FIRST'EXPAT+//RELAIS'EXPAT+

// INFORMATION BOOKLET SERVING AS THE GENERAL TERMS & CONDITIONS

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

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

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

MSH International, the designer and Administrator of ASFE plans, is a world leader in international benefits with over 500,000 globally-mobile individuals insured worldwide. MSH International provides you with the services of a dedicated team which is on hand to support and advise you day after day. MSH International, an organization mandated by the Insurer to administer the plan will be referred to throughout this document as "MSH International", "the Administrator", "the Administrating Organization" whenever this term is used in the context of the administrative management of the plan.

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

1.2. / PURPOSE OF THE INSURANCE

The ASFE Insurance plans in which you are enrolled are a type of plan known as "open group". They provide coverage from the 1st euro/1st dollar or in addition to benefits provided by the CFE (Caisse des Français de l'Etranger), to the exclusion of any other healthcare insurance scheme.
Their purpose, within the limit of actual costs, is the payment of Benefits, from the 1st euro/1st dollar or as a top-up to benefits paid by the CFE, as a reimbursement of medical expenses incurred by ASFE Members living outside their 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.
Your membership of these plans will be referred to throughout this document as "Your membership". You and any dependents enrolled in the plan will be referred to as "Insured member".
Each plan provides basic healthcare coverage which can be supplemented by optional benefits and 4 levels of coverage within these options, Quartz, Pearl, Sapphire, and Diamond (see section 1.3/ COVERAGE OPTIONS). Each plan also includes 5 coverage zones (see section 1.5/ COVERAGE ZONES UNDER THE PLAN).
These plans are numbered as follows:
FIRST' EXPAT+ (1steuro/1st dollar):

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

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

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

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

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

1.3. / COVERAGE OPTIONS

The plan provides:

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

Important:

- Level 2 optional benefits can only be selected if Level 1 optional benefits have themselves been selected.
- Level 3 optional benefits can only be selected if Level 2 optional benefits have themselves been selected.
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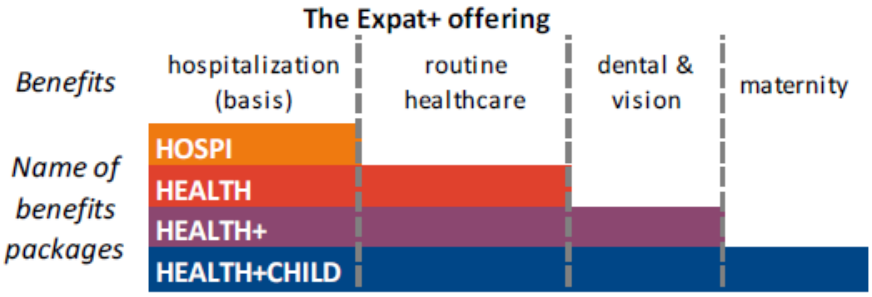

Within each of these benefits, four packages are offered to each Member on enrollment: Quartz, Pearl, Sapphire and Diamond, providing increasing levels of benefits and services.
The plan also offers, in respect of the Basic benefit (HOSPI), and Level 1 (HEALTH) and Level 2 (HEALTH+) Optional benefits (excluding Level 3 optional Maternity benefits), the possibility for the Member to choose a Deductible as defined in chapter 3/ HEALTHCARE BENEFITS: YOUR HEALTHCARE BENEFITS IN DETAIL. Four levels of Deductible are available as well as the option of having no Deductible:

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

See specific conditions depending on the zones and packages chosen in section 1.4/ DETAILS OF DEDUCTIBLES p.5.

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

It is specified that:

- the optional benefits, if they are selected by the Member, also apply to all of their Dependents listed on the Certificate of enrollment,
- a Member who has purchased optional benefits will only be able to withdraw from these optional benefits once for the entire duration of the plan in order to retain only the basic benefits.
- for Zone 5 (USA), it is not possible to purchase only the HOSPI benefit package: insured members must at least purchase the HEALTH option.

1.4. / DETAILS OF DEDUCTIBLES

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

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

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

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

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

1.5. / COVERAGE ZONES UNDER THE PLAN

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

- Zone 5: USA and territories under U.S. jurisdiction (Porto Rico, United States Virgin Islands, Northern Mariana Islands, United States Minor Outlying Islands, American Samoa) as well as countries in Zones 1, 2, 3 and 4,
- Zone 4: Bahamas, Brazil, China, Hong Kong, Jersey, Mexico, St. Barthelemy, St. Martin, Singapore, Switzerland, United Kingdom and countries in Zones 1, 2 and 3,
- Zone 3: Australia, Austria, Canada, French Polynesia, Greece, Ireland, Israel, Italy, Japan, New Caledonia, New Zealand, Portugal, Qatar, Saint Kitts and Nevis, Saint Pierre and Miquelon, Spain, Taiwan, Türkiye, United Arab Emirates, Vanuatu and countries in Zones 1 and 2,
- Zone 2: Andorra, Angola, Argentina, Azerbaijan, Bahrain, Barbados, Belgium, Belize, 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, Uruguay, Vietnam, Wallis and Futuna and countries in Zone 1,
- Zone 1: Worldwide (including France) excluding countries in Zones 2 to 5.

Territories not listed above are included in the same zone of coverage as the mainland country to which they belong

Reminder: For zone 5, only the HEALTH, HEALTH+ and HEALTH+CHILD benefit packages can be purchased (the HOSPI package is not available in zone 5).

1.6. / COVERAGE EXCLUSION ZONES (RED ZONES)

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 other than the Country of origin of the Member.

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

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

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

Aggregate limit (on healthcare benefits): The Benefits schedule for the plan stipulates 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 the Routine healthcare, Dental/Vision and Maternity options, if selected), per Member, per Insurance year, 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 Member and per Insurance year, unless otherwise stated in the Benefits schedule.

Alternative medicine: In the plan this refers to: Homeopathy, Acupuncture and Traditional Chinese medicine.

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).

Annual out-of-pocket maximum: The annual out-of-pocket maximum is the maximum amount of cost-sharing that you will have to pay during the Insurance year.

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

Benefits schedule: Document indicating, in respect of the level of healthcare coverage selected by the Member for themselves and any Dependents, details of the benefits provided under the plan, showing the upper limits, limits on the number of treatments or procedures, consultations and/or days covered for a given period of time and the Waiting periods, Deductibles, Cost-sharing, Annual out-of-pocket maximum or Co-payments which apply to them.

Bone density test: Medical examination to measure bone density by assessing bone mineral content (mainly calcium), which is most commonly performed using a special type of x-ray of the lumbar spine and/or femoral neck. It is used in screening for osteoporosis.

CFE: Caisse des Français de l'Etranger, French Social Security body whose purpose and mission is to insure expatriates worldwide.

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 5.2/ LIFE OF YOUR PLAN in the chapter CANCELING YOUR MEMBERSHIP BEFORE IT TAKES EFFECT: THE CANCELATION PERIOD).

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

Certificate of insurance: Document whose purpose is to serve as proof of insurance cover for the person presenting it. It contains the following information: name of the Member and 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, selected Coverage zone and chosen Deductible.

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

Childbirth complications: Term used to refer to the following conditions that may occur during childbirth and for which an obstetric procedure is essential: fetal distress during labor, retained placenta and postpartum hemorrhage. They also include C-section if it is Medically required. Childbirth complications are only covered if the person receiving the care has Maternity coverage (option commercialized as 'HEALTH+CHILD').

Childbirth without complications: This refers to childbirth not requiring any additional Emergency surgery: fetal distress during labor, retained placenta and postpartum hemorrhage. C-sections which are not Medically required will be classed as Childbirth without complications.

Chiropractic: Therapeutic approach which aims to treat a variety of conditions by manipulation.

Chronic conditions: These are conditions whose severity and/or long-term nature require prolonged treatment and costly therapy. The list of chronic conditions is defined under Article D. 322-1 of the French Social Security Code. This list is provided on page 100 as an appendix.

Common-law marriage: Union characterized by a continuous, stable, shared life between two persons of the opposite or same sex who are living together as a couple.

Common-law spouse:

- **for members who selected the coverage zone 5:**

Person under the age of seventy-one (71) on the date of enrollment, who is living in a Common-law marriage with the Member, whether or not they are in paid employment, if and only if the Member and their Common-law spouse share the same home and are free from any other ties of a similar nature (i.e. both partners are single, widowed or divorced and are not bound by a civil partnership). If there are several common-law spouses, only the eldest will be recognized.

- **for members who selected the coverage zone 1, 2, 3 or 4:**

Person under the age of seventy-six (76) on the date of enrollment, who is living in a Common-law marriage with the Member, whether or not they are in paid employment, if and only if the Member and their Common-law spouse share the same home and are free from any other ties of a similar nature (i.e. both partners are single, widowed or divorced and are not bound by a civil partnership).

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

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

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

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

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

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

Date of termination: Date on which the benefits provided under the insurance plan come to an end, on the initiative of the Member, the Insurer or the Contracting association (see section 5.2/ LIFE OF YOUR PLAN in the chapter CESSATION OF MEMBERSHIP AND END OF COVERAGE (right of withdrawal and termination)).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Coverage is acquired for a maximum of 60 days per trip and is also limited to the Aggregate limit and only covers treatment required in the event of an Accident or the onset of a sudden, unexpected and unforeseen Illness, requiring surgery or Medical treatment that cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness representing an immediate and serious danger to the health of the Member and/or their Dependents. Treatment dispensed by a General practitioner or a Specialist must begin within 24 hours of the event which triggered the claim.

The following are therefore not covered by this benefit: non-urgent therapeutic treatment which did not result from an Accident or unforeseen Illness requiring surgery, or Medical treatment that cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness representing an immediate and serious danger to the health of the Member and follow-up care, even in cases where the Member or their Dependents were not able to travel to a country within their Selected coverage zone. Costs related to Pregnancy, Maternity, childbirth or any other Complication during Pregnancy or childbirth are also excluded from the benefit. It is recommended that Members and any Dependents contact the Administrator, MSH International, if trips of more than 60 days are planned outside the Selected coverage zone.

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

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

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

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 l is valid for six (6) months.

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

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

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

(Hospital) day care: See under Outpatient hospitalization.

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

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

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

Insurance year: The Insurance year covers the period from the Effective date of Enrollment in the plan until the 365th day

following this date, with automatic renewal on each anniversary date.

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

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

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

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

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

Local transfer by ambulance: Refers to transportation by ambulance or road medical vehicle 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.

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

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

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

Medical network: Means all Hospitals or associated care facilities and healthcare practitioners officially listed by your plan Administrator (MSH International) or by the service partners selected by them (such as UnitedHealthcare and Optum RX in the United States) in order to receive treatment which is covered under the plan.

Medical treatment: Refers to any surgery or Medical treatment performed by a Doctor, considered to be Medically required, in order to diagnose, cure or alleviate an Illness or injury.

Medically assisted reproduction: See under Fertility treatment.

Medically required/medical necessity/absolute necessity: Refers in respect of this plan to treatment, services, supplies and equipment recommended by a qualified healthcare professional which are defined from a medical point of view as appropriate and necessary.
To qualify, they must meet the following criteria:

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

Member:

- **for members who selected the coverage zone 5:**

Person, under the age of seventy-one (71) on the date of enrollment regardless of their status, who is a member of ASFE and has submitted an Application for coverage under the plan which has been accepted in writing as defined in section 5.2. / Life of your plan in the chapter YOUR ENROLLMENT IN THE PLAN AND PERSONS INSURED, for themselves and any Dependents and who has agreed to fulfill the corresponding obligations, including payment of the Premium specified at the time of enrollment in the plan.

- **for members who selected the coverage zone 1, 2, 3 or 4:**

Person, under the age of seventy-six (76) on the date of enrollment regardless of their status, who is a member of ASFE and has submitted an Application for coverage under the plan which has been accepted in writing as defined in section 5.2/ LIFE OF YOUR PLAN in the chapter YOUR ENROLLMENT IN THE PLAN AND PERSONS INSURED, for themselves and any Dependents and who has agreed to fulfill the corresponding obligations, including payment of the Premium specified at the time of enrollment in the plan.

Open group insurance plan: Refers to insurance plans in which enrollment is available on an individual and voluntary basis. Individuals then form a group through a Contracting association and enroll in the insurance plan.

Orthodontics: Orthodontics is a dental specialty dedicated to the correction of improper positioning of the jaws and teeth in order to optimize the closure of the mouth (occlusion), to ensure proper functioning and alignment.

