Indigo Expat WeCare

Insurance Information Leaflet – 1st Euro

Policy No. G0406 – First Euro Healthcare Plan (1st Euro)

taken out by the "**Association Coopération, Mobility et Expatriation"** (ACME),

on behalf of **Assurances et Conseils Moncey** (code 75C024),

with **MGEN International Benefits,** acting on behalf of MFPrévoyance

Contractual document

Pre-contractual information specific to distance selling

1. Group policy no. G0406 relating to this information leaflet has been taken out with the Insurer by the Policyholder, the Association ACME (Policyholder Association), on behalf of this members, whose respective legal notices are set out in Section VI of this Insurance leaflet.

2. The authority responsible for regulating the Insurer is the Autorité de Contrôle Prudentiel et de Résolution (ACPR) - 4 Place de Budapest - CS 92459 - 75436 Paris Cedex 09, France.

3. The method for calculating premiums is set out in Section 5 ("Premiums") of this Insurance leaflet.

4. Membership lasts twelve (12 months following the policy start date. It is then renewed each year by tacit renewal for a period of one year. The start dates and length of membership are defined in article 2.1 ("Start, duration and renewal of membership certificate and cancellation") of this Insurance leaflet.

5. The object of the policy, as mentioned in article 1 ("Purpose of the leaflet") is to cover Insured Parties the payment of benefits under the conditions defined in Section III ("Benefits") of this Insurance leaflet.

6. Exclusions are set out in Section IV ("Excluded risks and benefits") of this Insurance leaflet.

7. In the case of distance selling, the policy provisions offered in the Insurance information leaflet for group policy no. G0406 are valid until the date indicated in the cover letter, enclosed with this Insurance leaflet.

8. In the case of distance selling, the policy no. G0406 may be taken out according to the method set out in article 13 ("Membership Conditions") of this Insurance leaflet.

9. Les modalités de paiement de la cotisation sont indiquées à la Section 5 « Les cotisations » de la présente notice d'information. The premium payment terms are set out in Section 5 ("Premiums") of this Insurance leaflet.

10. Fees relating to distance selling techniques used are payable by the Member. It means the cost incurred for sending letters and telephoning Insurer, the Policyholder and their service providers or for internet connections shall be paid by the Member and shall not be liable for any reimbursement.

11. A cancellation right exists and the procedure for exercising it and the address to which the cancellation notice should be sent are set out in article 2.3 ("Cancellation in the case of direct selling or distance selling") of this Insurance leaflet.

12. Pre-contractual and contractual relations between the Insurer, the Policyholder and the Member are governed by French law. The Insurer and the Policyholder undertake to use the French language during their pre-contractual and contractual relations. French courts shall have jurisdiction.

13. The procedures for assessing complaints are explained in article 3.3 ("Information – Complaints – Mediation") of this Insurance leaflet.

Table de matières

Section 1 – Purpose and basis of the insurance leaflet

1 – Purpose of the insurance leaflet

The policy corresponding to this Insurance leaflet is an optional-membership group insurance policy taken out by the Policyholder association « **Association Coopération, Mobility et Expatriation (ACME)** » or his representative, on behalf of its members, with the Insurer. The policy is subscribed by the Policyholder association with MFPREVOYANCE, the "Insurer", in the context of an underwriting delegation given to MGEN International Benefits.

It is covered by branch 2 Sickness defined in article R.321-1 the French Insurance Code and is governed by both its stipulations and the provisions of the French Insurance code and applicable French legislation.

Its purpose of the policy is to provide optional cover for individuals on international mobility, citizens or non-citizens of the European Union, residents in a Member State of the European Union and members of the Policyholder Association, for reimbursement of medical expenses recognised by the French social security Sickness-Maternity Insurance, in accordance with this Insurance leaflet.

The Policyholder Association has mandated "Assurances et Conseils Moncey" to design and distribute the contract, which is the subject of this Insurance leaflet.

2 – 2- Effective date, duration and renewal of the membership certificate

2.1 Affiliation

The application to take out the policy is made via a standard membership form approved by the Insurer, including a medical questionnaire. This document must be completed, dated and signed by the insurance applicant, and a medical examination, and an health form.

