting association may be enrolled in the insurance, for a specific coverage zone corresponding at least to their country of expatriation, subject to prior acceptance by the insurer and on condition that:

- they are of a different nationality from that of their Main country of residence for the duration of their membership of the plan,
- they have duly completed and signed the Application for coverage and the Health questionnaire,
- they are at least eighteen (18) and under the age of sixty-six (66).

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.

6.2. / LIFE OF YOUR PLAN

6.2.1. EFFECTIVE DATE, DURATION, RENEWAL, TERMINATION AND AMENDMENTS TO THE PLAN

Effective date and duration of the plan: The Open group insurance plan arranged between the Insurer and the Contracting association took effect on September 1, 2023 for an initial period ending December 31, 2023.

Renewal and termination: The plan is automatically renewed on January 1 of each year, for successive periods of one (1) year, unless terminated by the insurer or the Contracting association.

To exercise this right, the Contracting association must send its request to the insurer by mail, email or by any other means provided for in Article L.113-14 of the French Insurance Code. If the request comes from the insurer, it must be made by registered letter.

- ***Annual termination:*** Termination by either party must be notified two (2) months before the plan renewal date, in accordance with Article L.113-12 of the French insurance code. The plan will then come to an end on December 31 at twenty-four (24) hours.
- ***Mid-year termination:*** The Contracting association may terminate the plan after a period of one (1) year from the date of purchase, in accordance with Article L.113-15-2 of the French insurance code. The plan will come to an end one (1) month after receipt by the insurer of the notification sent by the Contracting association. This termination may be carried out free of charge and without penalties.
- ***Other cases of termination of the plan:*** The plan may be terminated in accordance with the provisions laid down in the event of:
  - refusal of the premium increase proposed by the insurer in application of the annual adjustment clause (See article "Premiums").
  - refusal of the amendment proposed by the insurer (See article "Revision"),

The plan may also be terminated at the insurer's initiative in the event of misrepresentation (See article "Misrepresentation").

Amendments to the plan: The plan may be amended by mutual agreement between the Contracting association and the insurer. In this case, an amendment to the plan will be drawn up.

It is understood that in this case, and unless otherwise specifically stipulated, the amendments agreed between the Contracting association and the insurer will automatically apply to each member.

6.2.2. YOUR ENROLLMENT IN THE PLAN AND PERSONS INSURED

The Member can choose enrollment in the plan for themselves only (Individual Premium) or for themselves and all or some of their Dependents as defined in the chapter 2 p.3 (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, if they are at least ten (10) and under the age of eighteen (18), subject to these children being expatriated outside their Country of origin and outside their parents' Country of residence and subject to the Application for coverage being duly completed and signed by the Member.

When enrolling, the Member selects the Hospitalization package and decides whether or not to purchase one or several optional benefits for the same level of coverage.
The Member may then purchase or terminate one or more of the optional benefits under the conditions set out in section 6.2.10 "Making changes to your membership" of the chapter "Life of your plan".

It is specified that the Hospitalization package and the optional benefits selected for all of the Member's Dependents are 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 Health questionnaire as enrollment in the plan or amendments to the benefits is subject to the medical approval of the Insurer.

Having reviewed the Health questionnaire(s), the Administrator (MSH) 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 Health questionnaire which gave rise to denial of coverage will be notified by secure email.

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

Membership, or its amendment, is formalized by the issuing of a Certificate of enrollment showing the name and address of the Member, those of the insured Dependents and the Effective date of enrollment, the benefits selected, the Selected coverage zone, the corresponding Premium and the fixed term of membership.

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

You may request the addition of a Dependent family member during the period of membership of your plan by completing the Application form provided for this purpose, subject to this Dependent completing and signing a Health questionnaire. The Dependent's enrollment is subject to the Insurer's medical acceptance.

If a dependent is added, the premium payable for your membership of the plan will be revised.

Children may be covered provided they are declared and at least 10 days old.

The request to add a child must be made in writing, enclosing the birth certificate issued by the hospital.

Please note that the addition of all children to your membership (including adopted children) is subject to approval.