Orthoptics: Paramedical specialty aiming to evaluate and measure ocular deviation and ensure rehabilitation of the eyes in case of binocular vision disorders: strabismus, heterophoria (deviation of the visual axes) or convergence insufficiency.

Osteopathy: Manual therapeutic method using techniques of spinal or muscular manipulation of the musculoskeletal and myofascial system in order to alleviate certain functional disorders.

Outpatient surgery: Surgery performed in a healthcare facility or medical office where the patient is admitted and discharged on the same day.

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

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

Partner:

- **for members who selected the coverage zone 5:**

Person under the age of seventy-one (71) at the time of enrollment bound to the Member by a civil partnership agreement. A civil partnership is a contract signed by two adult persons of the opposite or same sex in order to share their life together (Article 515-1 of the French Civil Code). See also *Common-law spouse and Spouse.*

- **for members who selected the coverage zone 1, 2, 3 or 4:**

Person under the age of seventy-six (76) at the time of enrollment bound to the Member by a civil partnership agreement. A civil partnership is a contract signed by two adult persons of the opposite or same sex in order to share their life together (Article 515-1 of the French Civil Code). See also *Common-law spouse and Spouse.*

Period of benefits/period of coverage: Continuous period of 365 days during which the Member and any Dependents are covered by virtue of enrollment in the plan. It starts from the effective date of enrollment in the plan as specified on the Certificate of insurance (other than in cases of early termination under the rules of the plan 5.2.9 CESSATION OF MEMBERSHIP AND END OF COVERAGE (RIGHT OF WITHDRAWAL AND TERMINATION)).

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

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

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

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

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

Postnatal care: All post-partum medical care received by the mother in a period of up to six weeks after the birth.

Prenatal care: Refers to all standard, customary screening and follow-up examinations during Pregnancy.
In respect of high-risk pregnancies, Prenatal care may include:
- amniocentesis and DNA tests if directly linked to amniocentesis covered under the insurance plan;
- tests for Spina Bifida;
- triple (Bart's) or quadruple tests.

Pre-existing medical condition: Pre-existing conditions: any Illness, disorder or injury or associated symptoms which developed before the date of enrollment in the plan, of which the Member or their Dependents were aware, or of which they could reasonably have been aware.

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).

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

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

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

Premium notice.

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: Certain medical expenses, or types of treatments or Services such as hospitalization, medical treatments provided as a series of treatments (e.g.: physical therapy sessions), costly treatments or Prostheses of any kind are covered by the insurer provided that a prior approval has been issued by the insurer's medical advisor. Before commencing the treatments, the Insured member must first request and obtain the agreement of the Insurer or the Administrator to obtain a Precertification agreement: to do so, the Insured member must ask the practitioner who prescribed these treatments to fill out a request for prior approval and to sent it together with a detailed estimate. The corresponding expenses are shown in the Benefits Schedule.

Private, semi-private or shared room: Service offered by healthcare facilities, allowing an inpatient to be accommodated in:

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

Deluxe and VIP rooms and suites are not covered.

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

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

Psychologist: Professional holding a degree in psychology, recognized in the country in which care is provided and authorized to practice as a psychologist.

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

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

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

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

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

Routine 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. Subject to payment of the appropriate Premium, the Member may opt for a Selected coverage zone for themselves and their Dependents which is higher than that corresponding to their Main country of residence. They cannot, however, opt for a Selected coverage zone lower than that corresponding to their Main country of residence. The plan offers 5 coverage zones (see section 1.5/COVERAGE ZONES).

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

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

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

Spouse:

- **for members who selected the coverage zone 5:**

Spouse who is not legally separated or divorced, whether or not they are in paid employment, and under the age of seventy-one (71) on the date of enrollment. To facilitate the reading of this information booklet serving as the general terms and conditions, the term 'Spouse' will refer generically to the Spouse, partner or Common-law spouse of the Member.

- **for members who selected the coverage zone 1, 2, 3 or 4:**

Spouse who is not legally separated or divorced, whether or not they are in paid employment, and under the age of seventy-

six (76) on the date of enrollment. To facilitate the reading of this information booklet serving as the general terms and conditions, the term 'Spouse' will refer generically to the Spouse, partner or Common-law spouse of the Member.

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

Termination: Termination is the formal process by which the Insurer, the Contracting association or the Member puts an end to the plan or enrollment in the plan which binds them, see chapter 5.2.9 CESSATION OF MEMBERSHIP AND END OF COVERAGE (RIGHT OF WITHDRAWAL AND TERMINATION).

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

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

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

Usual, customary and reasonable costs: Usual, customary and reasonable costs which will be reimbursed under the plan are defined as reasonable medical expenses commonly charged in the relevant country for the specific treatment received, in accordance with standard and generally accepted medical procedures. Usual, customary and reasonable costs (UCR) are based on MSH's experience data, on the observed standard medical costs in the country where the treatment is provided, and on the reimbursement scales of the French Social Security when care is provided in France.
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 Hong Kong Adventist Hospital, Hong Kong Sanatorium and Hospital Medical Group, the Matilda International Hospital and the Matilda Medical Center in Hong Kong, 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. In the event of hospitalization or treatment in this type of facility, the Insurer draws your attention to the fact that only the usual, customary and reasonable costs defined by the Insurer will be covered. Therefore, you may be responsible for a significant portion of the costs.**

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

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

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

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 FOR MEMBERS WHO SELECTED THE COVERAGE ZONE 1, 2, 3 OR 4[1]

3.1.1. LEVEL OF BENEFIT: HOSPI (HOSPITALIZATION)

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

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
AGGREGATE LIMIT ON HEALTHCARE BENEFITS (€)	€500,000	€1,000,000	€1,600,000	€5,000,000
AGGREGATE LIMIT ON HEALTHCARE BENEFITS ($)	$625,000	$1,250,000	$2,000,000	€6,250,000

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

No waiting period for Hospitalization benefit

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

If you need to stay in Hospital longer than the period specified in the prior approval agreement, or if changes are made to your treatment, your General practitioner or Specialist must send us a medical report as soon as possible. This medical report must include:
- The diagnosis,
- The treatment you have already received,
- The treatment you require,
- The additional length of time you will need to stay in Hospital.

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

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Transportation by road medical vehicle	100% UCR up to €550/$690	100% UCR up to €550/$690	100% UCR up to €550/$690	100% UCR up to €550/$690
Emergency transportation to hospital				
Medically required transfer (ambulance, taxi)				
Hospital room	**Private, semi-private or shared room** €100 / $125 per day	**Private, semi-private or shared room** €150 / $190 per day	**Private, semi-private or shared room** €250 / $310 per day	**Private, semi-private or shared room** 100% UCR

The type of room and the amount per night that we will cover under each package is shown in this **Benefits schedule**.

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

Room and board fees for a parent staying in Hospital with a dependent child under the age of 16	100% UCR up to €300 / $375 per year	100% UCR up to €400 / $500 per year	100% UCR up to €700 / $875 per year	100% UCR
	We will cover reasonable room and board fees for a parent staying in the same **Hospital** as their **Dependent** child under the age of 16, in the event of hospitalization lasting more than one day and up to the maximum amount specified in this **Benefits Schedule**.			
Outpatient hospitalization (including Outpatient surgery)	100% UCR	100% UCR	100% UCR	100% UCR
	We will pay all covered hospital expenses for hospitalization which does not require the **person receiving the treatment** to stay overnight.			
Emergency hospitalization within the selected coverage zone (including ambulance)	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover treatment administered following admission to a **Hospital** or medical day center, following the onset of a sudden and unforeseen medical condition requiring immediate treatment within 24 hours for the sole purpose of preventing a life-threatening risk. All **services** provided in the Emergency room which are not followed by admission to hospital will be covered under **routine healthcare if the option has been purchased**. We must be notified of any **emergency hospitalization** within 48 hours of admission.			
	QUARTZ	**PEARL**	**SAPPHIRE**	**DIAMOND**
Emergency hospitalization following an accident or a **sudden, unexpected and unforeseen illness, requiring an emergency hospitalization outside the selected coverage zone, <u>for any trip of less than 60 consecutive days</u>**	100% UCR up to 60 days / year	100% UCR up to 60 days / year	100% UCR up to 60 days / year	100% UCR up to 60 days / year
	We will cover all Emergency hospitalization expenses (only if they are the result of an Accident or a sudden, unexpected and unforeseen Illness requiring surgery or medical treatment that cannot wait until repatriation to the main country of residence or the worsening of a serious illness representing an immediate and serious danger to the health of the Insured Member) in a country located in a coverage zone higher than the selected coverage zone during trips of less than 60 consecutive days. Travel for medical reasons, and consequently all scheduled treatment in a coverage zone higher than the selected coverage zone, is also excluded (unless the medical advisor rules otherwise). In this respect, you must keep any supporting documents showing the duration of your temporary stay outside your usual coverage zone, as they will be requested for control purposes by the plan administrator in case of claim for reimbursement of hospitalization care or emergency treatment following an accident or unforeseen illness as defined under Article 2 and occurring during a temporary stay or trip of less than 60 consecutive days outside the geographical coverage zone. The insurer may deny coverage to the insured member if they are unable to provide these supporting documents. We must be notified of any **emergency hospitalization outside the coverage zone** within 24 hours of admission. It is recommended that Members and any dependents contact the administrator MSH International, if trips of more than 60 days are planned in a higher coverage zone than the selected coverage zone, so that the level of coverage under your plan can be adjusted.			
Hospitalization - Intensive care	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover hospital expenses in case of treatment in a general or cardiac **intensive care** unit (including a Critical care unit) for patients presenting with organ failure or who are at risk of severe complications.			
Hospitalization - Surgical procedures including fees, operating room and anesthesia	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover the following costs in the event of hospitalization: - operating room - recovery room - drugs and dressings used in the operating room and the recovery room - drugs and dressings used during your stay in **hospital.** We will cover the fees for surgeons and anesthetists and the care required immediately before and after the operation (on the same day). This also includes operations performed on an **outpatient** basis.			
Hospitalization - Consultations with general practitioners and specialists during hospitalization covered under this plan (excluding physiotherapy and alternative medicine) and including specialist treatments and procedures	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover consultations with **general practitioners** or **specialists** during your stay in **hospital** following a covered Event.			
Hospitalization - Emergency dental care with hospitalization	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover **emergency** dental care received in **hospital** if it is **medically required** following an accident requiring hospitalization. This care must be administered within 24 hours of the Accident. This benefit does not cover routine **dental surgery**, routine dental care, **dentures**, implantology, **orthodontics** or **periodontics** (these treatments are only covered under the optional benefit Health+).			