The membership form states Member's identity, elements required to determine coverage and calculate premium. The insurance applicant acknowledges that he/she is familiar with the Insurance information leaflet.

The cover must be the same for the Member and his/her Spouse or any Beneficiaries covered by this policy, if applicable.

Nevertheless, in light of the documents and information received, the Insurer, or its Delegate where relevant, may:

- stipulate a revised price on a membership certificate compared with that initially stated on a membership form, or a specific exclusion.
- the insurance applicant may reject this price by informing the Insurer in writing within 30 days from the date of receipt of the proposal. The termination shall be effective from the first day of the calendar month following the applicant's rejection notice. If no response is received within thirty days, the Insurer shall consider that the Member has accepted the new conditions proposed.

Members and their Beneficiaries shall then have the status of Insured Party, once admitted to the insurance cover. Membership of the policy is recorded in a membership certificate, particularly stating :

- the Membership number,
- the Membership start date,
- the Member's full name,
- the full names of any Beneficiaries,
- the category of beneficiaries defined,
- the coverage area,
- the type of cover and the amount of subscribed benefits
- the calculation of premiums including terms of payment

At the time the Member or a Beneficiary takes out the policy, the Member must pay an advance on the first premium. If a cancellation request is made, the premium shall be returned in full.

2.2 Start date and renewal

For the Member, the insurance takes effect on the date indicated on the membership certificate, for a period of twelve (12) months.

It is then renewed tacitly for a period of one year, unless cancelled by the Insured Party by means of a letter sent by registered mail to the Policyholder Association or her representative, at the latest two (2) months before the renewal date, and the said cancellation taking effect at the annual date of the renewal.

Membership may also end under one of the following conditions:

- **In the event of non-payment of premiums by the Member,**
- **On the date on which the Insured Party ceases to be a Member of the Policyholder,**
- **In the event of cancellation of this group insurance policy, according to this information leaflet**
- **Following the dissolution of the Policyholder.**

2.3 Cancellation in the case of direct selling or distance selling

The Policyholder undertakes to send the Member, who has acquired the status of Insured Party, information concerning the cancellation right in the case of direct selling or distance selling of the policy which is the object of this summary of benefits.

In the case in of direct selling:
The provisions of article L. 112-9 of the French Insurance Code apply:
"*Any natural person that has been subject to door to door selling at their home address or workplace, even at their request, and who signed within this framework an insurance proposal or contract for purposes not falling within the context of their commercial or professional activity, has the right to cancel the latter by registered mail with request for notification of receipt during a deadline of 14 consecutive calendar days, as of the date of the conclusion of the policy, without having to give reasons or bear penalties. (….) Once he/she becomes aware of an incident calling the contract coverage into play, the subscriber may no longer exercise this right of cancellation*."

En cas de vente à distance :
Distance selling provisions apply if the policy is concluded via one or more distance selling techniques, particularly sale via correspondence or via the internet.
In accordance with article L 112-2-1 of the French Insurance Code, a cancellation period of 14 calendar days applies in the case of distance selling. This period begins on the date the policy is concluded or from the date the applicant receives the policy conditions and information mentioned in article L.222-6 of the French Consumer Code (if this is after the date the policy is concluded).

The date of conclusion of the policy corresponds to the membership start date.

This cancellation right shall not apply if the policy is entirely executed by the two parties at the Member's explicit request before the Member exercises his/her cancellation right.

Cancellation procedure in the case of direct selling or distance selling : To exercise his/her cancellation right, the Member must send the Insurer, through ***l'Association Coopération, Mobility et Expatriation (ACME), 9 rue du 4 septembre, 75002 Paris, France***, a letter by registered mail stating his/her desire to cancel his/her membership. The following template may be used:

"*By this letter, I the undersigned …… (full name and address) hereby cancel my membership of policy G0389 which I signed on ……in …… (place of membership) and ask for reimbursement of the payment I made, corresponding to the sum of € …. [amount in euros]. On … (date and signature)."*

2.4 Effects of cancellation (direct selling, distance selling or on receipt of the membership certificate)

The Insurer, via the Third Party MSH International, **then reimburses the premiums paid within 30 calendar days from the date the registered mail is received.**

Membership is considered never to have existed and cover does not apply, from receipt by the Insurer, via MSH International, of the cancellation letter sent via registered mail. After the period of thirty (30) days, the sum due accrues interest at the legal rate.