6.2.4. THE VARIOUS COMPONENTS OF YOUR MEMBERSHIP

Your membership of the neoTempo plan is formalized by all of the following documents:

- **Certificate of enrollment:** this is a single document, issued only at the time of enrollment, which confirms the Member's enrollment in the plan and specifies, in addition to the name and address of the Member, those of any insured Dependents, the Effective date of enrollment and its duration, the Selected coverage zone, and the corresponding Premium. The Certificate of enrollment corresponds to the special conditions of your membership of the plan.

  Each time the membership is renewed, a new certificate of enrollment is issued by the administrator, MSH.
- **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 and its duration, the benefits selected, the corresponding plan number and the Selected coverage zone.
- **Premium notice:** this is a document which shows the amount of your insurance Premium and the Period of coverage. The insurance Premium is paid on the date shown on the Premium notice.
- **This Information booklet serving as the general terms & conditions:** this refers to this document which defines the benefits, exclusions and conditions of use of the insurance plan (including all information relating to claims procedures), and which should be read in conjunction with the Certificate of enrollment.

IMPORTANT

When you enrolled in the plan, you received a welcome letter by email, including your MSH card. Keep it in a safe place, as it will help you in your dealings with healthcare professionals.

6.2.5. OBTAINING A CERTIFICATE OF ENROLLMENT FOR A NEW DEPENDENT

If there is a change in family status, the member may ask for a new dependent to be enrolled, provided they make the request

to MSH within one (1) month of the change in family status. Otherwise, **enrollment of the new dependent is only possible on the membership renewal date**. On enrollment of a new dependent, subject to their prior acceptance where applicable, following the medical formalities process carried out by our Medical advisor, we will send you a new Certificate of enrollment to reflect the addition of the new Dependent. This certificate replaces any other versions in your possession.

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

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

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

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

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

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

  The member may cancel by registered letter or by registered email, with proof of receipt, sent to the insurer using the following wording:
  "I, the undersigned (last name - first names) expressly cancel my membership (membership no. to be specified) of plan no. 0210/670381/10000 neoTempo USA in euros, no. 0210/670381/55555 neoTempo USA in dollars, no. 0210/672462/10000 neoTempo excluding the USA in euros, no. 0210/672462/55555 neoTempo excluding the USA in dollars or no. 0329/672462/10014 neoTempo in France and in euros (plan name and plan membership no. to be specified), entered into:
  - as a result of door-to-door selling (*),
  - or remotely(*) on .../... /....
  and request the reimbursement of the Premium paid, less the portion corresponding to the period during which the plan was in force.
  (Date and signature). "

  (*) *as appropriate*

  Termination of membership of the plan takes effect from the date of receipt of the registered mail or registered email by the Administrator, MSH.
  In case of cancelation, the Member is only required to pay the portion of the Premium corresponding to the period during which the risk was covered, that period being calculated until the Date of termination.
  The insurer is required to reimburse the balance of the premium no later than thirty (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.

6.2.7. START OF MEMBERSHIP AND EFFECTIVE DATE OF BENEFITS

For the Member: The effective date of membership is subject to acceptance by the insurer once they have received:

- the Application for coverage and the Health questionnaire(s) duly completed and signed,
- and full payment of the first quarterly, bi-annual or annual installment of the Premium.

Membership takes effect on the 1st day or 15th day of the month following the date of notification of acceptance of membership. This date is specified on the Certificate of enrollment.

When membership of the plan is purchased by the Member solely on behalf of one or more Dependent children aged between ten (10) and seventeen (17) inclusive, who are expatriated outside their Country of origin and outside their parents' Main country of residence, membership also takes effect under the conditions specified above.

Membership is purchased for a fixed term shown on the Certificate of enrollment, with a minimum of three (3) months and a maximum of thirty-six (36) months. It may be renewed under the conditions set out in the paragraph "Renewing your membership of the plan" below.