Hospitalization - Laboratory tests, MRI, x-rays, scans, tomography	100% UCR	100% UCR	100% UCR	100% UCR
	For your hospitalization covered under the plan, we will cover all expenses related to: - **Medical imaging**, such as x-rays, scans, MRI, etc., - tests such as blood tests or urine samples, - diagnostic tests such as electrocardiograms. If these examinations are prescribed by your **general practitioner** or **specialist** to help diagnose or assess your health during your stay in hospital.			
Hospitalization - Prescription drugs	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover the cost of any **drugs prescribed** by the **general practitioner or specialist** in charge of your treatment during your hospitalization.			
	QUARTZ	**PEARL**	**SAPPHIRE**	**DIAMOND**
Hospitalization - Renal dialysis	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover the cost of renal dialysis, with the exception of transportation costs to and from the care facility where the dialysis is carried out.			
Hospitalization - Oncology (Treatment of cancer)	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover the cost of any medically justified treatment you receive in the **treatment of cancer**, including chemotherapy, radiotherapy, **oncology**, diagnostic tests and drugs, as part of hospitalization (on both an inpatient and outpatient basis). **Preventive laboratory tests or imaging to diagnose cancer will not be covered.**			
Hospitalization - Treatment of AIDS	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover any costs related to the treatment of conditions related to HIV.			
Hospitalization - Internal surgical and medical prostheses/devices	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover costs related to **prostheses, devices or appliances** fitted during a surgical procedure.			
Hospitalization - External surgical and medical prostheses/devices	100% UCR up to €1,200 / $1,500 Per prosthesis – max. 2 prostheses	100% UCR up to €1,800 / $2,250 Per prosthesis – max. 2 prostheses	100% UCR up to €2,500 / $3,100 Per prosthesis – max. 2 prostheses	100% UCR max. 2 prostheses
	We will cover: - **essential prostheses or devices** immediately following surgery if medically required, - **medically required prostheses or devices** during the short-term recovery process. For adults and children over the age of 20, we will cover one external prosthesis per Insurance year, and for children up to the age of 20, we will cover the first prosthesis and a maximum of two changes of prosthesis, within the limit of the maximum amount specified for the entire period of membership of the plan.			
Hospitalization - Palliative care	100% UCR up to €10,000 / $12,500	100% UCR up to €15,000 / $19,000	100% UCR up to €25,000 / $31,000	100% UCR
	If a **member** is diagnosed with a terminal **illness** and can no longer be treated with a view to being cured, we will cover: - the cost of a room in a **hospital** or hospice, - the cost of **palliative** home care, - nursing costs - **prescribed drugs.**			
Hospitalization - Organ transplant: room and board, cost of treatment and hospitalization fees during an organ transplant	100% UCR	100% UCR	100% UCR	100% UCR
Hospitalization - Medical expenses for an organ transplant (including for the organ donor: coverage of medical expenses and transportation to the place of hospitalization)	Not covered	100% UCR up to €3,000 / $3,800 per transplant	100% UCR up to €4,500 / $5,600 per transplant	100% UCR up to €6,000 / $7,500 per transplant
	We will cover medical expenses related to a **member** receiving an organ transplant from a verified and certified donor. We will also cover medical expenses for a bone marrow donation (using either your own bone marrow or that of a compatible donor) or a stem cell donation, with or without chemotherapy when these procedures are carried out as part of the treatment of cancer. We will cover the following donor expenses for each event requiring an organ donation whether or not the donor is **covered** under the plan: - transporting the donated organ, - tissue compatibility tests, - the donor's operation and **hospital** costs. **We do not cover organ acquisition costs and 'anti-rejection' drugs.**			
Hospitalization - **Physiotherapy/physical therapy, Chiropractic and Osteopathy**	100% UCR up to €1,000 / $1,250 per year	100% UCR up to €2,500 / $3,100 per year	100% UCR up to €5,000 / $6,200 per year	100% UCR

Osteopathy:	We will cover consultations, treatments and procedures in **physiotherapy/physical therapy** **chiropractic** and **osteopathy** prescribed during your **hospitalization**.			
Hospitalization - Psychiatric treatment and care	Not covered	100% UCR up to €3,500 / $4,400 (limited to 10 days per year)	100% UCR up to €7,000 / $8,750 (limited to 20 days per year)	100% UCR (limited to 30 days per year)
	We will cover psychiatric treatments and care in Hospital (on an inpatient or outpatient basis), including room and board fees (within the limits specified in the section 'Hospital room') to treat the covered event. By covered event, we mean any treatment of mental illnesses and disorders with respect to this benefit.			

HEALTHCARE FOLLOWING COVERED HOSPITALIZATION

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Home hospitalization (on prescription)	Not covered	100% UCR up to €1,500 / $1,900 per year	100% UCR, up to 20 days per year	100% UCR, up to 30 days per year
	We will cover nursing care at home following hospitalization covered under the plan, where such care: - is prescribed by your specialist, - commences immediately after you leave Hospital, - reduces the duration of your stay in Hospital, - is provided as medical care and does not constitute personal assistance.			
Reconstructive surgery following an Accident occurring during the Period of coverage	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover the cost of reconstructive surgery which is Medically required and approved by our Medical advisor following a covered Accident or Illness occurring during the period of the insurance.			
Immediate rehabilitation following a stay in hospital and commenced within 30 days of hospitalization	100% UCR up to 20 days / year	100% UCR up to 30 days / year	100% UCR up to 40 days / year	100% UCR up to 50 days / year
	We will cover any rehabilitation, including room and board fees and treatments such as physical therapy, occupational therapy or **speech therapy** following a covered event such as a cardiovascular Accident. **We do not cover rehabilitation expenses or treatment which do not follow hospitalization covered under the plan.** We will cover rehabilitation: - if you received confirmation of our prior approval before commencing the treatment, - which commences a maximum of 30 days following hospitalization. We must have received all the medical data from your **Doctor** or surgeon, including the diagnosis, treatment received and planned, and your future date of discharge before agreeing to cover you under this benefit.			

3.2. / Optional benefits for members (coverage zone 1, 2, 3 or 4[2])

3.2.1. Level of benefit "Health": addition of the Routine healthcare option

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

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Consultations with general practitioners and specialists (other than dentists and psychiatrists) and specialist procedures	100% UCR up to €80 / $100 per treatment, procedure or consultation	100% UCR up to €130 / $160 per treatment, procedure or consultation	100% UCR up to €180 / $225 per treatment, procedure or consultation	100% UCR
	We will cover consultations with **General practitioners** and **Specialists** (other than dentists and psychiatrists) and **Specialist** treatments or procedures. We will cover these consultations under **Routine healthcare**, whether carried out in a medical office, in the home, in hospital (excluding during periods of hospitalization) or via teleconsultation.			
Emergency dental care without hospitalization	100% UCR up to €200 / $250 per year	100% UCR up to €300 / $375 per year	100% UCR up to €500 / $625 per year	100% UCR up to €750 / $950 per year
	We will cover consultations for Emergency dental care, such as sudden toothache that does not require hospitalization. Non-emergency dental expenses (e.g.: dental check-up, scaling, dentures, etc.) will be covered under the Health+ Option if selected. Dental care carried out during a consultation with a stomatologist will be covered only under the Health+ option.			
Prescribed sessions of speech therapy, orthoptics, occupational therapy and nursing care	100% UCR up to €500 / $625 per year	100% UCR up to €1,500 / $1,900 per year	100% UCR up to €2,000 / $2,500 per year	100% UCR Limited to 52 sessions/year
	We will cover prescribed sessions of Speech therapy, Orthoptics, occupational therapy and nursing care. We will cover these sessions under Routine healthcare, whether carried out in a medical office, in the home or in hospital (excluding during periods of hospitalization).			
Physical therapy and **physiotherapy, on prescription**	100% UCR up to €1,000 / $1,250 per year limited to 12 sessions per year	100% UCR up to €2,000 / $2,500 per year limited to 17 sessions per year	100% UCR up to €3,500 / $4,400 per year limited to 22 sessions per year	100% UCR limited to 32 sessions per year
	We will cover consultations and teleconsultations in physical therapy/physiotherapy prescribed as Routine healthcare. The limit on the number of sessions includes all specialties combined.			
Osteopathy and **chiropractic**	100% UCR up to 10 sessions, with a maximum of €50 / $60 per session	100% UCR up to 15 sessions, with a maximum of €100 / $125 per session	100% UCR up to 25 sessions, with a maximum of €150 / $190 per session	100% UCR up to 35 sessions
	We will cover consultations in Osteopathy and Chiropractic for which you do not have a prescription. The limit on the number of sessions includes all specialties combined.			

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

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Homeopathy, acupuncture **and traditional Chinese medicine**	100% UCR up to 3 sessions per year, with a maximum of €50 / $60 per session	100% UCR up to 5 sessions per year, with a maximum of €100 / $125 per session	100% UCR up to 7 sessions per year, with a maximum of €150 / $190 per session	100% UCR up to 10 sessions per year
	We will cover sessions of Acupuncture and **Traditional Chinese medicine** and consultations with a **Homeopath**. The limit on the number of sessions includes all specialties combined.			
Laboratory tests, MRI, x-rays, scans, tomography and physical diagnostic examinations on an outpatient basis	100% UCR up to €2,000 / $2,500 per year	100% UCR up to €3,500 / $4,400 per year	100% UCR up to €7,500 / $9,400 per year	100% UCR
	We will cover all types of Laboratory tests and medical examinations recognized by the medical scientific community, such as x-rays, scans, MRI, blood tests, etc. which are prescribed by a General practitioner or Specialist for diagnostic purposes or as part of your medical care.			
Prescription drugs	100% UCR up to €3,000 / $3,800 per year	100% UCR up to €9,000 / $11,200 per year	100% UCR up to €15,000 / $18,800 per year	100% UCR
	We will cover (under **Routine healthcare**) the cost of drugs: - prescribed by your **General practitioner** or **Specialist**, - which are used only in case of illness or injury.			
Prescribed contraceptives	100% UCR up to €80 / $100 per year	100% UCR up to €100 / $125 per year	100% UCR up to €200 / $250 per year	100% UCR up to €300 / $375 per year
	We will cover methods of contraception that are mechanical, medicinal or prescribed by a general practitioner or specialist. This includes the pill, condoms, diaphragm, intrauterine device, implants and patches.			
Prescription drugs for chronic conditions Waiting period: 12 months	100% up to €10,000 / $12,600 per year, with a maximum of €50,000 / $63,000 for the duration of membership of the plan €50,000/$63,000	100% up to €15,000 / $18,800 per year, with a maximum of €75,000 / $94,000 for the duration of membership of the plan €75,000/$94,000	100% up to €20,000 / $25,000 per year, with a maximum of €100,000 / $126,000 for the duration of membership of the plan €100,000/$126,000	100% UCR
	We will cover prescription drugs for chronic conditions provided that **you have been covered under the plan for at least one year** and drugs have been prescribed for at least 6 months. If the chronic condition is included in the list attached to the plan, supporting documentation from your specialist doctor or GP is needed. Otherwise, the insurer's approval is required and a medical report specifying the following will have to be submitted: the medical condition for which drugs are being prescribed, and the medical requirement for you to take this drug for at least 6 months. During the 12-month waiting period, the 'Prescription drugs' benefit can be used.			
Vaccinations and preventive treatments prescribed for adults and children aged 20 and over	100% UCR up to €200 / $250 per year	100% UCR up to €350 / $440 per year	100% UCR up to €500 / $625 per year	100% UCR
	We will cover mandatory or recommended vaccinations and preventive treatments prescribed for expatriation, such as antimalarials or the yellow fever vaccine.			
Vaccinations and preventive treatments prescribed for children under the age of 20	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover all vaccines and preventive treatments prescribed for children under 20 who are enrolled in the plan.			
Prescribed medical equipment	100% UCR up to €1,000 / $1,250 per year	100% UCR up to €1,500 / $1,900 per year	100% UCR up to €2,500 / $3,100 per year	100% UCR up to €4,000 / $5,000 per year
	We will cover the cost of equipment and **medical**, orthopedic and hearing **Prostheses**. This would include, for example, the purchase of a hearing aid if a hearing problem is diagnosed by a **General practitioner** or **Specialist. It does not include any consumables (batteries, repairs, etc.) related to the covered equipment.**			

MENTAL HEALTH

Psychiatry Waiting period: 12 months	100% UCR Max 5 sessions per year	100% UCR Max 10 sessions per year	100% UCR Max 15 sessions per year	100% UCR Max 20 sessions per year
	We will cover, after expiration of the 12-month Waiting period, consultations with psychiatrists within the limit of the number of consultations specified in your **Benefits schedule**.			
Consultations with psychologists on medical prescription Waiting period: 12 months	100% UCR up to 5 sessions, with a maximum of €50 / $60 per session	100% UCR up to 10 sessions, with a maximum of €100 / $125 per session	100% UCR up to 15 sessions, with a maximum of €150 / $190 per session	100% UCR up to 25 sessions, with a maximum of €200 / $250 per session

