Terms & Conditions

Insurance Plan GoldExpat & GoldImpat

www.mondassur.com

To declare a claim, please read information guide:
This document is an English translation, for a better understanding of terms and conditions of the health insurance plan GoldExpat & GoldImpat; translation made from the French original notice “Notice Précontractuelle” which remains the only lawful applicable document.

**HEALTH PLAN "IMPATS No. 129/863807 AND EXPATS No. 210/863806" - PRE-CONTRACT INFORMATION MEMORANDUM**

The insurance contract with optional application "MEDICAL EXPENSES" subscribed by the Interproge association with Groupama Van Vie is governed by the French Insurance Code and in particular Articles L.141-1 and the following ones. It comes under the branch 2 (Disease) of Article R.321-1 of the Insurance Code.

The contract between the association and the insurance takes effect on January 1, 2016. It is then automatically renewed on January 1 of each year for successive periods of one year, unless terminated by either party notified by registered letter at least two months prior to each renewal date.

**Prescription:** Pursuant to Article L. 114-1 of the Insurance Code, any action arising from the prescribed two years after the event giving rise thereto.

However, this time period shall not apply:
1°) in cases of concealment, omission, false statement or misrepresentation on the risk involved, the day when the insurer has knowledge;
2°) in case of loss, until the day on which those involved were aware, if they prove that they have ignored it so far.

Pursuant to Article L114-2 of the Insurance Code, prescription is interrupted by an ordinary interrupt it causes. They are listed in Articles 2240 and following of the Civil Code. These include:
- A legal claim, even an interim, until the expiration of the instance. It is the same when the demand for justice is brought before a court without jurisdiction or where the act of referral to the court is cancelled by the effect of a procedural flaw (Articles 2241 and 2242 of the Civil Code).
- The interruption is void if the applicant withdraws his application or let expire the instance, or if the application is finally rejected (Article 2243 of the Civil Code).
- An act of enforcement or precautionary measures taken under the Code of civil enforcement proceedings (Article 2244 of the Civil Code).

The prescription is interrupted by:
- The appointment of experts following an application for benefits,
- a registered letter with acknowledgment of receipt sent by the insurer to yourself regarding the sending action for payment of dues and you or the beneficiary to the insurer with respect to the payment of the service.

Renunciation: In accordance with Article L.112-9 of the Insurance Code, you will have the option to cancel your membership to the contract by registered letter with acknowledgment of receipt within a period of 14 calendar days from the date of mailing of the certificate of insurance coverage without having to give reasons or to pay penalties. This waiver must reproduce the following:

"I hereby expressly renounce to the renewal of my membership Contract No. 210/84679 and request a refund of the premium paid under the conditions defined in Article L.112-9 of the Insurance Code."

The exercise of the right of renunciation within the period specified in the first paragraph results in the termination of membership of the contract from the date of receipt of the registered letter referred to above by the insurer. Once you become aware of an incident involving contract warranty, you can not exercise your right to cancel. Any waiver, you can not be required to pay part of the premium for the period during which the risk ran, this period being calculated until the date of termination. The insurer is liable to refund the balance no later than 30 days following the date of termination. However, the full fee is payable to the insurer if the right of withdrawal is exercised when a disaster involving the warranty contract and you did not have knowledge occurred during the period of consideration.

**ARTICLE 1 - OBJECT OF THE CONTRACT**

This group insurance contract is for, within the limits of actual costs, the payment of benefits in reimbursement of medical expenses incurred by any member of the contracting Association as defined:

- Expatriate Participant: any person, hereinafter referred to as "Participant" living abroad outside his country of nationality for private or professional purpose and dependents living in the same foreign country if they are enrolled in the association,
- Impatriate Participant: any person, hereinafter referred to as "Impatriate Participant" living outside France and emigrating to France, outside their country of origin, in a private or professional context and assigns residing in France also if they are registered for membership.

Depending on your status (expatriate or impatriate) benefit formulas offered are:

1) If you have membership status "expatriate"

Five benefit formulas granting different levels of benefits are available under basic benefits:
- A high formula "EXPAT PREMIUM" (hospital - medicine - pharmacy)
- A high formula "EXPAT PREMIUM HOSPITAL" (hospital - Medicine and Pharmacy uncovered)
- An intermediate formula "EXPAT SAFE" (hospital – medicine - pharmaceutical )
- An intermediate formula "EXPAT SAFE HOSPITAL" (hospital - Medicine and Pharmacy uncovered)
- A low formula "Expatriate Access" (hospital - medicine - pharmacy).

These basic benefits (excluding formulas Expatriate Premium Hospitalization and Safe Hospitalization) can be supplemented by optional benefits that provide support for expenses incurred in dental and optical.

Depending on your situation vis-à-vis the CFE - Case of French Abroad - Benefits are paid either in addition to those provided by the CFE, or 1 euro completed.

The formula you have chosen, completed if necessary by the optional dental and optical benefits, and your situation with respect to the CFE are shown on your membership certificate.

2) If your membership status is "impatrate"

Three forms of benefits (Hospital - Medicine - Pharmaceutical - Dental - Optical - Prevention) providing different levels of services are available:
- A high formula "IMPAT Premium"
- An intermediate formula "IMPAT Safe"
- A low formula "IMPAT Access."

Depending on your situation vis-à-vis the French Social Security scheme, the benefits provided above, you shall be paid in addition to those provided by the French Social Security scheme, or at 1st euro spent.

The formula that you have selected as well as your situation with respect to the French social system based is shown on your membership certificate.

The tables below show the guarantees offered, the amounts of refunds and benefits provided under each formula.