For the Member's Dependents: Subject to acceptance by the insurer based on the required medical formalities, the enrollment of Dependents in the plan takes effect:

- on the same date as the Members themselves if they are registered at the time of the original enrollment,
- if there is a change in family status as a result of marriage, civil partnership, Common-law marriage, birth or adoption of a child, from the 1st day or 15th day of the month following the date of acceptance by the Insurer to enroll these new Dependents in the plan, **subject to this change being declared to the Administrator (MSH) within thirty (30) days of the change. Otherwise, the Dependent's enrollment will be postponed until the renewal date of the enrollment 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:
  - hospitalization and routine healthcare following a Medical emergency, Accident or Unexpected illness,
  - Emergency dental/ophthalmic consultations and care following a medical Emergency, Accident or Unexpected illness,
  - vaccinations and anti-malaria treatments covered under the "Prevention" option.

- Or after application of the Waiting periods detailed below (depending on the benefits selected):

Waiting periods in detail:

Three (3) month waiting period for:
- **the cost of hospitalization**
- **routine healthcare**
- **the cost of vision care**
- **the cost of dental care**

No Waiting period will be applied if the membership follows on from a previous plan purchased through the Administrator (MSH) and offering equivalent coverage, both in terms of the benefits purchased and the reimbursement levels, that has been in place for at least six (6) months.

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

If the Member wishes to purchase optional benefits **after six (6) months of membership of the plan**, the optional benefit(s) will take effect, subject to the results of the medical formalities, on expiration of the Waiting periods described in the paragraph above. The waiting periods will be counted from the date of acceptance of the amendment by the Insurer. **Until these waiting periods have expired, only the benefits initially purchased as part of the membership will be granted**.

6.2.8. Renewing and terminating your membership of the plan

Membership is purchased for a fixed term, with a minimum of three (3) months and a maximum of thirty-six (36) months.

Membership of the plan may be renewed at the express request of the member, provided the member and their dependents continue to meet the conditions set out in the plan and subject to:
- the request for renewal reaching the insurer two (2) weeks before the date on which the membership comes to an end,
- the insurer's agreement.

Changing the level of coverage, purchasing and/or terminating the optional "Routine healthcare", "Vision and dental" and/or "Prevention" benefits is possible under the conditions set out in paragraph 6.2.2 "Your enrollment in the plan and persons insured".

Membership may be renewed for successive and continuous periods of at least one (1) month and up to a total maximum of thirty-six (36) months. The new membership expiration date will be sent to the member.

In any event, the maximum duration of a plan, including any renewals, is thirty-six (36) months.

- ***Mid-year termination:*** In all cases, after a period of one (1) year of continuous insurance from the effective date of their membership, the member may terminate their membership of the plan at any time, in accordance with Article L.113-15-2 of the French insurance code.

  Membership will cease one (1) month following receipt by the insurer of the notification sent by the member.

  This termination may be carried out free of charge and without penalties. To exercise this right, the member's request must be sent to the insurer by mail, email or by any other means provided for in Article L.113-14 of the French Insurance Code.

- ***Other cases of termination of membership of the plan:*** Membership of the plan ends in the event of termination notified in accordance with the provisions set out above as well as those set out in Article "Cessation of membership and end of coverage" and can be terminated in accordance with the provisions set:
  - in the event of non-payment of the premiums,
  - in the event of refusal of the premium increase proposed by the insurer in application of the annual adjustment clause (see article "Premiums"),
  - in the event of refusal of the amendment proposed by the insurer (see article "Revision" article),

  The plan may also be terminated at the insurer's initiative in the event of misrepresentation (see article "Misrepresentation").

To exercise this right of termination, the member's request must be sent to the insurer by mail, email or, failing that, by any other means provided for in Article L.113-14 of the French Insurance Code. If the request comes from the insurer, it must be made by registered letter.

In addition, during the period of membership, the rights and obligations of the member may be modified by amendments to the contract entered into by the Contracting association and the insurer. In this case, the member will be informed of the changes at least three (3) months before the date on which they are due to come into force. If the member does not accept these changes, they may, within one month of the date on which they were informed, terminate their membership by mail, email or by any other means provided for in Article L.113-14 of the French Insurance Code.