WELLBEING & WELLNESS

	QUARTZ	PEARL	SAPPHIRE	DIAMOND
Health check-up	100% UCR up to €150 / $190 every 3 years	100% UCR up to €300 / $375 every 3 years	100% UCR up to €500 / $625 every 3 years	100% UCR up to €1,000 / $1,250 (every 3 years)
	We will cover one Health check-up for every Member over the age of 20. The purpose of this Health check-up is to review the state of health and focus on prevention. It is limited to the following tests: - Blood tests (complete blood count, biochemical Laboratory tests, lipid profile, and thyroid, liver and kidney function) - Cardiovascular examination (physical examination, electrocardiogram and blood pressure) - Neurological examination (physical examination) - X-ray of the lungs			
Preventive Package covering all the procedures listed below	100% UCR up to €250 / $310	100% UCR up to €500 / $625	100% UCR up to €800 / $1,000	100% UCR
Cervical screening (1 per year)	We will cover one cervical screening per year for Members aged 16 and over.			
Mammogram for women aged 45 and over (every 2 years)	We will cover one mammogram for breast cancer screening or diagnostic purposes from age 45. This test is carried out as a preventive measure without the presence of any symptoms or pain. If a mammogram is prescribed by a General practitioner or Specialist as a Medical necessity, it will be covered, if it is carried out in addition to the preventive examination, under 'Laboratory tests, MRI, x-rays, scans, tomography and physical diagnostic procedures on an outpatient basis.'			
Prostate cancer screening, for men aged 45 and over (every year)	We will cover an annual screening for prostate cancer for men aged 45 and over.			
Screening for oral cancer (every 5 years)	We will cover screening for oral cancer every 5 years, for all Members.			
Screening for skin cancer (every 5 years)	We will cover screening for skin cancer every 5 years, for all Members.			
Colonoscopy, from age 50 (every 5 years)	We will cover colonoscopy every 5 years, for all Members aged 50 and over.			
Annual screening for fecal occult blood	We will cover an annual screening for fecal occult blood, for all Members.			
Bone density test, for women aged 45 and over (every 5 years)	We will cover a Bone density test every 5 years for all Members aged 45 and over.			
Consultations with a Dietitian	Not covered	Not covered	100% UCR maximum 2 sessions per year, up to €150 / $190 per consultation	100% UCR maximum 3 sessions per year, up to €200 / $250 per consultation
	We will only cover the consultation itself **and will not cover any weight loss treatments or, for example, costs related to food supplements.**			
Nicotine replacement	Not covered	100% UCR up to €50 / $60 per year	100% UCR up to €75 / $90 per year	100% UCR up to €100 / $125 per year
	We will cover the following costs related to smoking cessation support: - nicotine patches - nicotine gum - nicotine tablets			
Medically prescribed spa therapy	Not covered	100% UCR up to €11/day and within the limit of 1 therapy per year and 21 days per therapy	100% UCR up to €11/day and within the limit of 1 therapy per year and 21 days per therapy	100% UCR up to €11/day and within the limit of 1 therapy per year and 21 days per therapy

3.2.2. LEVEL OF BENEFIT "HEALTH+": ADDITION OF THE DENTAL + VISION OPTIONS

Available if the OPTIONAL BENEFIT HEALTH (HOSPI + ROUTINE HEALTHCARE) has been purchased

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
DENTAL	Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year			
ANNUAL AGGREGATE LIMIT ON DENTAL BENEFITS IN €/$ for the procedures listed below (excluding Orthodontics which has its own limit)	100% UCR up to €250 per tooth and €1,000 per year or $310 per tooth and $1,250 per year	100% UCR up to €400 per tooth and €1,500 per year or $500 per tooth and $1,900 per year	100% UCR up to €500 per tooth and €2,000 per year or $625 per tooth and $2,500 per year	100% UCR up to €600 per tooth and €3500 per year or $750 per tooth and $4400 per year
Routine dental care (up to the annual aggregate limit above) Waiting period: 3 months	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover consultations with a dentist as well as all treatments or procedures carried out during these consultations and listed below: -Scaling -Treatment of tooth decay (amalgam) -Sealing of fissures -Dental x-rays -Inlays / onlays -Fluoride application **Tooth whitening is not covered by the Plan.**			
Dentures and dental implants (up to the annual aggregate limit above) Waiting period: 6 months	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover inlay cores, posts, bridges, crowns, dentures and implant supports. Facets are not covered.			
Dental surgery (up to the annual aggregate limit above) Waiting period: 6 months	100% UCR	100% UCR	100% UCR	100% UCR
	We will cover any surgical procedures, with or without anesthesia, including tooth extraction, bone or gum grafts and the fitting of implants.			
Periodontics (up to the annual aggregate limit above) Waiting period: 3 months	Not covered	100% UCR	100% UCR	100% UCR
	We will cover all treatments of **disorders** of the retaining tissue of the tooth, including the gum.			
Orthodontics up to age 16 Waiting period: 12 months	100% UCR up to €400 / $500 per year for 3 years	100% UCR up to €800 / $1,000 per year for 3 years	100% UCR up to €1,200 / $1,500 per year for 3 years	100% UCR up to €1,500 / $1,900 per year for 3 years
	We will cover **Orthodontics** for any treatment commenced before the age of 16 and for a maximum of 3 consecutive years.			
	QUARTZ	PEARL	SAPPHIRE	DIAMOND
VISION	Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year			
Lenses and frames, limited to one pair every 2 years Waiting period: 6 months	100% UCR up to €100 / $125	100% UCR up to €250 / $310	100% UCR up to €400 / $500	100% UCR up to €600 / $750
	We will cover, after expiration of the **Waiting period**, the cost of prescription lenses and frames with vision correction, limited to one pair every 2 years. **Protective glasses (sunglasses or other types) without vision correction are not covered.**			
Cost of surgical treatments for visual corrections – refractive surgery: the cost of lenses or contact lenses will not be covered during the year following the reimbursement of the refractive surgery treatment Waiting period: 6 months	Level of coverage and limit shared with 'Lenses and frames' benefit	Level of coverage and limit shared with 'Lenses and frames' benefit	Level of coverage and limit shared with 'Lenses and frames' benefit	Level of coverage and limit shared with 'Lenses and frames' benefit
	We will cover, after expiration of the **Waiting period**, the cost of the surgical treatment of myopia, hyperopia, astigmatism and keratoconus. This benefit can be used **only once per eye for the duration of the membership.**			
Corrective contact lenses including disposable lenses Waiting period: 6 months	100% UCR up to €100 / $125 per year	100% UCR up to €200 / $250 per year	100% UCR up to €300 / $375 per year	100% UCR up to €400 / $500 per year
	We will cover, after expiration of the **Waiting period**, the cost of corrective contact lenses on prescription.			

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

3.2.3. LEVEL OF BENEFIT "HEALTH+CHILD": ADDITION OF THE MATERNITY OPTIONS

Available if the OPTIONAL BENEFIT HEALTH+ (DENTAL + VISION) has been purchased

A CHOICE OF 4 LEVELS OF COVERAGE	QUARTZ	PEARL	SAPPHIRE	DIAMOND
MATERNITY	Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year			
Maternity and childbirth preparation classes, prenatal and postnatal care received by the mother and **Immediate care of newborns** Waiting period: 10 months	100% UCR up to €3,500 / $4,400 per year	100% UCR up to €5,000 / $6,250 per year	100% UCR up to €8,000 / $10,000 per year	100% UCR up to €11,000 / $13,800 per year
	We will cover the cost of **Maternity** and childbirth. This includes: - the cost of hospitalization, anesthesia and surgical fees for Childbirth without complications, - **postnatal care** required immediately following Childbirth without complications (removal of stitches following an episiotomy, etc.), - childbirth preparation classes, - diagnostic tests for chromosomal **Disorders**, - routine care of the newborn within 7 days following birth. Treatments due to the following conditions are not covered under this benefit but are covered under Hospitalization: - abnormal growth of cells in the uterus (molar **Pregnancy**), - the fetus growing outside the uterus (ectopic **Pregnancy**).			
Childbirth without complications (single or multiple births) Waiting period: 10 months	Level of coverage and limit shared with the benefit above	Level of coverage and limit shared with the benefit above	Level of coverage and limit shared with the benefit above	Level of coverage and limit shared with the benefit above
	We will cover the cost of midwives or other **Specialists** for home births or in a birth center.			
Childbirth complications (C-sections are only covered if they **are recognized as required and justified)** Waiting period: 10 months	Annual limit for **Maternity** benefit doubled	Annual limit for **Maternity** benefit doubled	Annual limit for **Maternity** benefit doubled	Annual limit for **Maternity** benefit doubled
	We will cover room and board fees, obstetrician fees and all other medical costs for delivery by C-section, if the C-section is recognized as medically required and justified; for example if the birthing process is not progressing normally (dystocia, fetal distress, bleeding, etc.). Note: if we are unable to determine that the C-section was not medically required and justified, we will cover you up to the limit of the **Maternity** benefit.			
Fertility treatment Waiting period: 12 months	**Not covered**	100% UCR €900 / $1,100 per attempt (limited to €3,600 / $4,400 for the entire duration of the membership)	100% UCR €1,200 / $1,500 per attempt (limited to €4,800 / $6,000 for the entire duration of the membership)	100% UCR €1500 / $1900 per attempt (limited to €6,000 / $7,600 for the entire duration of the membership)
	We will cover the cost of pharmacy items, Laboratory tests, follow-up examinations and fertilization involved in **Fertility treatment**. For the purposes of this plan, fertility treatment means all of the following methods of **Medically Assisted Reproduction**: • in vitro fertilization (IVF), • artificial insemination, • hormone treatments, • tubal surgery, • oocyte cryopreservation.			
Voluntary termination of pregnancy For expatriates in Switzerland only	**Not covered**	90% UCR up to €1,000/procedure	90% UCR up to €1,000/procedure	90% UCR up to €1,000/procedure
	Voluntary termination of pregnancy performed within the statutory period limited to 1 procedure per year			

Coverage in the event of an emergency

Worldwide coverage only applies to treatments provided as an emergency during temporary stays (trips for leisure or business purposes) of less than 60 consecutive days.
Medical emergency means emergencies following an accident or sudden, unexpected and unforeseen illness requiring surgery or medical treatment which cannot wait until repatriation to the main country of residence or the worsening of a serious illness which poses an immediate and serious threat to the health of the insured member.
In the event of a medical emergency as defined under the plan, please contact your claims department as soon as possible. If the insured member traveled to a higher coverage zone for the sole purpose of receiving treatment, if the symptoms of the disease were known to the recipient of the treatment before they enrolled in the plan or if the treatment is not subsequent to an accident or sudden, unexpected and unforeseen illness requiring surgery, treatment dispensed in this zone will not be covered, even in an emergency.

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

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

NB: the Hospitalization costs / HOSPI benefit package is not available in zone 5 (USA).

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

If you have opted for the Coverage zone including the USA and territories under U.S. jurisdiction and require treatment or hospitalization there, or need to see a local Doctor, your plan enables you to benefit from specific agreements set up by MSH International with 2 local partners: UnitedHealthcare and Optum RX.
These agreements mean you can:

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

IMPORTANT: Your coverage in the USA and Territories under U.S. 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 U.S. 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 50-kilometer radius of the Insured member's home:

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

CO-PAYMENT (APPLIES ONLY TO THE COVERAGE ZONE INCLUDING THE USA AND TERRITORIES UNDER U.S. JURISDICTION)

A Co-payment applies to certain treatments or procedures covered under the plan for medical care received in the USA and in territories under U.S. jurisdiction.
The Co-payment is a fixed amount determined in the plan per treatment, procedure or visit which is payable by the Member and any Dependents, applicable to each Dependent, for each treatment, procedure or visit.
It is the responsibility of any Insured member to pay the amount of the Co-payment directly to the Doctor, Hospital or clinic.
For details of the treatments or procedures affected, please refer to the benefits schedule below. If you have opted for a deductible, it will be applied after the co-payment. The deductible is not included in cost-sharing.

COST-SHARING AND ANNUAL OUT-OF-POCKET MAXIMUM

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

A CHOICE OF 3 LEVELS OF COVERAGE	PEARL		SAPPHIRE		DIAMOND	
AGGREGATE LIMIT ON HEALTHCARE BENEFITS($)	$1,250,000		$2,000,000		$625,000	
	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
Out-of-pocket maximum, per year	$4,000	$6,000	$2,000	$4,000	$1,500	$3,000
Co-payment, per hospitalization	$400	$800	$200	$400	$100	$200

The **QUARTZ option is not available for members who selected coverage zone 5.**

. The schedules below detail the benefits and the levels of coverage.

Level of coverage	PEARL		SAPPHIRE		DIAMOND	
Level of reimbursement	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Co-payment per visit or procedure	$35	$45	$25	$35	$15	$25

HOSPITALIZATION

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

No waiting period for Hospitalization benefit

We will cover hospital expenses if:

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

If you need to stay in Hospital longer than the period specified in the prior approval agreement, or if changes are made to your treatment, your General practitioner or Specialist must send us a medical report as soon as possible. This medical report must include: the diagnosis, the treatment you have already received, the treatment you require, the additional length of time you will need to stay in Hospital.