**ARTICLE 2 - TERRITORIAL SCOPE**

If your membership status is "expatriate", cover is valid worldwide. However, care should be practiced in the region that corresponds to the subscription price:

Zone A: Worldwide except the countries of zones B and C.
Zone B: Saudi Arabia, Australia, Bahrain, Brazil, United Arab Emirates, Hong Kong, Israel, Italy, Lebanon, New Caledonia, Qatar, United Kingdom, Russia, Singapore, Japan, Switzerland.
Zone C: USA, Canada and Bahamas.

As an exception to this rule will be accepted tolerance for hospital care or consecutive emergency accident or an unexpected illness as defined in section 3 below for travel 60 days outside the area of subscription.

In addition, guarantees are also acquired in France and in the overseas departments during travel or vacation whose duration does not exceed 90 days.

In events that might occur there function, coverage for some countries is subject to prior approval by the insurer.
If you have membership status "impatriate" cover is acquired in France and in all other countries when traveling less than 60 days and only for hospitalization or emergency consecutive to an accident or an unexpected illness such as defined in Article 3.

In addition, warranties are also acquired in your country of origin, during travel or vacation whose duration does not exceed 90 days.

**ARTICLE 3 – DEFINITIONS**

For the purposes of the contract, the following definitions are:

- **ACCIDENT**: Any bodily injury, unintentional on the part of the person who suffers from sudden external cause action. Pursuant to Article 1315 of the Civil Code, it is your responsibility to provide proof of the accident and direct causal relationship between it and the costs incurred.

- **MEMBER**: Yourself as a member of the contracting organization, to the extent that you meet the membership requirements set out in Article 10.

- **BENEFICIARY**: Your spouse or partner with whom you're bound by a Civil Solidarity Pact or partner and dependent children.

- **CERTIFICATE OF MEMBERSHIP**: Document which indicates your family situation and your choice (time commitment, name and address, coverage selected ...).

- **CONCUBINAGE**: A union that is characterized by a stable and continuous life together between two persons of the opposite sex or the same sex.

- **COMMON-LAW PARTNER**: Person with whom you live, you and your partner share the same address, and are free of any other link of the same nature (i.e. that everyone is single, widowed, divorced and is not bound in a PACS) and a sworn statement signed by each applicant certifying that cohabitation is known is sent to the insurer. In case of multiple concubinates, the oldest one will be retained.

- **SPOUSE**: Your legally non-separated or non-divorced spouse, exercising or not an occupation.

- **FEE**: The amount that you pay to the insurer in return for guarantees.

- **WAITING PERIOD**: Period defined in the contract for which a benefit is not paid. The waiting period starts from the date of coverage.

- **REQUEST FOR PRELIMINARY AGREEMENT**: Before committing to certain types of care costs or benefits (e.g., hospitalization, treatment in series or prostheses of any kind), you must first apply for and obtain the consent of the insurer obtain the requested care. The request for prior agreement also covers all acts of an amount greater than €1,000.

- **DEPENDENT CHILD**: Your child or your spouse, partner or cohabitant, child under 26 years old, self-employed, your tax office or your spouse and continuing his studies.

- **DAILY PACKAGE**: Part of the price of day of hospitalization supported by the French Social Security.

- **DEDUCTIBLE**: Annual sum remains at your expense.

- **HOSPITALISATION**: Living in a hospital (public or following private) an accident, illness or maternity.

- **ILLNESS**: Any alteration of health recognized by a medical competent authority.

- **UNINTENTIONAL DISEASE**: You are recognized as suffering from a sudden illness if you are a victim of neurological origin of myocytic or infected with one of the following infectious diseases: cholera, whooping cough, diphtheria, anabolic or bacillary dysentery, avian flu, cerebrospinal meningitis, meningitis, malaria, polio, measles, scarlet fever, tetanus, typhoid, typhus, chicken pox, smallpox, herpes zoster.

- **MATERNITY**: Un-pathological pregnancy, childbirth and its aftermath. Motherhood is considered neither a disease nor an accident.

- **NOMENCLATURE**: The bill defines the actions, products and services that are supported by the French system of compulsory social protection and conditions of redemption. The main classifications are:
  - Acts done by dentists, midwives and physician assistants and clinical Medical Acts (consultations, visits):
    - General List of Professional Acts,
    - Medical and paramedical technical acts (acts of surgery, anaesthesia ...):
      - Common Classification of Medical Procedures
      - Medical biology: List of Acts of Medical Biology
      - Medical goods other than drugs (equipment ...):
        - List of Products and Services

- **PACS**: A civil partnership is a contract by two major natural persons of opposite sex or the same sex, to organize their life (Article 515-1 of the Civil Code).

- **PARTNER**: Person with whom you are bound by a PACS

- **CARE HOSPITAL**: After prior approval of the insurer, you (or your beneficiary) hospital can benefit from direct support of your costs in all hospitals.

**ARTICLE 4 - CLAIMS - MEDIATION - DATA PROTECTION**

**CLAIM – MEDIATION**

For any claim (disagreement, dissatisfaction) on the contract, please contact your usual adviser or department in charge of customer relations at the following address:

- By mail: Customer Relations Groupama Gan Vie - Building Michelet 4-8 Cours Michelet - 92882 LA DEFENSE CEDEX - Tél. 01 70 96 62 68
- By email: src.collectiones@ggvie.fr

If this demand is not met, the claim may be addressed to the "Claims" department of the insurer at the following address:

- By mail: Groupama Gan Vie - Claims Service - 160 avenue Charles de Gaulle - TSA 41269 91246 Morangis Cedex
- By email: service.reclamations@ggvie.fr

In both cases, the insurer undertakes to acknowledge receipt of the complaint within a maximum of 10 working days. This will be processed within 2 months. If this is not the case, you will be notified.

Finally and without prejudice to your right to enter possibly justice, you or your beneficiaries can use the mediator to the insurer by writing to the following address: Mediator of Groupama Gan Vie - 5-7 rue du Centre - 93199 Noisy-le-Grand Cedex.