3 – Limitation period

The provisions relating to the limitation on actions resulting from the policy which is the object of this Summary of benefits are governed by articles L 114-1 to L 114-3 of the French Insurance Code reproduced below:

Article L.114-1 of the French Insurance Code:
All actions resulting from an insurance policy are limited to two years from the triggering event.
However, this period only runs:
- **In the event of any reticence, omission, or false or inaccurate declaration on the insured risk, from the date on which the insurer becomes aware of this,**
- **In the event of a claim, from the date on which the parties become aware of it, if they can prove they were previously unaware of it.**

Article L.114-2 of the French Insurance Code:
The limitation shall be interrupted by usual causes of interruption to the limitation on action and the selection of appraisers following a claim. The interruption to the limitation on action may also result from the sending of a letter by registered mail with proof of receipt sent by the Insurer to the Insured Party in relation to action regarding payment of the premium and by the Insured Party to the Insurer provider in relation to settlement of compensation.

Article L.114-3 of the French Insurance Code:
By way of exception to article 2254 of the French Civil Code, the parties to the insurance policy may not, even by agreement, either amend the limitation period, or add reasons for suspending or interrupting it.
The ordinary causes for interrupting the limitation period are defined in articles 2240 et seq. of the French Civil Code. The ordinary causes for interrupting the limitation period stipulated in the French Civil Code are:
- **Recognition by the debtor of the right of the person against whom the time limitation was imposed (article 2240 the French Civil Code),**
- **Legal proceedings (articles 2241 to 2243 of the French Civil Code),**
- **Measures taken to preserve rights pursuant to the French Code of Civil Procedure or an order for enforced execution (article 2244 of the French Civil Code),**
- **A service of process made upon one a joint and several debtor or an order for enforced execution or recognition by the debtor of the right of the person against whom the time**

limitation was imposed (article 2245 of the French Civil Code),
- **A service of process made upon the principal debtor or an acknowledgement for cases of time limitations applicable to guarantors (article 2246 of the French Civil Code).**

4 – Recourse action

In accordance with the French Insurance Code, the Beneficiary of benefits subrogates the Insurer to undertake any recourse proceedings against any liable third party, within the limit of expenses incurred. If the recourse, due to the Insured member, can no longer be exercised in favour of the Insurer, then the Insurer will be relieved of its obligations to the Insured member insofar as the subrogation could have been exercised.

5 – Information - Complaints – Mediation

For any information or complaints relating to the policy which is the object of this Summary of benefits, without prejudice to the Member's right to bring legal proceedings to enforce execution of the policy in the event of a dispute, he/she may contact:
« Association Coopération, Mobility et Expatriation » (ACME), 9 rue du 4 septembre, 75002 Paris, France. Email : moncey@moncey-assurances.com , in following circumstances:
- ✓ Information and complaints regarding the insurance admission conditions
- ✓ Information and complaints regarding payment of premiums
- ✓ Information and complaints in the event of a claim

After receiving a complaint, the Policyholder sends the Member or his/her beneficiaries confirmation of receipt of the complaint within a maximum of ten (10) business days. The response is sent to the Insured Party or his/her beneficiaries within the following two (2) months. Any request for further information suspends this time limit. If Members are not satisfied by the Policyholder's response, they can send a standard letter or email to :

MGEN International Benefits - Customer Relations Department, 3/5/7 Square Max-Hymans 75748 Paris Cedex 15, France. Email: clients@mgen-ib.com.

In the event of disagreement with a decision by the Insurer and having exhausted all means of appeal offered by the Insurer, within a maximum of one year from the date of the written complaint, the Member or his/her beneficiaries may contact the Insurance ombudsman at the following address:
La Médiation de l'Assurance - TSA 50110 - 75441 Paris Cedex 09.
The Ombudsman's opinion is not binding on the parties in dispute and they retain the right to bring proceedings before the competent court. The Ombudsman is not authorised to give an opinion on insurance admissibility conditions.