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

	PEARL		SAPPHIRE		DIAMOND	
	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
Transportation by road medical vehicle Emergency transportation to hospital Medically required transfer (ambulance, taxi)	100% UCR up to $690		100% UCR up to $690		100% UCR up to $690	
Hospital room	**Private, semi-private or shared room** 80% UCR	**Private, semi-private or shared room** 60% UCR	**Private, semi-private or shared room** 90% UCR	**Private, semi-private or shared room** 70% UCR	**Private, semi-private or shared room** 100% UCR	**Private, semi-private or shared room** 80% UCR
	The type of room and the amount per night that we will cover under each package is shown in this **benefits schedule**.					
Room and board fees for a parent staying in hospital with a dependent child under the age of 16	80% UCR up to $500 per year	60% UCR up to $500 per year	90% UCR up to $875 per year	70% UCR up to $875 per year	100% UCR	80% UCR
	We will cover reasonable room and board fees for a parent staying in the same **hospital** as their **dependent** child under the age of 16, in the event of hospitalization lasting more than one day and up to the maximum amount specified in this **benefits schedule**.					
Outpatient hospitalization (including outpatient surgery)	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will pay all covered hospital expenses for hospitalization which does not require the **person receiving the treatment** to stay overnight.					
Emergency hospitalization within the selected coverage zone (including ambulance)	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover treatment administered following admission to a **Hospital** or medical day center, following the onset of a sudden and unforeseen medical condition requiring immediate treatment within 24 hours for the sole purpose of preventing a life-threatening risk. All **services** provided in the Emergency room which are not followed by admission to hospital will be covered under **routine healthcare**. We must be notified of any **Emergency hospitalization** within 48 hours of admission.					
Hospitalization - Intensive care	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover hospital expenses in case of treatment in a general or cardiac **Intensive care** unit (including a Critical care unit) for patients presenting with organ failure or who are at risk of severe complications.					
Hospitalization - Surgical procedures including fees, operating room and anesthesia	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover the following costs in the event of hospitalization: Operating room, Recovery room, Drugs and dressings used in the operating room and the recovery room, Drugs and dressings used during your stay in **hospital**. We will cover the fees for surgeons and anesthetists and the care required immediately before and after the operation (on the same day). This also includes operations performed on an **outpatient** basis.					
Hospitalization - Consultations with General practitioners and Specialists during hospitalization covered under this plan (excluding Physiotherapy and Alternative medicine) and including Specialist treatments and procedures	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover consultations with **General practitioners** or **Specialists** during your stay in **Hospital** following a covered Event.					

	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Emergency dental care with hospitalization	We will cover **emergency** dental care received in **Hospital** if it is **medically required** following an accident requiring hospitalization. This care must be administered within 24 hours of the Accident. This benefit **does not cover** routine dental surgery, routine dental care, dentures, implantology, Orthodontics or Periodontics (these treatments are only covered under the optional benefit Health+).					
	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Laboratory tests, MRI, x-rays, scans, tomography carried out as part of your hospitalization covered under this plan	We will cover all expenses related to: - **medical imaging**, such as x-rays, scans, MRI, etc., - tests such as blood tests or urine samples, - diagnostic tests such as electrocardiograms. If these examinations are prescribed by your **general practitioner** or **specialist** to help diagnose or assess your health during your stay in hospital.					
	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Prescription drugs	We will cover the cost of any **drugs prescribed** by the **general practitioner** or **specialist** in charge of your treatment during your hospitalization.					
	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Renal dialysis	We will cover the cost of renal dialysis, with the exception of transportation costs to and from the care facility where the dialysis is carried out.					
	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Oncology (Treatment of cancer)	We will cover the cost of any medically justified treatment you receive in the **treatment of cancer**, including chemotherapy, radiotherapy, **oncology**, diagnostic tests and drugs, as part of hospitalization (on both an inpatient and outpatient basis). Remote follow-up examinations will be covered under **'routine healthcare'**.					
	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Treatment of AIDS	We will cover any costs related to the treatment of conditions related to HIV.					
	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
Hospitalization - Internal surgical and medical prostheses/devices	We will cover costs related to **prostheses, devices or appliances** fitted during a surgical procedure.					
	80% UCR up to $2,250	60% UCR up to $2,250	90% UCR up to $3,100	70% UCR up to $3,100	100% UCR	80% UCR
	Per prosthesis – max. 2 prostheses					
Hospitalization - External surgical and medical prostheses/devices	We will cover: - **essential prostheses or devices** immediately following surgery if Medically required, - Medically required Prostheses or devices during the short-term recovery process. For adults and children over the age of 20, we will cover one external prosthesis per Insurance year, and for children up to the age of 20, we will cover the first prosthesis and a maximum of two changes of prosthesis. Within the limit of the maximum amount specified per period under the plan.					
	80% UCR up to $19,000	60% UCR up to $19,000	90% UCR up to $31,000	70% UCR up to $31,000	100% UCR	80% UCR
Hospitalization - Palliative care*	If a **member** is diagnosed with a terminal **illness** and can no longer be treated with a view to being cured, we will cover: - the cost of a room in a **hospital** or hospice (even if palliative home care is also covered), - nursing costs, - **prescribed drugs.**					
Hospitalization - Organ transplant: room and board, cost of treatment and hospitalization fees during an organ transplant *	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	80% UCR up to $3,800 per transplant	60% UCR up to $3,800 per transplant	90% UCR up to $5,600 per transplant	70% UCR up to $5,600 per transplant	100% UCR up to $7,500 per transplant	80% UCR up to $7,500 per transplant
Hospitalization - Medical expenses for an organ transplant (including for the organ donor: coverage of medical expenses and transportation to the place of hospitalization)*	We will cover medical expenses related to a **member** receiving an organ transplant from a verified and certified donor. We will also cover medical expenses for a bone marrow donation (using either your own bone marrow or that of a compatible donor) or a stem cell donation, with or without chemotherapy when these procedures are carried out as part of the treatment of cancer. We will cover the following donor expenses for each event requiring an organ donation whether or not the donor is **covered** under the plan: transporting the donated organ, tissue compatibility tests, the donor's operation and **hospital** costs. **We do not cover organ acquisition costs and 'anti-rejection' drugs.**					
Hospitalization – Physiotherapy/physical therapy, chiropractic and osteopathy*	80% UCR up to $3,100 per year	60% UCR up to $3,100 per year	90% UCR up to $6,200 per year	70% UCR up to $6,200 per year	100% UCR	80% UCR

	We will cover consultations, treatments and procedures in **physiotherapy**/physical therapy, **chiropractic** and **osteopathy** prescribed during your hospitalization.					
Psychiatric treatment and care*	80% UCR up to $4,400 (limited to 10 days per year)	60% UCR up to $4,400 (limited to 10 days per year)	90% UCR up to $8,750 (limited to 20 days per year)	70% UCR up to $8,750 (limited to 20 days per year)	100% UCR (limited to 30 days per year)	80% UCR (limited to 30 days per year)
	We will cover **psychiatric treatments and care** in **Hospital** (on an inpatient or outpatient basis), including room and board fees (within the limits specified in the section '**Hospital** room') to treat the covered event. By covered event, we mean any treatment of mental **illnesses** and disorders with respect to this benefit.					

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

HEALTHCARE FOLLOWING COVERED HOSPITALIZATION

	PEARL		SAPPHIRE		DIAMOND	
	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
Home hospitalization (on prescription)*	80% UCR up to $1,900 per year	60% UCR up to $1,900 per year	90% UCR up to 20 days per year	70% UCR up to 20 days per year	100% UCR up to 30 days per year	80% UCR up to 30 days per year
	We will cover nursing care at home following hospitalization covered under the plan, where such care: - is prescribed by your **specialist**, - commences immediately after you leave **hospital**, - reduces the duration of your stay in **hospital**, - is provided as medical care and does not constitute personal assistance.					
Reconstructive surgery following an Accident occurring during the Period of coverage*	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover the cost of reconstructive surgery which is **medically required** and approved by our Medical advisor following a covered Accident or Illness occurring during the period of the insurance.					
Immediate rehabilitation following a stay in hospital and commenced within 30 days of hospitalization* We must have received all the medical data from your **doctor** or surgeon, including the diagnosis, treatment received and planned, and your future date of discharge before agreeing to cover you under this benefit.	80% UCR up to 20 days per year	60% UCR up to 20 days per year	90% UCR up to 30 days per year	70% UCR up to 30 days per year	100% UCR up to 30 days per year	80% UCR up to 30 days per year
	We will cover any rehabilitation, including room and board fees and treatments such as physical therapy, occupational therapy or **speech therapy** following a covered event such as a cardiovascular Accident. **We do not cover rehabilitation expenses or treatment which do not follow hospitalization covered under the plan.** We will cover rehabilitation: - if you received confirmation of our prior approval before commencing the treatment, - which commences a maximum of 30 days following hospitalization.					

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

ROUTINE HEALTHCARE

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

Co-payment per visit, treatment or procedure	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
	$35	$45	$25	$35	$15	$25

	PEARL		SAPPHIRE		DIAMOND	
Consultations with general practitioners and specialists (other than dentists and psychiatrists) and specialist procedures	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover consultations with **general practitioners** and **specialists** (other than dentists and psychiatrists) and **specialist** treatments or procedures. We will cover these consultations under **routine healthcare**, whether carried out in a medical office, in the home, in hospital (excluding during periods of hospitalization) or via teleconsultation.					
Emergency dental care without hospitalization*	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover consultations for **emergency** dental care, such as sudden toothache that does not require hospitalization. Non-emergency dental expenses (e.g.: dental check-up, scaling, dentures, etc.) will be covered under the Health+ Option if selected, and will not be covered if you have not purchased this option. Dental care carried out during a consultation with a stomatologist will be covered only under the Health+ option.					
Prescribed sessions of Speech therapy,	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR

Orthoptics, occupational therapy and nursing care*	We will cover up to **52 prescribed sessions** per year of **speech therapy**, **orthoptics**, occupational therapy and nursing care. We will cover these sessions under **routine healthcare**, whether carried out in a medical office, in the home or in hospital (excluding during periods of hospitalization).					
Physical therapy and physiotherapy on prescription *	80% UCR limited to 17 sessions per year	60% UCR limited to 17 sessions per year	90% UCR limited to 22 sessions per year	70% UCR limited to 22 sessions per year	100% UCR limited to 32 sessions per year	80% UCR limited to 32 sessions per year
	We will cover consultations and teleconsultations in physical therapy/physiotherapy prescribed as Routine healthcare. The limit on the number of sessions includes all specialties combined.					
Osteopathy and chiropractic*	80% UCR up to 15 sessions	60% UCR up to 15 sessions	90% UCR up to 25 sessions	70% UCR up to 25 sessions	100% UCR up to 35 sessions	80% UCR up to 35 sessions
	We will cover consultations in **osteopathy** and **chiropractic** without prescription. The limit on the number of sessions includes all specialties combined.					
Homeopathy, Acupuncture and Traditional Chinese medicine*	80% UCR up to 5 sessions per year	60% UCR up to 5 sessions per year	90% UCR up to 7 sessions per year	70% UCR up to 7 sessions per year	100% UCR up to 10 sessions per year	80% UCR up to 10 sessions per year
	We will cover consultations in Acupuncture, **homeopathy** and **traditional Chinese medicine**. The limit on the number of sessions includes all specialties combined.					
Laboratory tests, MRI, x-rays, scans, tomography and physical diagnostic examinations on an outpatient basis*	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover all types of Laboratory tests and medical examinations recognized by the medical scientific community, such as x-rays, scans, MRI, blood tests, etc. which are prescribed by a **general practitioner** or **specialist** for diagnostic purposes or as part of your medical care.					
Prescription drugs	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover (under **routine healthcare**) the cost of drugs: - prescribed by your **general practitioner** or **specialist**, - which are used only in case of illness or injury.					
Prescribed contraceptives	80% UCR up to $125 per year	60% UCR up to $125 per year	90% UCR up to $250 per year	70% UCR up to $250 per year	100% UCR up to $375 per year	80% UCR up to $375 per year
	We will cover methods of contraception that are mechanical, medicinal or prescribed by a general practitioner or specialist. This includes the pill, condoms, diaphragm, intrauterine device, implants and patches.					