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

Membership and benefits cease for each Member and their Dependents:
- **On the date of termination of the membership shown on the certificate of enrollment,**
- **On the Date of termination of the optional group insurance plan by the Contracting association or by the insurer:** 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) of this within a period of one (1) month. This request can be submitted at any time but at the earliest after twelve (12) months of membership of the plan,
- on the effective date of termination of membership as set out in Article 6.2.8 "Renewing and terminating your membership of the plan". This request may be made at any time, but at the earliest after 12 months of membership of the plan,

- **In the event of non-payment of the premiums:** at the end of the period covered by the last Premium paid, if the Premium corresponding to the membership is no longer being paid.
  During the course of the year: as soon as the member does no longer qualify for membership of the plan, for example in the event of a return to the Country of origin, enrollment by the employer in a similar plan or the French or local social security; termination of membership will take effect on the 1st or 15th of the month following the date of receipt of an official supporting documentation. The end date of membership 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 (1) 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 membership of the plan will not end until March 1.
  The administrator, MSH, reserves the right to check that the official supporting documents are authentic. If the supporting documents prove to be false, cessation of membership will not take place during the course of the year and the premiums will remain due until a mid-year termination where applicable or on the date of termination of membership provided for on the certificate 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 in chapter LIFE OF YOUR PLAN. However, no medical formalities will be required by the Insurer.

Membership and coverage cease in any event:
- at the end date shown on the certificate of enrollment or notified to the member when the membership is renewed,
- on the date of permanent return to the Country of origin (uninterrupted stay of more than six (6) months),

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

If membership of the plan is purchased by the Member solely on behalf of one or more dependent children who are at least ten (10) and under the age of eighteen (18), who are expatriated outside their Country of origin and outside their parents' Main country of residence, membership and coverage cease, for each of the relevant children, when they reach their eighteenth (18th) birthday. On this date, this membership may be extended, 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 twentieth (20th) birthday or twenty-sixth (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.

Membership of 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.

6.2.10. MAKING CHANGES TO YOUR MEMBERSHIP

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

- **CHANGING YOUR PLACE OF RESIDENCE, MAILING ADDRESS OR EMAIL ADDRESS**

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

IMPORTANT

If you move to another country, it is your responsibility to notify us of this immediately. This is because the levels of healthcare costs in your new Main country of residence may be different from those in your current Main country of residence and your coverage zone and the corresponding Premium may need to be increased or decreased as a result. You should also keep us informed of any change of address for you and/or your Dependents no later than two (2) weeks before the said change.

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

If the primary Member dies, we should be informed within a period of one (1) month following the death. Membership of the plan will then come to an end and the Premium, calculated on a pro rata basis, will be refunded. If they so wish, the first Dependent shown on the Certificate of enrollment would then have the option of sending us an application to become the primary Member of the plan (if they have reached the age of eighteen (18)) and including the other Dependents in their plan.
In the event of death of a Dependent, their coverage will come to an end and the Premium for this Dependent, calculated on a pro rata basis, will be refunded.

- **ENROLLMENT AND CESSATION OF A DEPENDENT'S MEMBERSHIP**

In the event of a change in family status (marriage, entering into a civil partnership, birth of a child, etc.), the member may request the enrollment of a new dependent, provided they submit a request to MSH within one (1) month of the date of the change in family status. **Failing this, enrollment of the new dependent is only possible on the membership renewal date.**

If there is a change in family status (divorce, termination of a civil partnership or cohabitation, completion of a child's education, child's 20th or 26th birthday, etc.), membership comes to an end in any event on the date on which the person in question ceases to qualify as a dependent. The Primary member must report this to MSH as soon as possible. **If this change is not reported, the insurer reserves the right to claim back any undue benefits it may have been led to pay in error.**

- **CHANGE OF LEVEL OF COVERAGE**

A change in the level of coverage is possible, subject to informing us at least one (1) month in advance, under the following conditions:

To increase the level of coverage:
Only one change is possible per twelve (12) month period (insurance year), provided membership of the plan has been in place for at least six (6) months on the date on which the request to change is made.