The detailed arrangements for handling complaints are available to you and your beneficiaries with the usual adviser and under “Legal Notices” on the website www.gan-eurocourtage.fr.

**DATA PROTECTION**

**Personal data protection**: The personal data are processed in compliance with the Data Protection Act of 6 January 1978. Processing is necessary for the conclusion and management of the insurance contract. With the exception of health data, they are intended to usual adviser, services of the insurer and its agents, contractors and subcontractors, reinsurers as well as professional and administrative agencies under legal obligations. They can also be used for evaluation and acceptance of risk, internal control (monitoring portfolio) and in accordance with statutory provisions, such as the fight against money laundering and terrorist financing. In the context of the fight against insurance fraud, personal information about you may be transmitted to professional bodies that fight against fraud as well as certified investigators. You have, with proof of your identity, a right of access, rectification, cancellation and opposition at no charge by sending a mail to the insurer Groupama Gan Vie - Department of General Affairs - Correspondent and Freedoms 4-8 Cours Michelet - 92882 La Defense Cedex.

**Collection and processing of health data**: You or your beneficiary expressly consents to the collection and processing of data about your health. Necessary for claims and management of the contract. Only identified data are processed. We respect the confidentiality of your data.

**Correspondent and Freedoms**

- By e-mail: service.reclamations@ggvie.fr
- By mail: claims@ggvie.fr

The personal data are processed in compliance with the General Data Protection Regulation (GDPR). In both cases, the insurer undertakes to acknowledge receipt of the complaint within a maximum of 10 working days. This will be processed within 2 months. If this is not the case, you will be notified.

Finally and without prejudice to your right to enter possibly justice, you or your beneficiaries can use the mediator to the insurer by writing to the following address: Mediator of Groupama Gan Vie - 5-7 rue du Centre - 93199 Noisy-le-Grand Cedex.

The detailed arrangements for handling complaints are available to you and your beneficiaries with the usual adviser and under “Legal Notices” on the website www.gan-eurocourtage.fr.
You and your entitled have a right of access, rectification and opposition to information about you by sending you by mail accompanied by a photocopy of an identity document to the medical officer of the insurer.

**Record phone calls:** You and / or your estate may be asked to call the insurer to ask all kinds of information. The insurer informs you that telephone calls may be recorded to ensure the proper performance of its services to you and generally to improve the quality of service. These records are for services only of the insurer in charge of the call in question.

If you were registered and want to listen to the recording of an interview, you can make a request by letter to the insurer to address indicated above. You will be issued, without charge, a copy of the call recording or transcript of the content of the conversation within the shelf life of these records.

**Transfer of information outside of the European Union:** As part of the contract and the implementation of safeguards and in accordance with agreed objectives, the personal data about you may be a transfer to countries outside the European Union or European Union, you are informed by these provisions and you expressly authorize.

**ARTICLE 5 ARBITRATION - JURISDICTION**

Members report to submit to the jurisdiction of the French courts and waive any proceedings in any other country.

---

### TITLE 4 REIMBURSEMENT OF ILLNESS AND MATERNITY

**ARTICLE 6 - NATURE OF REFUNDS**

Unless otherwise provided in the tables below, the following shall be reimbursed all medical and surgical expenses, the nature prescribed by the qualified medical authority are supported by the French Social Security scheme (including CFE) or be supported by this organization.

For treatment in France, the requirements for the implementation of benefits are defined by reference to classifications of French Social Security.

Acts considered by the insurer are the following one, and are subject to be contained in the formula you have chosen:

- **Hospital**
  - Surgical Hospitalisation: Acts and surgery costs
    - Surgical hospitalization day
    - Surgical operations provided in a facility hospital as well as those related to trauma
    - Acts of Anaesthesiology
    - Acts using radium chloride in unsalted sources
    - Assistance expenses of the attending physician, operative pharmacy, operating room, examination, provision of blood, plasma, oxygen, material plastered
    - Cost of transportation of patient medical vehicle, excluding sanitary repatriation
    - Daily hospital package. Payment of the daily hospital plan is made by reference to text in effect setting the amounts of this package
    - Private room costs
    - Charges accompanying a child covered by the contract (costs taken into account include the parent accompanying the child, the cost of accommodation (bed) and food (meals) billed by the hospital. Also supported in this respect by the insurer, the cost of accommodation food and engaged in "houses of parents")
  - Medical hospitalisation
    - Hospitalization Day including medical hospitalization in a rehabilitation center in children sanitary character house (within the limit of 30 days per calendar year in both cases).
    - Fees chemotherapy or radiotherapy
    - Cost of transportation of patient medical vehicle, excluding sanitary repatriation
    - Daily hospital package. Payment of the daily hospital plan is made by reference to text in effect setting the amounts of this package
    - Private room costs
    - Charges accompanying a child covered by the contract (costs taken into account include the parent accompanying the child, the cost of accommodation (bed) and food (meals) billed by the hospital. Also supported in this respect by the insurer, the cost of accommodation food and engaged in "houses of parents")

- **Childbirth and Maternity**
  - Sessions of preparation for childbirth by prior agreement
  - Costs of delivery
  - Pre and post-delivery tests
  - Screening for chromosomal abnormalities by prior agreement
  - Amniocentesis deemed medically necessary

- **General Medicine - Specialties - Analysis - Orthopaedics - Non Dentures prosthesis**
  - Practitioner or specialist consultations
  - Acts of medical auxiliary
  - Prostheses fees (excluding dentures), orthopaedics (including renewal, repairs, shipping materials and expenses of the person's displacement)
  - Examinations and medical treatment practiced in less than 24 hours in hospital
  - Acts of specialties
  - Analysis costs, laboratory work
  - Acts of radiology
  - Preventive medicine: osteopathy, chiropractic, acupuncture and podiatry

- **Pharmacy**
  - Pharmaceutical expenses including homeopathic treatments, contraceptives on medical prescription and vaccines.