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

Vaccinations and preventive treatments prescribed **for adults and children aged 20 and over**	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover mandatory or recommended vaccinations and preventive treatments prescribed for expatriation, such as antimalarials or the yellow fever vaccine.					
Vaccinations and preventive treatments prescribed **for children under the age of 20**	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover all vaccines and preventive treatments prescribed for children under 20 who are enrolled in the plan.					
Prescribed medical equipment	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover the cost of equipment and **medical**, orthopedic and hearing **prostheses**. This would include, for example, the purchase of a hearing aid if a hearing problem is diagnosed by a **general practitioner** or **specialist. It does not include any consumables (batteries, repairs, etc.) related to the covered equipment.**					
MENTAL HEALTH						
Psychiatry Waiting period: 12 months	80% UCR Maximum of 10 sessions per year	60% UCR Maximum of 10 sessions per year	90% UCR Maximum of 15 sessions per year	70% UCR Maximum of 15 sessions per year	100% UCR Maximum of 20 sessions per year	80% UCR Maximum of 20 sessions per year
	We will cover, after expiration of the 12-month Waiting period, consultations with psychiatrists within the limit of the number of consultations specified in your **benefits schedule**.					
Consultations with a psychologist on medical prescription Waiting period: 12 months	80% UCR 10 sessions maximum, up to $125 per session	60% UCR 10 sessions maximum, up to $125 per session	90% UCR 15 sessions maximum, up to $190 per session	70% UCR 15 sessions maximum, up to $190 per session	100% UCR 25 sessions maximum, up to $250 per session	80% UCR 25 sessions maximum, up to $250 per session

WELLBEING & WELLNESS

Co-payment per visit, treatment or procedure	PEARL		SAPPHIRE		DIAMOND	
	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
	$35	$45	$25	$35	$15	$25
Health check-up	80% UCR up to $375 (every 3 years)	60% UCR up to $375 (every 3 years)	90% UCR up to $625 (every 3 years)	70% UCR up to $625 (every 3 years)	100% UCR up to $1,250 every 3 years	80% UCR up to $1,250 every 3 years
	We will cover one Health check-up for every Member over the age of 20. The purpose of this Health check-up is to review the state of health and focus on prevention. It is limited to the following tests: - Blood tests (complete blood count, biochemical Laboratory tests, lipid profile, and thyroid, liver and kidney function) - Cardiovascular examination (physical examination, electrocardiogram and blood pressure) - Neurological examination (physical examination) - X-ray of the lungs					
Prevention, for all the procedures listed below	80% UCR up to $625	60% UCR up to $625	90% UCR up to $1,000	70% UCR up to $1,000	100% UCR	80% UCR
Cervical screening (1 per year)	We will cover one cervical screening per year for **members** aged 16 and over.					
Mammogram for women aged 45 and over (every 2 years)	We will cover one mammogram for breast cancer screening or diagnostic purposes from age 45. This test is carried out as a preventive measure without the presence of any symptoms or pain. If a mammogram is prescribed by a **general practitioner** or **specialist** as a **medical necessity**, it will be covered, if it is carried out in addition to the preventive examination, under 'Laboratory tests, MRI, x-rays, scans, tomography and physical diagnostic procedures on an outpatient basis.'					
Prostate cancer screening, for men aged 45 and over (every year)	We will cover an annual screening for prostate cancer for men aged 45 and over.					
Screening for oral cancer (every 5 years)	We will cover screening for oral cancer every 5 years, for all Members.					
Screening for skin cancer (every 5 years)	We will cover screening for skin cancer every 5 years, for all Members.					
Colonoscopy, from age 50 (every 5 years)	We will cover colonoscopy every 5 years, for all Members aged 50 and over.					
Annual screening for fecal occult blood	We will cover an annual screening for fecal occult blood, for all **members**.					
Bone density test, for women aged 45 and over (every 5 years)	We will cover a Bone density test every 5 years for all Members aged 45 and over.					
Consultations with a Dietitian	Not covered	Not covered	90% UCR 2 sessions per year	70% UCR 2 sessions per year	100% UCR 3 sessions per year	80% UCR 3 sessions per year
	We will cover consultations with a dietician holding a recognized qualification in the country in which they are practicing. We will only cover the consultation itself **and will not cover any weight loss treatments or, for example, costs related to food supplements.**					
Nicotine replacement	80% UCR $60 per year per year	60% UCR $60 per year	90% UCR $90 per year	70% UCR $90 per year	100% UCR $125 per year	80% UCR $125 per year
	We will cover the following costs related to smoking cessation support: - nicotine patches - nicotine gum - nicotine tablets					
Medically prescribed spa therapy	100% UCR up to €11/day and within the limit of 1 therapy per year and 21 days per therapy					

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

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

3.4.1. OPTIONAL BENEFIT HEALTH+: DENTAL + VISION

A CHOICE OF 3 LEVELS OF COVERAGE	PEARL		SAPPHIRE		DIAMOND	
DENTAL	Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year					
ANNUAL AGGREGATE LIMIT ON **DENTAL BENEFITS** FOR PROCEDURES LISTED BELOW (EXCLUDING ORTHODONTICS WHICH HAS ITS OWN LIMIT)	80% UCR up to $500 per tooth and $1,900 per year	60% UCR up to $500 per tooth and $1,900 per year	90% UCR up to $625 per tooth and $2,500 per year	70% UCR up to $625 per tooth and $2,500 per year	100% UCR up to $750 per tooth and $44,00 per year	80% UCR up to $750 per tooth and $4,400 per year
Co-payment per visit, treatment or procedure	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
	$35	$45	$25	$35	$15	$25
Routine dental care Waiting period: 3 months	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover consultations with a qualified dentist who is authorized to practice in the country where they are located, as well as all treatments or procedures carried out during these consultations and listed below: scaling, treatment of tooth decay (amalgam), sealing of fissures, dental x-rays, inlays/onlays, fluoride application. **Tooth whitening is not covered by the plan.**					
Dentures and dental implants Waiting period: 6 months	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover inlay cores, posts, bridges, crowns, dentures and implant supports. **Facets are not covered.**					
Dental surgery Waiting period: 6 months	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover any surgical procedures, with or without anesthesia, including tooth extraction, bone or gum grafts and the fitting of implants.					
Periodontics Waiting period: 3 months	80% UCR	60% UCR	90% UCR	70% UCR	100% UCR	80% UCR
	We will cover all treatments of **disorders** of the retaining tissue of the tooth, including the gum.					
Orthodontics up to age 16 Waiting period: 12 months	80% UCR up to $1,000 per year for 3 years	60% UCR up to $1,000 per year for 3 years	90% UCR up to $1,500 per year for 3 years	70% UCR up to $1,500 per year for 3 years	100% UCR up to $1,900 per year for 3 years	80% UCR up to $1,900 per year for 3 years
	We will cover **orthodontics** for any treatment commenced before the age of 16 and for a maximum of 3 consecutive years.					

VISION	Based on Usual, customary and reasonable costs (UCR) as determined by us, per Member and per Insurance year					
Co-payment per visit, treatment or procedure	PEARL		SAPPHIRE		DIAMOND	
	In network	Out-of-network	In network	Out-of-network	In network	Out-of-network
	$35	$45	$25	$35	$15	$25
Lenses and frames, limited to one pair every 2 years Waiting period: 6 months	80% UCR up to $310 per year	60% UCR up to $310 per year	90% UCR up to $500 per year	70% UCR up to $500 per year	100% UCR up to $750 per year	80% UCR up to $750 per year
	We will cover the cost of prescription lenses and frames with vision correction, limited to one pair every 2 years. Protective glasses (sunglasses or other types) without vision correction are not covered.					
Refractive surgery (cost of surgical treatments for visual corrections) Waiting period: 6 months	Level of coverage and limit shared with 'Lenses and frames' benefit	Level of coverage and limit shared with 'Lenses and frames' benefit	Level of coverage and limit shared with 'Lenses and frames' benefit	Level of coverage and limit shared with 'Lenses and frames' benefit	Level of coverage and limit shared with 'Lenses and frames' benefit	Level of coverage and limit shared with 'Lenses and frames' benefit
	We will cover the cost of the surgical treatment of myopia, hyperopia, astigmatism and keratoconus. This benefit can be used only once per eye for the duration of the plan. **The cost of lenses, frames or contact lenses will not be covered during the year following the reimbursement of the refractive surgery treatment.**					
Corrective contact lenses including disposable lenses Waiting period: 6 months	80% UCR up to $250 per year	60% UCR up to $250 per year	90% UCR up to $375 per year	70% UCR up to $375 per year	100% UCR up to $500 per year	80% UCR up to $500 per year
	We will cover the cost of corrective contact lenses on prescription.					

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

3.4.2. OPTIONAL BENEFIT HEALTH+CHILD: MATERNITY

Available if the optional benefit HEALTH+ (DENTAL + VISION) has been purchased

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

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

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

The following are excluded from the insurance:

- costs incurred before the effective date of the plan and after coverage has ceased;
- travel and accommodation expenses related to healthcare;
- the cost of an ambulance or road medical vehicle which is not medically required;
- any medical or surgical expenditure prescribed by a medical authority which is not recognized (practitioners, therapists, clinics, hospitals and medical centers who/which are not recognized):

· by the authorities in force in the country where the treatment takes place as having particular expertise in the treatment of the relevant Accident or illness;

· by the Medical advisor as being properly qualified, competent or authorized to prescribe treatment and who have been notified in writing by him or her;

- non-prescription drugs;
- treatments, consultations and drugs prescribed by the Member, their Dependents or any member of their family;
- costs deemed unnecessary and/or inappropriate by the Insurer's Medical advisor;
- in the event of hospitalization, additional expenses with no direct medical purpose such as charges for telephone, television, internet access, newspapers, taxi fares, meals for visitors etc.;
- costs deemed to be excessive, unreasonable or unusual considering the country in which they were incurred. Therefore, only Usual, Customary and Reasonable costs will be covered and reimbursed under the plan, i.e. reasonable medical expenses which are commonly charged in the relevant country for the specific treatment received, according to standard medical and generally accepted procedures;
- with respect to physical therapy/physiotherapy, only conventional treatments approved by the medical advisor are covered. Lymphatic drainage, massage and colonic irrigation are not covered;
- the cost of hospitalization in a deluxe or VIP room or other suites;
- experimental treatments or drugs, namely all forms of treatment or medication which, in the opinion of the Medical advisors, are not conventional or whose effectiveness has not been proven;
- in respect of pharmacy items, products which are not recognized as drugs such as sunscreen, makeup, over-the-counter products, formula milks, vitamins, probiotics, gluten-free products, etc.;
- the cost of cosmetic, esthetic or reconstruction treatments performed by a plastic surgeon to improve or transform the appearance - even for psychological reasons - unless this treatment is linked to the restoration of a physical feature or function following a disfiguring Accident or surgery related to the Treatment of cancer occurring during the Period of insurance coverage;
- pre-exposure prophylactic treatment for HIV (pre-exposure);
- growth hormones unless supporting medical documents are provided and approved by the medical advisor;
- medication for and treatment of erectile dysfunction;
- treatments and stays in fitness centers, convalescent homes or nursing homes, spas and other similar establishments which are not recognized as Hospitals;
- all tests and treatments for obesity/anorexia, or which are required as a result of obesity or anorexia, including, in particular, programs and fees for weight loss/weight gain and medicinal support and drugs prescribed for obesity/anorexia. In some clinical cases, with the approval of the Medical advisor, surgical procedures for morbid obesity (BMI = Body Mass Index> 40) may be covered;
- products classified as vitamins or minerals and dietary supplements (except in the treatment of a serious vitamin deficiency), over-the-counter products and cosmetics;
- consultations for Mental illnesses or disorders (excluding consultations with Psychiatrists and Psychologists, if covered under the plan and limited to the number of days/sessions specified in the plan) or behavioral disorders (chapter V of the WHO International Classification of Diseases, version 10);
- the care, treatment and all consequences of attempted suicide or self-inflicted injuries or Illnesses, or the use of narcotics without a medical prescription;
- consultations in psychotherapy and/or psychoanalysis with a therapist or family counselor (even if such consultations are conducted by a Psychiatrist);
- cognitive developmental delay, except for a child under 20 who has not attained the level of cognitive development expected for a child of their age. Treatments are not covered if the development of the child is only slightly or temporarily delayed. The cognitive developmental delay must have been quantitatively measured by qualified personnel;
- Speech therapy will only be covered in the native language of the person receiving the treatment, unless the Medical advisor rules otherwise;
- expenditure arising when receiving an organ donation or purchasing an organ, namely:
- mechanical or animal organs, except in cases where a mechanical device is used temporarily for the sole purpose of maintaining vital functions while awaiting a transplant;
- any purchase of an organ from a donor regardless of origin;
- the cultivation and storage of stem cells, for prevention purposes, for hypothetical future use in the event of a possible Illness;
- costs generated by complications caused directly by an injury or Illness which is not covered or only partially covered under the plan;
- pre-existing conditions: any Illness, condition or injury, or related symptoms, which developed before the date of enrollment in the plan of which the Member or their Dependents were aware, or of which they could reasonably have been aware and which we have not expressly agreed to cover;
- repatriation and evacuation costs, including medical evacuation from a ship to a medical center on land. However, some of these costs will be covered by the assistance company under the terms and conditions of 'Medical Evacuation and Medical Transportation' benefits and under the 'Repatriation' option if selected;
- the cost of medical or surgical hospitalization or stays in sanatoriums or preventoriums if the establishments where the