To decrease the level of coverage:
The change is possible provided you have had coverage at the level you wish to leave for twelve (12) months on the date of the change. The level of coverage selected will remain in effect for the entire duration of membership of the plan.

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

A change in the level of coverage is only possible if membership of the plan has been in force for at least six (6) months. Please inform us at least one (1) month before the date of the change. **There can be only one change of level of coverage during the entire duration of membership of the plan.**

- **CHANGE OF OPTION(S)**

The purchase and/or termination of the optional "Routine healthcare", "Vision and dental" and/or "Prevention" benefits is possible, subject to informing us at least one (1) month in advance, under the following conditions:

To add an optional benefit:
Only one change per optional benefit and per twelve (12)- month period (insurance year) may be made, provided membership of the plan has been in place for at least six (6) months on the date on which the request to change is made.

To terminate an optional benefit:
Termination of an optional benefit is possible provided this option has been part of the plan for (12) months on the date on which the request for termination is made. The optional benefit which is then terminated will remain terminated for the entire duration of membership of the plan.

- **CHANGING THE CURRENCY (EURO OR DOLLAR)**

Any change of currency is only possible on the renewal date 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

6.3.1. CALCULATION OF THE PREMIUM ON THE DATE OF YOUR ENROLLMENT IN THE PLAN

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

- the insured person's age (calculated based on the difference in years),
- the Selected coverage zone,
- the level of coverage purchased (BASIC, REGULAR or PLUS),
- the benefits purchased ("Hospitalization" benefit only or "Hospitalization" benefit + optional benefit(s)): These include "Routine healthcare", "Vision and Dental" and/or "Prevention",
- the coverage (from the 1st euro/dollar or in addition to CFE benefits).
- and the rate in force on the date of purchase of the membership.

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

6.3.2. CHANGES IN THE LEVEL OF YOUR PREMIUM

- **Changes in taxes:** Any taxes or contributions of a social or fiscal nature 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 and increase the amount to be paid to the insurer.
- **Changes to the premium depending on age:** The amount of the Premium is reviewed on **January 1 of each year**, based on the age of the Member and each of the insured Dependents, calculated based on the difference in years, according to the **rate in force on the effective date of membership of the plan.**
- **Changes to the premium when a dependent is added:** When a new dependent is added, the premium for your membership of the plan will be revised. The amount of the new annual Premium is reviewed based on age, calculated based on the difference in years, of the new Dependent to be insured on the basis of the **rate in force on the date on which they are added** (amended as appropriate), taking into account the application of the adjustment clause described below. It is specified that the premium for the Member and each of the other insured Dependents will continue to be determined on the basis of the rate in force on the effective date of membership of the plan.
- **Consequences of a change in coverage zone:** If you change your coverage zone, the premium for your membership of

the plan will be revised. The amount of the new annual Premium is reviewed based on the age of the Member and each of the insured Dependents, calculated based on the difference in years and on the basis of the **rate in force on the date on which the zone is changed** (amended as appropriate), taking into account the application of the adjustment clause described below.

- **Changes to the premium in the event of a change in the level of coverage or the optional benefits purchased:** Changing the level of coverage, purchasing and/or terminating the "Routine healthcare", "Vision and dental" and/or "Prevention" optional benefits is possible once (1) per year and per benefit. This change will result in a revision of the premium for your membership of the plan. The amount of the new annual Premium is reviewed based on the age of the Member and each of the insured Dependents, calculated based on the difference in years and on the basis of the **rate in force on the date on which the membership is renewed** (amended as appropriate), taking into account the application of the adjustment clause described below.

6.3.3. Adjustment of the premium for the Open group insurance plan:

Premium rates for the plan 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.

From the day it becomes aware of an increase in premium rates, the Contracting association will have the option of terminating the plan within thirty (30) days. To this end, it will send a letter or email to the insurer, or any other means provided for in Article L.113-14 of the French insurance code. Termination will take effect one (1) month after the date of dispatch or delivery of the notification.

6.3.4. Ways of paying your premium and additional charges

Premiums are payable to ASFE 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: quarterly, bi-annually or annually.