- **Optical**
  - Costs of optical glasses, frames and contact lenses including disposable.

- **Dental**
  - Dental expenses, dentures and orthodontics (if treatment starts before the age of 16 years old).

- **Medically assisted procreation**
  - Research expenses of causes of infertility
  - Costs related to in vitro fertilization (consultations, surgical acts, acts of medical biology)
  - Pharmaceutical expenses

The insurer pays a maximum of four attempts, by prior agreement, for the duration of the registration to the contract.

In addition to the expatriate participant, when the insurer's repayments involved in addition provided by the French Social Security scheme under Maternity insurance benefits, the insurer also supports in contractual limits defined in table following guarantees for the items concerned, the relative costs of maternity (including the fees of the practitioner, living expenses and the cost of a private room in case of hospitalization on maternity) and those not related to maternity (medical, pharmaceutical, medical testing, hospitalization, laboratory tests, devices, optical and dental).

**ARTICLE 7 AMOUNT OF REIMBURSEMENTS**

Fees are served in the limit of real fees, or to supplement the benefits provided by the French Social Security scheme (including CFE) or from 1 euro, depending on your situation regarding the French Social Security scheme and your contract.

If your membership status is "expatriate":

- **Deductible:** Under the formula "EXPAT PREMIUM" providing all guarantees (Hospitalization, Medicine and Pharmacy), you can choose whether to apply a € 500 deductible, calculated per calendar year.

  - **Cumulative insurance:** Reimbursements of the potential social security scheme, of the insurer and any other organisation can exceed the amount of expenses actually incurred. Cumulative insurance operate within the limits of each coverage regardless of their date of purchase. In this limit, you can get compensation by contacting the organization of your choice. Subject to decline, you must declare the cumulative insurance. This requirement is valid for the duration of membership. The limitation of reimbursement of expenses actually incurred is determined by the insurer for each service or treatment covered.

  - **Subrogation:** It is stated that the insurer does not waive the rights and system basis of the insurer and any other organisation may not exceed actions held pursuant to article L.121-12 of the Insurance Code relating to subrogatory recourse he may exercise for the responsible third party.

**ARTICLE 8 - NOT COVERED**

The following fees are excluded from the guarantee:

- any expenses relating to medical and surgical sequence:
- not prescribed by a qualified medical authority
- which is not supported by the French Social Security (except opposite dispositions set out in the guarantee table)
- caused by the use of narcotic drugs or psychotropic without a medical prescription,
- relating to pathological states of alcohol consumption
- caused following a trip that was made contrary to medical advice
- transport
- Of a pregnant woman to the hospital for a normal delivery unless the insurer does deem it necessary due to medical complications related to a non-guaranteed service,
- of accommodation and treatment relating to
  - a stay in a nursing/recovery home including when the stay follows an hospitalization
  - a stay in a residential aftercare or similar establishment
  - a stay in a hydrotherapy, spa, naturopathic clinic or similar place, even if it has the characteristics or is registered as a hospital
- Treatment psychotherapy, psychoanalysis, mental, illness, depression or anxiety
- Treatment of infertility, except for medically assisted procreation,
- Care requiring a prior agreement, dispensed without prior agreement,
- rejuvenating, slimming and fattening treatment
- Care related to a treatment or a plastic surgery operation not resulting from an injury,
- medically unjustified (including: non-medical drugs or costs deemed excessive, unreasonable or unusual considering the country in which they were incurred).

Furthermore, guarantees do not apply in the following cases:
- Suicide or attempted suicide occurring during the first year of insurance
- Civil or foreign war, insurrection, riots, brawls, regardless of the location events take place and whoever the protagonists, unless you do not take an active part,
- Accident or disease resulting from a war involving the French State,
- Facts resulting from violations of the law of the country where the insured is,
- Direct or indirect effects of changing the structure of the atomic nucleus,
- the consequences of the practice of sports listed below: Extreme sports : bungee jumping, speleology, extreme canoeing and kayaking (on torrents superior to class V, river superior to class II, on the seas and oceans over two miles from the coast), sailing (transoceanic, solo sailing more than 20 miles from a shelter), base jumping;
- Mountain sports: mountaineering, rock climbing (without artificial support with security), self-guided hiking beyond 3000 meters, ski jumping, bobsleighs, skijoring, skiing (downhill, cross, snowboard) and sledging off the signposted slopes open to the public, rafting, canyoning;
- air sports: acrobatics, gliding, parachuting, ultralight, hang gliding, paragliding, kitesurfing, balloonning;
- water Sports: scuba diving as part of a sports competition or as a personal hobby without the PADI or equivalent and not accompanied by a professional, jet skiing, surfing, competition, hydro speed, kitesurfing;
- Defense and combat sports in competition;
- Motorsports: auto racing, motorcycle racing or karting;
- however, introduction courses to these type of sports when they are supervised by a professional with diplomas and skills required by the state, are covered with the exception of "extreme" sports,
- participation in all sports competitions and training, practice sports as part of a club or federation professionally
- air navigation accident unless the insured is an ordinary passenger and is aboard an aircraft for which the owner and the pilot have all permits and licenses.

ARTICLE 9 - REGULATION OF BENEFITS
In case of illness or accident giving entitlement to a refund, you required to submit to the insurer or its agent the refund request, duly filled in, accompanied by the following:
- If you can not claim benefits in kind of the social system of French base (including CFE), original copies of fees, medical prescriptions and paid orders, detailed and paid invoices.
- If you are entitled to benefits in kind of the French Social Security scheme (including CFE) : slips of the organization to which you must attach a proof of the amount of actual costs when they are not specified in the slip issued by the Social Security scheme or when it does not intervene.