Insured member was treated are not approved by the competent public authority;
- foot care from a podiatrist or chiropodist, such as treatments for corns/calluses, thickened and/or deformed nails, except in cases of Medical necessity approved by the Medical advisor;
- fetal surgery, i.e. treatment or surgery carried out in the womb before birth, unless it is the result of complications reported during Pregnancy;
- the cost of gestational surrogacy, namely all treatments directly related to the use of a surrogate mother (gestational surrogacy) whether the Insured member is the surrogate mother or the intended parent;
- termination of pregnancy (unless there is a threat to the health of the mother, and except for insured members expatriated in Switzerland who have purchased the HEALTH+CHILD package with the PEARL, SAPPHIRE or DIAMOND level of coverage, within the limits provided for under the plan);
- all devices, operations and treatments for sexual dysfunction (sexual deficiencies such as impotence, regardless of cause) or disorders related to gender (disorders related to sex changes or gender reassignment);
- the cost of infertility treatments (and, in particular, Medically assisted reproduction) unless the optional benefit HEALTH+CHILD (Maternity) was purchased by the Member and/or their Dependents;
- sleep disorders, including insomnia, unless the Insured member is diagnosed as suffering from severe sleep apnea;
- pre and postnatal care costs during the waiting period or if the 'Maternity' benefit has not been purchased;
- the consequences of breaking the laws of the country where the Insured member is staying;
- the cost of psychomotor therapy;
- disorders of the temporomandibular joint (TMJ), except in cases of Medical necessity approved by the Medical advisor;
- costs for which the Insured member has not submitted a Request for prior approval; the level of reimbursement of medical care provided under the plan may then be reduced. The plan administrator applies a penalty to the benefit amount of between 40% and 100%. This penalty is in addition to any penalties that may apply if the medical care is received in zone 5 outside the UnitedHealthcare International medical network;
- life-sustaining treatments, unless the Medical advisor rules otherwise;
- administrative costs;
- doctors' fees for purely administrative purposes (for example, to obtain a visa, complete a claim form, etc.);
- care provided in a nursing facility or retirement home and the costs resulting from personal assistance with daily activities, even if that person has been declared as being in a state of temporary or permanent disability. Such services are classed as home care even if they are prescribed by a Doctor and delivered by providers with medical or paramedical status;
- non-medical admissions or hospital stays which include:
  - treatment which could be administered in day care or on an outpatient basis,
  - treatment which is not medically justified in the opinion of the Medical advisor,
  - convalescence.
- treatment of a condition which is subject to a specific exclusion. Specific exclusions are listed on your Certificate of enrollment;
- costs which were paid by another insurance provider, person, organization or state program;
- all care, treatment and consultations provided under HEALTH (Routine healthcare), HEALTH+ (Dental/Vision) and/or HEALTH+CHILD (Maternity) benefits if the Member and any Dependents did not purchase these options;
- all care, treatment and consultations outside the selected geographical Coverage zone, if in a Coverage zone higher than the one selected, other than in an Emergency following an Accident or sudden, unexpected and unforeseen Illness requiring surgery or Medical treatment which cannot wait until repatriation to the Main country of residence or the worsening of a serious Illness which poses an immediate and serious threat to the health of the Insured member or if we have authorized its treatment by way of an exception with the approval of the Medical advisor;
- all care, treatment and consultations received within a Coverage zone which is higher than the selected Coverage zone, particularly in the United States, in the following cases:

· If the Member did not opt for the higher Coverage zone where the care was received, we will not cover the care, treatment and consultations received in this zone, except in cases of medical Emergency as defined in the plan (Emergencies following an Accident or sudden, unexpected and unforeseen Illness requiring surgery or Medical treatment which cannot wait until return to the Main country of residence or the worsening of a serious Illness which poses an immediate and serious threat to the health of the Insured member).

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

The consequences of the following are also excluded from the insurance:
- intentional acts committed by the Member or the Dependent;
- civil or foreign war, insurrection, rebellion (with or without declaration of war), riots, military coups or any usurping of power, martial law or acts committed by any illegally constituted authority, regardless of the location and the protagonists of the events, except in cases of legitimate self-defense;
- the direct or indirect effects of changes in the structure of the atomic nucleus, chemical contamination, radioactivity or any nuclear material,
- explosions and any conflict or disaster, if the Insured member has endangered themselves by entering a conflict zone recognized by the Government of their country of nationality, has actively taken part in the conflict or has shown a blatant disregard for their own safety;
- harmful, dangerous or addictive use of alcohol, narcotics and/or drugs and any treatment arising from the harmful, dangerous or addictive use of these substances;
- alcoholism or drunkenness on the part of the Member or Dependent;
- participation in any sporting competitions and training for these competitions as well as the practice of any sports in a club or federation;
- the practice of sports for professional purposes;
- the practice of the sports listed below:

· extreme sports: bungee jumping, caving, extreme canoeing and kayaking (in rapids greater than Class V, rivers greater than Class II, on seas and oceans more than two nautical miles from land), sailing (transoceanic and single-handed navigation

more than 20 nautical miles from shelter) and base jumping,

- mountain sports: mountaineering, climbing (excluding artificial holds without a safety rope), rock climbing, hiking and trekking requiring special equipment (ropes, ice axes and crampons), ski jumping, bobsleigh, Skeleton, skiing (alpine, cross-country and snowboarding) off marked trails which are open to the public and canyoning,
- air sports: aerobatics, gliding, parachuting, microlighting, hang gliding, paragliding and skysurfing,
- water sports: scuba diving as part of a sporting competition or for leisure purposes, riverboarding and kite surfing,
- competitive self-defense and combat sports,
- motor sports: motor racing, motorcycle racing or kart racing.

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

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

5. / GENERAL OPERATING PROCEDURES

5.1. / YOUR PLAN

5.1.1. ELIGIBILITY FOR THE INSURANCE

Primary member

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

- they are of a different nationality from that of their Main country of residence for the duration of their membership of the plan,
- they have duly completed and signed the Application for coverage and the Health questionnaire,
- they are at least eighteen (18) and under the age of seventy-six (76) (for zones 1, 2, 3 and 4)
- they are at least eighteen (18) and under the age of seventy-one (71) (for zone 5).

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,
- staff of embassies and consulates.

5.1.2 SPECIFIC COUNTRY OF RESIDENCE AND COVERAGE ZONE UNDER THE PLAN

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

It is specified that:

- the Selected coverage zone must be the same for both the Member and the Dependents,
- a higher Coverage zone than the one including the Main country of residence or expatriation may be selected, particularly if the Country of origin is located in a higher Coverage zone.

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

- Zone 5: USA and territories under U.S. jurisdiction (Porto Rico, United States Virgin Islands, Northern Mariana Islands, United States Minor Outlying Islands, American Samoa) as well as countries of Zones 1, 2, 3 and 4
- Zone 4: Bahamas, Brazil, China, Hong Kong, Jersey, Mexico, St. Barthelemy, St. Martin, Singapore, Switzerland and United Kingdom + Zones 1, 2, 3
- Zone 3: Australia, Austria, Canada, French Polynesia, Greece, Ireland, Israel, Italy, Japan, New Caledonia, New Zealand, Portugal, Qatar, Saint Kitts and Nevis, Saint Pierre and Miquelon, Spain, Taiwan, Türkiye, United Arab Emirates, Vanuatu and countries in Zones 1 and 2
- Zone 2: Andorra, Angola, Argentina, Azerbaijan, Bahrain, Barbados, Belgium, Belize, 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, Uruguay, Vietnam, Wallis and Futuna and countries in Zone 1
- Zone 1: Worldwide (including France) excluding the countries in Zones 2 to 5

Territories not listed above are included in the same zone of coverage as the mainland country to which they belong

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

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

5.2. / LIFE OF YOUR PLAN

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

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

5.2.2. YOUR ENROLLMENT IN THE PLAN AND PERSONS INSURED

The Member can choose enrollment in the plan for themselves only (Individual Premium) or for themselves and all or some of their Dependents as defined in the chapter '2 / DEFINITIONS OF HEALTHCARE BENEFITS' p.6 (with as many individual Premiums as Dependents in addition to the individual Premium for the primary Member)
The Member can also choose to enroll one or several dependent children under the age of eighteen (18), subject to these children being expatriated outside their Country of nationality and outside their parents' Country of residence and subject to the Application for coverage being duly completed and signed by the Member. On enrollment, the Member selects the healthcare package, decides whether or not to purchase optional benefits, and chooses the level of benefits and the amount of the Deductible and Co-payment.
It is specified that the package and level of benefits for all of the Member's Dependents, as well as the deductible and Co-payments, must be the same as those selected for the Member themselves.

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

These choices are made by the Member at the time of their enrollment in the plan.
To be eligible for benefits, or if the selected benefits are amended, the Member and each Dependent must complete and sign a Health questionnaire as enrollment in the plan or amendments to the benefits is subject to the medical approval of the Insurer.
Having reviewed the Medical questionnaire(s), the Administrator (MSH International) may request further medical examinations.
If a Member or a Dependent presents an Increased health risk, the Insurer may either accept them under special conditions or deny them coverage.
The special conditions of acceptance of enrollment in the plan or the conditions declared in the Health questionnaire l which gave rise to denial of coverage will be notified by registered mail.
The period of membership is an absolute minimum of 6 months.
If the Administrator (MSH International) denies a request to amend the benefits during the period of membership, it is specified that the Member and any of their Dependents registered on enrollment remain covered under the conditions which were in place before the requested amendment(s).
Membership, or its amendment, is formalized by the issuing of a Certificate of enrollment showing the name and address of the Member, those of the insured Dependents and the Effective date of enrollment, the benefits selected, the Selected coverage zone, the Deductible, the Co-payment where applicable, the corresponding Premium and, if applicable, the fixed term of membership.

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

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

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

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

If the insurer is informed of the addition of a newborn more than 30 days after birth, medical formalities will be required for this child and they will only be covered from the date of the insurer's acceptance.

Please note that all children from multiple births, children adopted from a care home or foster family and children born from surrogacy must be subject to prior acceptance in order to be registered on enrollment.

5.2.4. THE VARIOUS COMPONENTS OF YOUR MEMBERSHIP

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

- **Certificate of enrollment:** this is a single document, issued only at the time of enrollment, which confirms the Member's enrollment in the plan and specifies, in addition to the name of the Member and of any insured Dependents, the Effective date of enrollment, the selected benefits and packages, the Selected coverage zone, the Deductible(s) and the corresponding Premium. The Certificate of enrollment corresponds to the special conditions of your membership of the plan.
- **Certificate of insurance:** this is a document which can be reissued, the purpose of which is to serve as proof of insurance coverage for the person presenting it. It contains the following information: name of the Member and any of their Dependents, Effective date of enrollment, number and type of plan purchased, the Insurer of the plan, the benefits and packages selected and the Selected coverage zone.
- **Premium notice:** this is a document which shows the amount of your insurance Premium and the Period of coverage. The insurance Premium is paid on the date shown on the Premium notice.

- **This information booklet serving as the general terms & conditions:** this refers to this document which defines the benefits, exclusions and conditions of use of the insurance plan (including all information relating to claims procedures), and which should be read in conjunction with the Certificate of enrollment.

IMPORTANT

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

5.2.5. OBTAINING A CERTIFICATE OF ENROLLMENT FOR A NEW DEPENDENT

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

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

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

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

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

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

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

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

In case of cancelation, the Member is only required to pay the portion of the Premium corresponding to the period during which the risk was covered, that period being calculated until the Date of termination.
The insurer is required to reimburse the balance of the premium no later than 30 days following the Date of termination. However, the entire Premium remains due to the Insurer if the right to cancel is exercised when an event that may result in a claim under the plan, and of which the Member was not aware, occurred during the cancelation period.