To make your payment, you can choose between several different payment methods:

- ONLINE, BY BANK CARD (VISA - MASTERCARD - AMERICAN EXPRESS):
  at www.msh-intl.com, via your Members' Area, under the Online payment section.
- BY DIRECT DEBIT (ONLY FROM A BANK ACCOUNT IN FRANCE OR MONACO):
  Complete and sign the direct debit authorization form provided with your Premium notice (also available on request).
- BY WIRE TRANSFER
  - from France: use MSH's bank details.
  - or from abroad: by Swift, use MSH'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.

6.3.5. 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.

6.3.6. Procedure if you fail to pay your premium

In accordance with the provisions of article L.113-3 of the French Insurance Code, all Premiums due remain payable and may be recovered by any legal means.

In case of non-payment of a Premium by the Member, in accordance with the provisions of article L.141-3 of the French Insurance Code, the Contracting association must, at the earliest, ten (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 forty (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.

6.3.7. Bank charges

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

6.3.8. Reimbursement of the premium

In case of Termination of membership of the plan, membership and benefits are maintained until the end of the period covered by the last Premium paid.

7. / MISCELLANEOUS PROVISIONS

7.1. / LEGAL INFORMATION

7.1.1. APPLICABLE LEGISLATION AND JURISDICTION

The Open group insurance plan is 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.

7.1.2. INFORMATION TO MEMBERS

This Information booklet, 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.

In accordance with Article L141-4 of the French insurance code, it is the responsibility of the Contracting association to inform members in writing of any changes to their rights and obligations, at least three (3) months before the date on which they are due to take effect. 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 information.

If the Member does not accept these changes, they may, within one (1) month of the date on which they were informed, terminate their membership by mail, email or by any other means provided for in Article L.113-14 of the French Insurance Code.

7.1.3. APPLICABLE LANGUAGE

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

7.1.4. LIMITATION PERIOD

In accordance with Article L.114-1 of the French Insurance Code: "All legal actions arising from the contract are barred two (2) years from the event that gave rise to them. However, this time limit runs:

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

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

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

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

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

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

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

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

The limitation period can also be interrupted by:

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

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

7.2. COMPLAINTS PROCEDURES AND MEDIATION SERVICE

To make a complaint, the Member or Dependent may contact the Insurer's customer relations department by telephone on 01 70 96 62 68.

If the verbal complaint is not resolved to their satisfaction, the member or any other person likely to benefit from the plan can write, clearly stating the references of their membership of the plan, to:

- the Administrator, MSH, by writing to the following address: MSH, Service réclamation, 23 allées de l'Europe 92587 Clichy Cedex, France;
- or by email at src-collectives@ggvie.fr
- or by mail to: Groupama Gan Vie - Service des relations avec les consommateurs - Immeuble WP2 - 2 boulevard de Pesaro - 92024 Nanterre - France.

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

If this response does not satisfy the person making the complaint, or if no response has been received within two (2) months, they have the right to refer the matter to the Ombudsman, Médiation de l'Assurance on the website: www.médiation-assurance.org or by post (Médiation de l'Assurance, TSA 50110, 75441 Paris Cedex 09, France), without prejudice to their right to take legal action.

If the person so wishes, the insurer's Complaints Department is available on the website: https://reclamations.ggvie.fr or by post (Groupama Gan Vie Service Réclamations - TSA 91414 - 35090 Rennes CEDEX 9, France).

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

7.3. PROTECTION OF PERSONAL DATA

Personal data are collected at different stages of commercial or insurance activities with respect to members or persons involved in or affected by the insurance plans.

These personal data are processed by the insurer, in its capacity as data controller, in accordance with the regulations in force relating to the processing of such data and the protection of privacy, in particular the provisions of the French Data Protection and Freedom of Information Act No. 78-17 of January 6, 1978 (amended) and the General Data Protection Regulation (Regulation 2016/679 of April 27, 2016).

Personal data are stored for the duration required for the implementation of the insurance plan and then archived until the expiration of the applicable statutory limitation periods.