It is particularly clear in the context of a complement of the French Social Security scheme coverage (including CFE), that for acts or fees rejected or not supported by the Social Security scheme but guaranteed in accordance to the contract, the reimbursement of the insurer is subject to the presentation of itemized bills and proofs, including medical prescriptions.

For the fees of unregulated acts of dental treatment (dental and orthodontics prosthesis), reimbursement of the insurer is in any case subject to the provision of a preliminary estimate of the treatment and the note including detailed fee after treatment.
Moreover, as regards the reimbursement of services or expenses of osteopaths, chiropractic and acupuncture are not supported by the French Social Security scheme (provided that the acts concerned and the practitioner who performed meets the conditions set by legislation and / or regulations in force), the intervention of the insurer is subject to the provision of paid invoice paper letterhead, indicating the details of the practitioner who performed acts , allowing the verification of its quality.

The insurer reserves the right to carry out checks, even medical examinations for dental fees, or ask for any other justifications that could be considered necessary.
Any supporting complementary documentation of medical nature claimed by the consulting physician or insurer's dentist consultant must be addressed by the participant or beneficiary under confidential cover.

If you or your beneficiary following treatment or dental procedures refuse to transmit to the dental insurer consultant, the evidence he claims or if you refuse to submit to the medical expertise requested by the insurer , the insurer may refuse the involvement of the guarantee and the payment of his reimbursement benefits according to the fees considered.
In the case of a recovery from the French Social Security scheme, following the audit of a practitioner performed after a refund, the insurer reserves the right to recover any benefits that you will have unduly received, according to the contract.
- For expenses subject to a request for prior agreement and, in particular, all acts with an amount greater than € 1,000: the prior agreement form accepted by the insurer doctor.

For costs incurred in countries outside the area of subscription: the evidence that the costs incurred are well included within the scope of warranty ( less than 60 days travel), hospitalization for an accident or an unpredictable disease before traveling ).
To qualify for benefits, claims for reimbursement of health expenses must reach the insurer at the latest within 12 months following the date of treatment.
In case of disagreement on the settlement amount, you must notify the insurer within 6 months from the date of the statement. Benefits owed by the insurer according to the contract are payable in France and in euros.
If you or your beneficiary intentionally provide false information or preferring one false document or denatured during a claim, you lose all rights to safeguards for claim in question.

TITLE 3 – MEMBERSHIP – COVERED PERSONS
ARTICLE 10 - CONDITIONS OF MEMBERSHIP
To apply to the contract, you must be a member of the contracting association and:
- Be aged 18 or over and under 65,
- If you have expatriate status : live in France or be an employee of a company registered in France and emigrate abroad, outside your country of origin,
- Be aged 18 or over and under 65, if you have “impatriate” status : live outside France and emigrate abroad, outside your country of origin,
- Have completed and signed the application form,
- Have completed and signed the health profile up to three months before the desired effective date.
In addition, the agreement of the insurer will be required to the subscription of any person working in a dangerous or very specific profession.
Membership is subject to medical approval by the insurer, it is reserving the right to request additional medical information based on the responses made on the health profile. If you are at risk worse, the insurer may be required either to accept you with special conditions, or to refuse you.
The person whose membership contract is accepted is called “Participant”.
Membership is notified by the issuance of a membership certificate which includes:
- Your status (“expatriate” or “impatriate”) and your registration or not to the social plan scheme (including CFE),
- The chosen guarantees formula, supplemented if necessary, if you have an expatriate status, by the optional optical and dental status coverage and the possibly retained franchise.
- If you have expatriate status, the coverage area corresponding to the country of expatriation,
- The effective date of accession,
- The Individual/Family restraint category,
- The corresponding contribution.

Accession shall take effect on the date indicated on the membership certificate provided it is regulated and returned to the insurer in due time. Subject to the provisions of Article 14, accession:
- Is taken out for a period ending on December 31 of the year during which it took effect,
- Then automatically renewed on January 1 of each year for successive one-year periods unless terminated by one of the parties notified by registered letter two months prior to each renewal date. It ends upon termination expressed in accordance with dispositions provided above and those of Article 13.

ARTICLE 11 – COVERED PERSONS
Depending on your choice and subject to the payment of corresponding dues, the guarantees of the contract are awarded:
- To you solely, excluding your estate; in this case, you are linked to the "Individual" category (individual contribution).
- To yourself and your dependents as defined in Article 3; in this case, you and your beneficiaries are related to the "Family" category (family contribution).
To be guaranteed, your beneficiaries must comply with the medical formalities in accordance with Article 10. You choose your annexation to one or the other of these Individual / Family categories and you can ask to change your affiliation in specified conditions in the fourth paragraph of Article 12.

ARTICLE 12 - EFFECTIVE DATE OF ACCESSION AND BENEFITS

1 - EFFECTIVE DATE OF ACCESSION
Your membership contract takes effect on the 1st day of the month following receipt:
- The membership application and health profile subject to the medical approval of the insurer,
- full payment of the first due date of the contribution.
Membership can also take effect on the exact date that you want but, at the earliest, on the first day of the month following the reception of the accession request. Membership of your estate takes effect, subject to the medical insurer’s acceptance:
- at the same time as yourself,
- the first day of the calendar month following the change of family status in the case of marriage, conclusion of a PACS, cohabitation or the birth of children,
- the 1st day of the month following the request of their inclusion in the contract, or the exact desired date but no earlier than the first day of the month preceding the receipt of the application.
Notwithstanding the foregoing, your children born after your membership are admitted without any medical requirements provided they are reported to the insurer within one month after the date of birth.