5.2.7. START OF MEMBERSHIP AND EFFECTIVE DATE OF BENEFITS

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

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

Membership takes effect on the 1st day or 15th day of the month following the date of notification of acceptance of membership. This date is specified on the Certificate of enrollment.
Membership of the plan is purchased for a fixed period shown on the Certificate of enrollment whose duration cannot be less than 6 months or for an annual period ending after 365 days of coverage with automatic annual renewal on the anniversary of enrollment under the conditions of paragraph 5.2.8 below and subject to payment of the Premiums specified by the Insurer.
When membership of the plan is purchased by the Member solely on behalf of one or more Dependent children under the age of eighteen (18), who are expatriated outside their country of nationality and outside their parents' Main country of residence, membership also takes effect under the conditions specified above.
When the Member applies for optional benefits after enrollment in the plan and, at the earliest, on the first anniversary of the effective date of their enrollment under the basic version of the plan, the optional benefit(s) will take effect, subject to the outcome of the medical formalities, on expiration of the Waiting periods specified in the paragraph below. The waiting periods will be counted from the date of acceptance of the amendment by the Insurer. Until these waiting periods have passed, the Member will only be covered by the basic benefits.

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

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

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

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

Waiting periods in detail:

- Waiting period of 4 weeks for Medical or surgical hospitalization - Surgical procedures and fees, General medicine - Specialties – Laboratory tests, Pharmacy items, Preventive Medicine and Alternative Medicine
- Waiting period of 3 months in respect of the following benefits: routine dental/vision consultations and care (excluding emergencies) and periodontics,
- Waiting period of 6 months in respect of the following benefits: Vision and Dental (HEALTH+) (excluding dental consultations and care): dentures, dental implants, bone grafts and dental surgery,
- Waiting period of 10 months in respect of the following benefits: Maternity (HEALTH+CHILD) (including pre and postnatal care),
- Waiting period of 12 months in respect of the following benefits: orthodontics, fertility treatment (including medically assisted reproduction), prescription drugs for chronic conditions (zone 1 to 4), consultations with psychologists, and psychiatric treatments and care (except in the event of hospitalization).

If the Member was previously enrolled in a plan which provided equivalent benefits both in terms of the benefits purchased and the levels of reimbursement, no Waiting period will be applied. **This provision does not apply to Maternity (including pre and postnatal care) and fertility treatment benefits, for which the 10 and 12-month waiting periods remain applicable.**
It is specified that the Insurer will only cover expenses incurred in respect of treatments and procedures prescribed from the Effective date of benefits.

5.2.8. RENEWING OR TERMINATING YOUR MEMBERSHIP OF THE PLAN

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

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

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

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

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

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

Membership and benefits cease for each Member and their Dependents:

- **On the Date of termination of the plan:** In this case, the Insurer will offer the Member a plan which provides continued coverage on an individual basis subject to payment of the Premium specified by the Insurer.
- If the Member no longer has membership of the Contracting association, the Association must inform the Administrator (MSH International) of this within a period of one month. This request may be made at any time but at the earliest after 6 months of membership of the plan.
- on the date of termination of membership as set out in Article 5.2.8 “Renewing or terminating your membership of the plan”.
- **In the event of non-payment of the premiums:** if the Premium corresponding to the membership is no longer being paid.
- **During the course of the year:** as soon as the insured member does no longer qualify for membership of the plan, for example in the event of a return to the 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 the letter of termination together with official supporting documentation. Requests to terminate the plan will not be accepted unless official supporting documentation[3]is provided. The end date of the plan will be determined by the date of receipt of the supporting documentation and will not be effective until the expiration of a minimum notice period of one month. For example, if we receive a request for termination, together with an official document proving that you have returned home, on January 26, the plan will not end until March 1. The administrator, MSH International, reserves the right to check that the official supporting documents are authentic. If the supporting documents prove to be false, termination will not take place during the course of the year and the premiums will remain due until a mid-year termination where applicable or termination on the anniversary date of enrollment.

- **In the event of the Member's death:** On this date, their surviving Spouse, Partner or Common-law spouse who is enrolled in the plan can take out membership of the plan for themselves and, if applicable, for their Dependents; in accordance with the conditions specified in the section 5.2.2 YOUR ENROLLMENT IN THE PLAN AND PERSONS INSURED in chapter 5.2/ LIFE OF YOUR PLAN.
  However, no medical formalities will be required by the Insurer.

Membership and coverage cease in any event:

- at the end of the fixed term shown on the Certificate of enrollment or at the end of the period covered by the last Premium paid, if the Member requests termination of their membership of the plan, by mail, email or, failing that, by any other means provided for in Article L.113-14 of the French Insurance Code, to the Administrator (MSH International), subject to a notice period of 2 months before the anniversary date of the plan. This request can be submitted at any time but at the earliest after 12 months of membership of the plan,
- on the date of permanent return to the Country of origin (uninterrupted stay of more than 3 months),
- It is specified that any removal from the plan is final. Termination of the Member's membership gives rise, in any event and on the same date, to termination of coverage and the removal of all of their Dependents from the plan.

If membership of the plan is purchased by the Member solely on behalf of one or more dependent children under the age of eighteen (18), who are expatriated outside their country of nationality and outside their parents' Main country of residence, membership and coverage cease, for each of the relevant children, when they reach their 18th birthday. On this date, this membership may be extended, with no new medical formalities, with the child acquiring Member status.

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

- for the Spouse: on the date of final judgment in a divorce or legal separation,
  - or for the Partner: on the date on which the civil partnership is terminated,
  - or for the Common-law spouse: on the date on which the Common-law marriage ends,
- for children: when they cease to be dependent on the Member and, at the latest, at the end of the school year in which they reach their 20th birthday or 26th birthday if they are in full-time education and are covered under the plan from the 1st euro.

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

5.2.10. MAKING CHANGES TO YOUR MEMBERSHIP

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

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

Please notify us in writing as soon as possible of any changes in:

- your private mailing address, even if you are staying in the same Main country of residence,
- your email address,
- your Main country of residence.

IMPORTANT

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

You should also keep us informed of any change of address for you and/or your Dependents.

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

If the primary Member dies, we should be informed within a period of one (1) month following the death. Membership of the plan will then come to an end and the current year's 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

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

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

- **CHANGING THE PACKAGE (QUARTZ, PEARL, SAPPHIRE OR DIAMOND)**

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

- **CHANGING THE DEDUCTIBLE**

Changes to the Deductible (or the introduction of a Deductible if the Member did not opt for one in the Application for coverage) are only possible on the anniversary of enrollment in the plan. **There can be only one change of Deductible during the entire duration of membership of the plan.** If the deductible is removed or reduced, MSH International may require the primary Member and their dependents if applicable, to complete a new health questionnaire and may apply new specific restrictions or exclusions.

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

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

- **CHANGING THE OPTION(S) (HEALTH, HEALTH+ OR HEALTH+CHILD)**

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

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

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

- **Changing the coverage zones (zone 1, 2, 3, 4 or 5) and adding a dependent to the plan**

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

5.3. / REIMBURSEMENTS

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

5.3.1 DEADLINE FOR SUBMITTING A CLAIM FOR REIMBURSEMENT

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

5.3.2 REIMBURSEMENT CURRENCIES

We will reimburse you in the currency you specified in your claim, unless it is illegal to make a payment in that currency under international banking regulations. In this case, we will reimburse you in the currency you normally use to pay your Premium.
If the currency of your bank account is not the one you used to pay for your treatment, the exchange rate used to calculate your reimbursements will be the one published by the United Nations on the last day of the month preceding the date of treatment.

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

You will receive your reimbursement:

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

BANK CHARGES WHICH MAY APPLY

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

5.3.3 REIMBURSEMENTS AND DEDUCTIBLES

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

5.3.4. REIMBURSEMENT FOLLOWING A REQUEST FOR PRIOR APPROVAL

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

5.4. / YOUR PREMIUM

5.4.1. CALCULATING YOUR PREMIUM

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

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

It is specified that, as long as at least 3 children are covered in respect of the membership of an Insured member, Premiums will only be payable for the 2 children, the highest of the amounts, with the other children being covered without payment of a Premium. In other words, when at least 3 children are covered in respect of the membership of an Insured member, Premiums will only be payable for the 2 children with the highest amounts.
The amount of the Premium is reviewed on each anniversary of enrollment in the plan taking into account the age of each person covered under the plan and the pricing in place on that date (taking into account the application of the Adjustment clause specified below) as set out in paragraph 5.4.2 Changes in the level of your premium.

5.4.2. CHANGES IN THE LEVEL OF YOUR PREMIUM

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

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

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

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

5.4.3. WAYS OF PAYING YOUR PREMIUM AND ADDITIONAL CHARGES

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

- ONLINE, BY BANK CARD (VISA - MASTERCARD - AMERICAN EXPRESS):
  at www.msh-intl.com, via your Members' Area, under the Online payment section.
- BY DIRECT DEBIT (ONLY FROM A BANK ACCOUNT IN FRANCE OR MONACO):
  Complete and sign the direct debit authorization form provided with your Premium notice (also available on request).
- BY CHECK
  Make your check payable to ASFE and include your ASFE membership number on the reverse of the check (this is very important for ensuring the check is correctly allocated). Please make your payment by the due date to avoid receiving a final demand.
- BY WIRE TRANSFER
  - from France: use MSH International's bank details.
  - or from abroad: by Swift, use MSH International's IBAN and BIC.

Please contact us for details of our bank account. Be sure to include your ASFE membership number (this is very important for ensuring the transfer is correctly allocated). You will pay the bank charges associated with this type of payment method.

5.4.4. ONLINE INFORMATION ON PAYING YOUR PREMIUM

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

5.4.5. PROCEDURE IF YOU FAIL TO PAY YOUR PREMIUM

In accordance with the provisions of article L.113-3 of the French Insurance Code, all Premiums due remain payable and may be recovered by any legal means.
In case of non-payment of a Premium by the Member, in accordance with the provisions of article L.141-3 of the French Insurance Code, the Contracting association must, at the earliest, 10 days after the due date of the unpaid Premium, send the Member a registered letter of formal notice. By mutual agreement between the Insurer and the Contracting association, it is agreed that the Contracting association authorizes the Insurer to prepare and send out this letter.
The letter will state that, at the end of a period of 40 days of dispatch of this letter, the Member is barred from the insurance plan due to non-payment of the Premium. The Member remains liable for the full Premium until the date of their removal from the plan.

5.4.6. BANK CHARGES

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

5.4.7. Reimbursement of the premium

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

5.5. / Legal information

5.5.1. Applicable legislation and jurisdiction

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

5.5.2. Information to members

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

5.5.3. Applicable language

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

5.5.4. Limitation period

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

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

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

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

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

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

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

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

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

The limitation period can also be interrupted by:

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

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

5.5.5. Complaints procedures and mediation service

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

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

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

or

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

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

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

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

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

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

5.5.6.1. PROTECTION OF PERSONAL DATA

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

5.5.6.2. RIGHTS OF THE INDIVIDUAL

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

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

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

5.5.6.3. WHY DOES THE INSURER COLLECT PERSONAL DATA?

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

Execution, administration and implementation of the plans and the commercial management of clients and prospects
The data collected by the insurer at various stages of the application for or administration of insurance plans are required for the following purposes:

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

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

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

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

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

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

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

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

Marketing

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

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

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

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

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

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

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

Combating insurance fraud

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

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

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

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

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

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

Anti-money laundering and the financing of terrorism

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

and the financing of terrorism may be exercised by contacting the French Data Protection Authority (Commission Nationale de l'Informatique et Libertés).

Satisfaction/Quality of service

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

Research and statistics

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

5.5.6.4. Transfer of information outside the European Union

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

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

5.5.6.5. Paperless communications in respect of the insurance plan

Paperless communications with the Contracting association and the member

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

By providing their email address when 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.

Provision of a secure client area

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

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

Access code

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

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

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

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

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

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

Agreement on evidence

This agreement on evidence applies to:

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

5.5.6.6. Anti-money laundering and the financing of terrorism

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

5.5.7. Force majeure

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

5.5.8. Fraud and concealment of facts - misrepresentation

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

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

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

Forfeiture of coverage

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

5.5.9. Subrogated claims

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

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

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

5.5.10. Liability

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

5.5.11. Communicating with dependents

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

6. / CONTACT MSH

GET YOUR LOGIN DETAILS

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

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

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7. APPENDIX 1: LIST OF CHRONIC CONDITIONS

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

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

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

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

YOUR CONTACTS

MSH

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

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on behalf of