It is agreed between the parties that any passing of information between the member and the delegated administrator, MSH, in either direction is to be considered as communication between the member and the insurer, under the conditions and within the limits defined by the administration mandate binding the delegated administrator and the insurer.

- ***Rights of the individual:***

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

  These rights may be exercised by mail, email or Internet, to the following department:
  Groupama Gan Vie - Data Protection Officer
  Immeuble West Park 2 - 2 Boulevard de Pesaro - 92024 Nanterre - France - contact.dpo@ggvie.fr

  In the case of health data, these rights may be exercised by writing to the insurer's medical advisor: Groupama Gan Vie – Monsieur le Médecin-conseil - Service médical Collectives - Immeuble West Park 2 - 2 Boulevard de Pesaro - 92024 Nanterre - France.

  Data subjects may also file a complaint with the French Data Protection Authority, Commission Nationale de l'Informatique et Libertés (CNIL) if they feel the insurer has failed to meet its obligations with respect to their data.

  As part of its obligations, the insurer is required to regularly check that personal data are accurate, complete and up to date. To this end, the insurer may be required to contact the aforementioned persons to check or complete this information.

- ***Why does the insurer collect personal data?***

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

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

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

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

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

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

Health data may be processed if they are required for the execution, administration and implementation of insurance or assistance plans. This information is processed in compliance with medical confidentiality and with the consent of the interested parties.

In the case of employee benefits, data subjects expressly agree to these data being collected and the required processing being carried out.

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

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

If no insurance contract has been entered into (prospect-related data):
- health data are stored for a maximum of five (5) years for evidentiary purposes;
- other data may be stored for a maximum of three (3) years.

Marketing

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

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

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

- using the Member's email address or telephone number for electronic marketing purposes;
- using the Member's browsing data to recommend them personalized offerings (see cookies notice on the website indicated in the special conditions for further information);
- passing on the Member's data to partners.

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

With respect to telephone or electronic marketing (by email or SMS/MMS), the above-mentioned persons may also opt out by changing their preferences in their personal online area or by using the unsubscribe link provided in the insurer's messages. With respect to telephone marketing, they may also opt out by registering free of charge with the BLOCTEL opt-out directory (www.bloctel.gouv.fr), which prohibits professionals with whom they do not have a current contractual relationship from contacting them by telephone for marketing purposes.

Combating insurance fraud

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

In this context, the personal data of the above-mentioned persons may be processed by all authorized persons working within the entities of the Groupama Group as part of its anti-fraud measures.

These data may also be passed on to authorized personnel of organizations directly affected by fraud (other insurance organizations or intermediaries; social or professional bodies; legal authorities, mediators, arbitrators, court officials, ministry officials; third party organizations authorized by a legal provision and, where applicable, victims of acts of fraud or their representatives).

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

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

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

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

Anti-money laundering and the financing of terrorism

To meet its legal obligations, the insurer has implemented a procedure the purpose of which is to combat money laundering and the financing of terrorism, as well as the implementation of restrictive measures and the freezing of assets. Data used for this purpose are stored for a minimum of five (5) years from the completion of the operations or the end of the business relationship.

The right of access to data relating to the procedures in place for the purposes of combating money laundering and the financing of terrorism may be exercised by contacting the French Data Protection Authority (Commission Nationale de l'Informatique et Libertés).

Satisfaction/Quality of service

In its own interest and that of its clients, the insurer measures and seeks to continuously improve the quality of its services and products. This may include the carrying out of satisfaction surveys. In this context, communications by mail, email or telephone between the insurer and the above-mentioned persons may be recorded and analyzed. Telephone recordings are kept for a maximum period of six (6) months and the elements required for the purpose of improving quality of service are kept for a maximum period of three (3) years.

Research and statistics

The insurer and the entities of the Groupama Group (or their processors) may also use and process personal data involving the above-mentioned persons for statistical or research purposes, particularly with a view to developing their product and service offerings and personalizing their relationship with the data subject.

These data may be linked, combined or include personal data in respect of the above-mentioned persons and collected automatically or provided by the person themselves. They may also be combined with statistical or aggregated data from various internal or external sources.