2 - EFFECTIVE DATE OF BENEFITS
The cover takes effect for yourself and your dependents at the date of accession to the contract as provided above, subject to the application of the following timeouts:
- 6 months for the cost of dental care, dentures, orthodontic and optical expenses.
- 3 months for all other expenses (this period is waived if the comm conversion or the connection to the family category, the effective date shall be the first day of calendar quarter following the modification request.
In case of decreasing of guarantees, waiting times set out in the second section of this present article shall be counted from the effective date of the guarantees of the previous formula.
In case of increase of guarantees and / or change of category (attachment to the family class), you must complete a new application form and submit both you and your dependents to the medical requirements.
The insurer reserves the right to refuse requests of increasing guarantees. Waiting times set out in the second section above are applied to the differential benefit from the effective date of new guarantees.

3 - BENEFITS OF BASIC PLAN AND OPTIONS

THE MEMBER EXPATRIATE - CHOICE OF BENEFITS
The contract provides under BASIC WARRANTIES care costs for hospital, medical and pharmaceutical. You can complete these basic guarantees with OPTIONAL GUARANTEES which provide support for dental and optical expenses.

The choice of optional benefits must be done by yourself:
- During your contract subscription; in this case, the optional-cover take effect on the same date as the basic guarantees in the conditions number 2 of this section,
- or, as appropriate:
  - January 1 of each year, provided that the application reaches the insurer not later than the first day of the calendar month preceding the year considered
  - the first day of the calendar month following the change in the family situation (marriage, birth, divorce, widowhood ... ) when the application is received within thirty days of such change,
  - in case of change of the expatriation country provided that the request reaches the insurer not later than the first day of the calendar month preceding said change.

4 - MODIFICATION OF BENEFITS
Change of status or geographical area
Whether you are an expatriate or “imparitaire”, you must inform the insurer of any change of status or geographical area at least 1 month before the date of effective change. The new pricing applies to you the first day of the calendar month following the date of modification. On this occasion, you can also change your coverage as provided below.

Purchase of optional coverage by the expatriate participant
When you ask your membership to optional coverage after you signed the contract, you must provide the insurer a new medical questionnaire in view of which the insurer may request additional medical examinations. If the subscription to optional coverage is accepted by the insurer, the dental and optical guarantees of this option will take effect upon the expiration of waiting periods prescribed in the previous section, the only basic guarantees being granted to the participant before absorption of these waiting periods.
It is said that if you purchase the optional coverage:
- These guarantees also apply to all of your dependents entered on the certificate of membership,
- You have the right to terminate your membership later to the optional guarantees to retain only basic coverage after two years of full accession to optional coverage (unless there is a modification of the marital status or a change of expatriation country).

Change of Benefits formula or category
You make your choice (which applies both for yourself and for your dependents) your contract's subscription:
You can then change your choice your attachment to the category Individual/Family:
- On January 1 of each period, provided that the request of modification reaches the insurer not later than the first day of the calendar month before the said period,
- The first day of the calendar month following the change in family status (marriage, birth, divorce, widowhood ... ) where the application is received within thirty days following the request,
- In case of change of the expatriation country, provided that the modification request reaches the insurer not later than the first day of the calendar month before the said modification.
However, it is clear that the change to a formula providing lower amounts of refunds is possible only after 2 years of membership in the above formula (except in case of modification of the marital status or a change of country of expatriation). In case of modification of warranties and / or of change of category (connection to the family category), the effective date shall be the first day of calendar quarter following the modification request.
In case of decreasing of guarantees, waiting times set out in the second section of this present article shall be counted from the effective date of the guarantees of the previous formula.
In case of increase of guarantees and / or change of category (attachment to the family class), you must complete a new application form and submit both you and your dependents to the medical requirements.
The insurer reserves the right to refuse requests of increasing guarantees. Waiting times set out in the second section above are applied to the differential benefit from the effective date of new guarantees.
ARTICLE 13 - CESSATION OF MEMBERSHIP AND BENEFITS

Membership and benefits stop for yourself:
- on December 31 of the year in which you requested termination of your membership to the contract, provided that the cessation was notified to the insurer at least two months before that date,
- on the date of termination. In this case, the insurer will offer you an individual guarantees maintenance contract, upon payment of the contribution indicated by the insurer,
- when you do not adhere to the association anymore,
- during the final return to your home country (the country in which you have your usual residence).

If the contributions for you are no longer set in the conditions under the Article 14 pursuant to Article L.141-3 of the Insurance Code.

(All quarterly fee is earned and not refundable)

- if your circumstances change, the date on which you required to benefit from the same kind of insurance from your employer or that of your spouse,
- at the latest on your 65th birthday. At this time, if you make the specific request to the insurer within a maximum period of six months, you can sign a contract holding individual guarantees, subject to the payment of the fee specified by the insurer.

It is stated that guarantees cease in any event for your dependents at the date of cessation of payment of contributions affecting them within the conditions laid down in Article 14 and at the latest, on the date on which they lose their quality of dependents in the respect of the contract.

In addition, it is stated that guarantees stop in any event:
- for your spouse: the date of the final decision in case of divorce or judicial separation, and at the latest during their 65th birthday,
- for your partner or common-law husband: on the date of cessation of PACS or concubinage, and at the latest during their 65th birthday,
- for your children: as soon as they cease to meet the definition of "child to support" under Article 3.

It is stated that the insurer only supports, for both yourself and your dependents, the expenses incurred in respect of acts prescribed prior to the date of cessation of guarantees.

TITLE 4 - PREMIUMS

ARTICLE 14 – ASSESSMENT

1 - DETERMINATION AND PAYMENT

Guarantees of subscription are granted upon payment of an annual fee fixed in euros, depending on your age (in individual subscription) or the age of the oldest guaranteed person (for family subscription), the formula of retained guarantees, the cover (at the first euro or completing either the CFE or the French social system basis), and, if you are an expatriate, the coverage area.

The amount in euro of the applicable fee as part of your membership will be shown on your membership certificate.

The fee is payable quarterly, semiannually or annually, in advance, in France and in euros. In case of temporary membership or departure occurred during an insured year, the fee is calculated in proportion. In case of termination of the contract, membership and guarantees are maintained until the end of the period covered by contributions.

The amount of the contribution is reviewed on April 1 of each year due to your age (determined by year difference) in individual contribution or the age of the oldest person covered by family contribution and of the rate prevailing at that date.

Any tax that would apply to the contract and whose recovery would not be prohibited would be at your expense and payable in the same time as the subscription.

2 – NON-PAYMENT OF THE Fee

Pursuant to the provisions of Article L.113-3 of the Insurance Code, any subscription remains due and may be recovered by any means of law.

Pursuant to the provisions of Article L.141-3 of the Insurance Code, the contracting association shall, at the earliest 10 days after the due date of an unpaid contribution, send you a registered letter of formal notice. By a mutual agreement between the insurer and the contracting association, it agreed that it mandates the insurer to establish and send this registered letter.

The letter will state that after a period of 40 days from the sending of this letter, you are excluded from the insurance contract because of non-payment of contributions.
BASIC BENEFITS

It is stated that under the Formulas EXPAT PREMIUM & EXPAT SAFE, you can subscribe only to the HOSPITALIZATION Formula which covers acts and benefit amounts such as shown in the table below, for each of these.

<table>
<thead>
<tr>
<th>Acts (*)</th>
<th>EXPAT Premium Package</th>
<th>EXPAT Safe Package</th>
<th>EXPAT Access Package</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalisation</td>
<td>100% AC</td>
<td>100% AC</td>
<td>100% AC</td>
</tr>
<tr>
<td>Fees and living expenses - Surgical operations(1)</td>
<td>100% AC</td>
<td>100% AC</td>
<td>100% AC</td>
</tr>
<tr>
<td>Medical treatments, laboratory tests, radiography and drugs during hospitalization(2)</td>
<td>100% AC</td>
<td>100% AC</td>
<td>100% AC</td>
</tr>
<tr>
<td>Private room</td>
<td>100% AC (with a utmost of 80€/day)</td>
<td>100% AC (with a utmost of 80€/day)</td>
<td>100% AC (with a utmost of 80€/day)</td>
</tr>
<tr>
<td>Accompanying costs for hospitalization of a child covered by the contract</td>
<td>100% AC (with a utmost of 70€/day)</td>
<td>100% AC (with a utmost of 70€/day)</td>
<td>100% AC (with a utmost of 70€/day)</td>
</tr>
<tr>
<td>Organ transplantation (1) with a maximum per diem diagnosis and for the treatment period, including all costs</td>
<td>90% AC</td>
<td>100% AC</td>
<td>100% AC</td>
</tr>
<tr>
<td>Medically prescribed rehabilitation center approved rehabilitation after hospitalization(1)</td>
<td>90% AC with a utmost of 200€/day (during 30 days utmost)</td>
<td>90% AC with a utmost of 130€/day (during 30 days utmost)</td>
<td>80% AC with a utmost of 130€/day (during 30 days utmost)</td>
</tr>
<tr>
<td>Ambulance (on prescription)</td>
<td>100% AC with a utmost of 1.500€/year</td>
<td>100% AC with a utmost of 1.000€/year</td>
<td>100% AC with a utmost of 1.000€/year</td>
</tr>
<tr>
<td>Ambulatory care in a hospital or clinic (&lt;24 hours)</td>
<td>100% AC</td>
<td>100% AC</td>
<td>100% AC</td>
</tr>
<tr>
<td>Treatment of surgery, chemotherapy, radiotherapy, dialysis(2)</td>
<td>100% AC</td>
<td>100% AC</td>
<td>100% AC</td>
</tr>
<tr>
<td>Medical treatment, laboratory tests and consecutive radiography ambulatory surgery(2)</td>
<td>100% AC</td>
<td>100% AC</td>
<td>100% AC</td>
</tr>
<tr>
<td>Treatment in the emergency department if acute illness or injury</td>
<td>90% AC</td>
<td>90% AC</td>
<td>80% AC</td>
</tr>
</tbody>
</table>

**BENEFITS MAXIMUM**

The insurer limits their repayments, per guaranteed person per year to:
- **Zone A**: (including hospital care or providing emergency in zones B and C and care provided in France and in the French Overseas Departments)
- **Zone B**: (including hospital care or providing emergency in zones B and C and care provided in France and in the French Overseas Departments)

- **Zone C**: (including care or providing emergency in the zones A and B in France and in the French Overseas Departments)
- 250.000 € for formulas ‘Expat Safe’ and ‘Expat Access’
- 500.000 € for the formula ‘Expat Premium’
- 750.000 € for formulas ‘Expat Safe’ and ‘Expat Access’
- 1.000.000 € for the formula ‘Expat Premium’
Benefits paid by the insurer are shown in the tables below. Repayments of the insurer, combined where appropriate with those of the basic social system, are limited in any event to the costs that you or your heirs have actually incurred.

MEANING OF THE ABBREVIATIONS

RB : Reimbursement basis, net, as part of a cover in addition to the French Social Security scheme, of the benefits granted by this body. RB is the rate used as a reference to French social system basis for determining the amount of the refund. It distinguishes the agreement rate (AR) where the acts are performed by a health professional under agreement with the compulsory health insurance (This is a fixed tariff by an agreement signed between health insurance and the representatives of the profession), the tariff authority (TA) where the acts are performed by a non-contracted health professional with compulsory health insurance and liability costs (LC) for drugs, equipment and other medical goods. As part of the contract, when the participant or beneficiary is aimed at a facility or practitioner non-contracted with the health insurance, the mandatory refund basis is reconstructed on the basis of the agreement rate defined above.

AC: Expenses actually incurred the participant or the right of deduction provided under French RB (for those who benefit with.