- ***Transfer of information outside the European Union***

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

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

- ***Who receives this information?***

  The personal data processed is intended, **within the limits of their attributions**, for the departments of the insurer or Groupama Group companies in charge of commercial relations and plan administration, the combatting of fraud, money laundering and the financing of terrorism, and audit and control.

  This information may also be passed on, where necessary, to reinsurers, intermediaries, partners and data processors, as well as to bodies likely to be involved in the insurance business, such as public bodies or supervisory authorities, or professional bodies (including ALFA for anti-fraud purposes and TRACFIN for the combating of money laundering and the financing of terrorism).

  Information relating to the insured person's health is intended exclusively for the insurer's medical advisors or those of other Group entities, for its medical department or for specially authorized internal or external persons (in particular our medical experts).

7.4. PAPERLESS COMMUNICATIONS REGARDING MEMBERSHIP OF THE PLAN

7.4.1. PAPERLESS COMMUNICATIONS WITH THE CONTRACTING ASSOCIATION AND THE MEMBER

With regard to information and documentation relating to their insurance plan, the Contracting association and the Member should be aware that the insurer may exchange information and documents in a paperless manner and in particular provide or make this information and documentation available to them using a medium other than paper, including email and/or via their respective secure client areas. By providing their email address when enrolling in the insurance or during the life of the plan, the Contracting association and the Member accept that paperless communications are appropriate to their circumstances.

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

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

The Contracting association and the Member agree to inform the insurer without delay if there are any changes to their email

address and, more generally, if there are any changes in their situation that may have any impact on the administration of their plan.

7.4.2. PROVISION OF A SECURE CLIENT AREA

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

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

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

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

If the confidential access code is lost or stolen, the Contracting association and the Member must inform the insurer immediately so that a new password can be assigned to them.

The Contracting association and the Member will be solely responsible for any direct or indirect consequences resulting from a failure to report the loss or theft of the access code to the insurer or a delay in doing so.

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

Acceptance of the General Terms and Conditions of Use (GTCU): When first logging in to the secure client area using their access code, the Contracting association and the Member must read and accept the general terms and conditions of use of this client area in order to view or carry out administrative operations on their insurance plan and read the information and documents made available by the insurer.

7.4.3. AGREEMENT ON EVIDENCE

This agreement on evidence applies to:

- the provision by the insurer of information or documents sent to the Contracting association and the Member by email,
- the provision by the insurer of information or documents in the secure client area,
- the viewing and management of their insurance plan by the Member in their secure client area.

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

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

7.5. ANTI-MONEY LAUNDERING AND THE FINANCING OF TERRORISM

As an insurance company, the insurer is subject to the legal and regulatory provisions relating to measures to combat money laundering and the financing of terrorism under the provisions of Articles L. 561-1 and following of the French Monetary and Financial Code.

The insurer is therefore under obligations to identify and know its clients and exercise constant vigilance, which justify the collection of information from its clients.

7.6. JURISDICTION

The Contracting association, the insurer and the Members declare that they submit to the jurisdiction of the Paris courts and waive their right to take legal action in any other country.

7.7. FORCE MAJEURE

The Insurer cannot be held responsible for failures in the execution of their obligations resulting from cases of force majeure (*any event that is unforeseeable, irresistible and beyond the control of the insured person, that is declared by the public authorities of the state in which they are staying*) 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.

7.8. LIABILITY

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

7.9. COMMUNICATING WITH DEPENDENTS

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

8. / CONTACTING US

GET YOUR LOGIN DETAILS

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

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

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9. APPENDIX: LIST OF CHRONIC CONDITIONS

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

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

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ASFE, the Association of Services For Expatriates, was created in 1992 and is governed by the French law of 1901 on associations.
Its purpose is to provide expatriates all over the world with solutions in the fields of healthcare coverage, life & disability, medical assistance/repatriation and third-party liability.

MSH, the designer and administrator of ASFE plans, is a world leader in international benefits with over 400,000 globally-mobile individuals insured worldwide.
MSH provides you with the services of a dedicated team which is on hand to support and advise you day after day.

YOUR CONTACTS

MSH

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

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