RO: French Social Security scheme as Social Security, MSA or any other French special arrangements legally binding social guarantees for employees and possibly the social compulsory security scheme for non-salaried employees or students Social Security.

<table>
<thead>
<tr>
<th>ACTS 1</th>
<th>IMPAT PREMIUM PLAN</th>
<th>IMPAT SAFE PLAN</th>
<th>IMPAT ACCESS PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenses in France</td>
<td>Expenses outside of France</td>
<td>Expenses in France</td>
<td>Expenses outside of France</td>
</tr>
<tr>
<td><strong>A) MEDICAL OR SURGICAL HOSPITALIZATION, INCLUDING MATERNITY (*)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fees and living expenses - Surgical operations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Social security Agreement sector</td>
<td>100% AC</td>
<td>90% AC (1)</td>
<td>100% AC</td>
</tr>
<tr>
<td>• Social security non-agreement sector</td>
<td>90% AC</td>
<td>90% AC (1)</td>
<td>90% AC</td>
</tr>
<tr>
<td>Daily hospital (by reference to the legislation establishing the amounts or at the time of hospitalization)</td>
<td>100% AC</td>
<td>N/A</td>
<td>100% AC</td>
</tr>
<tr>
<td>Private Room</td>
<td>100 % AC limited at 80 € / day</td>
<td>100 % AC limited at 70 € / day</td>
<td>100 % AC limited at 60 € / day</td>
</tr>
<tr>
<td>Accompanying costs in case of hospitalization of a child covered by the contract</td>
<td>100 % FR limited at 100% RB (1)</td>
<td>90% AC</td>
<td>100 % FR limited at 100% RB (1)</td>
</tr>
<tr>
<td>Cost of transporting the patient by medical vehicle</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(*) Additional costs (phone television, etc.) are in no way supported by the insurer.

<table>
<thead>
<tr>
<th><strong>B) GENERAL MEDICINE SPECIALTIES - MEDICAL ANALYSIS - ORTHOPAEDICS - NO DENTAL PROSTHESIS</strong></th>
<th>90% AC limited to :</th>
<th>90% AC limited to :</th>
<th>80% AC limited to :</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation / general medical visit</td>
<td>350% RB (1)</td>
<td>80 € / consultation or visit</td>
<td>250% RB (1)</td>
</tr>
<tr>
<td>Consultation / specialist medical visit</td>
<td>400% RB (1)</td>
<td>120 € / consultation or visit</td>
<td>300 % RB (1)</td>
</tr>
<tr>
<td>Paramedics (nurses, physiotherapist, midwife, podiatrist, speech therapist, orthopist)</td>
<td>350% RB (1)</td>
<td>70 € / consultation</td>
<td>250% RB (1)</td>
</tr>
<tr>
<td>Medical biology (medical and Analysis laboratory) - Radiology - Medical Imaging</td>
<td>350% RB (1)</td>
<td>400 € / act</td>
<td>250% RB (1)</td>
</tr>
<tr>
<td>Minor surgery</td>
<td>400% RB (1)</td>
<td>400 € / act</td>
<td>300 % RB (1)</td>
</tr>
<tr>
<td>Equipment - Medical Prosthetics and orthopedic (except hearing devices)</td>
<td>400% RB (1)</td>
<td>500 € / implant</td>
<td>300 % RB (1)</td>
</tr>
</tbody>
</table>

| **C) PHARMACY** | 100% AC limited at 100% RB (1) | 90% AC | 100% FR limited at 100% RB (1) | 90% AC | 100% FR limited at 100% RB (1) | 90% AC |
| Pharmaceutical costs supported by the RO | | | | | | |

<table>
<thead>
<tr>
<th><strong>D) OPTICAL</strong></th>
<th>90% AC limited at :</th>
<th>90% AC limited at :</th>
<th>80% AC limited at :</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lenses and frames supported by the RO - Corrective lenses not supported or not by the RO but listed in the social security nomenclature</td>
<td>90% AC limited at 300€ / person insured / year</td>
<td>90% AC limited at 200€ / person insured / year</td>
<td>80% AC limited at 150€ / person insured / year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>E) DENTAL</strong></th>
<th>90% AC limited at :</th>
<th>90% AC limited at :</th>
<th>80% AC limited at :</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservative care supported by the RO</td>
<td>350% RB (1)</td>
<td>80€ / consultation</td>
<td>250% RB (1)</td>
</tr>
<tr>
<td>Orthodontics supported by the RO</td>
<td>350% RB (1)</td>
<td>N/A</td>
<td>250% RB (1)</td>
</tr>
<tr>
<td>Dentures listed in nomenclature</td>
<td>450% RB (1)</td>
<td>500€ / implant</td>
<td>300% RB (1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>F) PREVENTIVE CARE</strong></th>
<th>90% AC limited at :</th>
<th>90% AC limited at :</th>
<th>80% AC limited at :</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccines not reimbursed by the RO (on prescription)</td>
<td>150€ / person insured / year</td>
<td>100€ / person insured / year</td>
<td>50€ / person insured / year</td>
</tr>
<tr>
<td>Osteopathy, Chiropractic and Acupuncture</td>
<td>30€ / session with a maximum of 8 sessions / person insured / year</td>
<td>30€ / session with a maximum of 8 sessions / person insured / year</td>
<td></td>
</tr>
<tr>
<td>Checkup</td>
<td>250€ every 2 years</td>
<td>200€ every 2 years</td>
<td>150€ every 2 years</td>
</tr>
</tbody>
</table>

(1) All acts superior to 1000€ are subject to, in all cases, a prior agreement

(2) Hospitalisation costs spent outside of France are subject to in all cases, whatever the costs, a prior agreement

(3) In the instance of a top-up cover to the French Social Security system, the benefits in %RB include the reimbursement of the social security.