In addition, the Insured or their Beneficiaries may, without prejudice to the legal actions they have the possibility to exercise and the claims they can formulate to the Insurer, refer to the "Autorité de Contrôle Prudentiel et de Résolution, Direction du contrôle des pratiques commerciales" - 4 Place de Budapest - CS 92459 - 75436 Paris Cedex 09, France.

6 – False declarations

ANY INFORMATION SUPPLIED BY THE INSURED OR ONE OF THEIR BENEFICIARIES THAT IS INCORRECT, FALSIFIED, EXAGGERATED OR ANY FRAUDULENT ACTS ON THEIR PART INVOLVES THE APPLICATION OF THE PENALTIES PROVIDED FROM THE INSURANCE CODE:

- **THE NULLITY OF YOUR POLICY IN THE EVENT OF INTENTIONAL MISREPRESENTATION (ARTICLE L.113-8); PREMIUMS PAID ARE KEPT BY THE INSURER, WHO IS ENTITLED, AS A COMPENSATION, TO THE PAYMENT OF ALL PREMIUMS DUE; IN SUCH A CASE, THE INSURED WILL HAVE TO REIMBURSE ALL THE CLAIMS PAID BY THE INSURER UNDER THE CONTRACT;**
- **IF THE INTENTIONAL MISREPRESENTATION, DISCOVERED BEFORE ANY CLAIM, IS NOT ESTABLISHED, PREMIUM INCREASE OR TERMINATION OF THE POLICY (ARTICLE L.113-9);**
- **IF THE INTENTIONAL MISREPRESENTATION DISCOVERED AFTER THE CLAIM, IS NOT ESTABLISHED, DECREASE OF CLAIM ACCORDING TO THE RATIO BETWEEN THE PAID PREMIUM AND THE PREMIUM THAT SHOULD HAVE BEEN PAID IF THE INITIAL DECLARATION HAD BEEN CONSISTENT WITH THE REALITY (ARTICLE L.113- 9).**

7 – Delegated management agreement

The operations relating to this policy delegated by the Insurer MGEN International Benefits to MSH International (39 Rue Mstislav Rostropovitch, 75017 Paris, France) are set out in a delegated management agreement, particularly MSH's obligations towards the Insurer in terms of acceptance, declaration, transfer of premiums, management of healthcare benefits and establishment of statistics.

8 – Data protection

According to the Data Protection Act of January 6th 1978, as amended, and in the context of the management of the insurance contract, the personal data of the Insured may be transferred to the Insurer, its administrators, its service providers, its subcontractors or reinsurers. Insured persons are informed that treatments concerning them, as well as those of their potential beneficiaries, are implemented as part of the execution, management and execution of this contract as well as for its commercial management. They may also be used in the context of control, prospecting, anti-fraud and money laundering and terrorist financing operations, the search for beneficiaries of unregulated death

contracts, the execution of legal and regulatory provisions.

The data collected is necessary for the implementation of these treatments and is intended for the relevant services of the Insurer and its Managing Delegate and, where appropriate, its subcontractors, service providers or partners. The Insurer is required to ensure that this data is accurate, complete and, if necessary, updated. The data collected will be kept for the duration of the contractual relationship increased legal requirements or in respect of the terms provided by the Commission Nationale Informatique et Libertés (CNIL).

This personal data may be transferred to service providers or subcontractors established in countries outside the European Union. These transfers concern only countries recognized by the European Commission as having an adequate level of protection of personal data, or recipients with appropriate guarantees.

The Insured person and / or beneficiaries have the right to access, rectify or erase data, limit the processing of their data, portability, opposition to treatments, as well as the right to define guidelines for their fate after their death. They can exercise their rights by mail addressed to MSH International : dpo@s2hgroup.com, When exercising their rights, the production of an identity document is requested. In case of persistent litigation, they have a right to seize the CNIL on www.cnil.fr or at 3, place de Fontenoy - TSA 80715 - 75334 Paris cedex 7, France.

Data relating to the state of health of the insured persons, the treatment of which is necessary for the purposes of the performance of the obligations and the exercise of the rights proper to the insurer, or to the insured persons themselves, may be dealt with in the framework of the management and execution of the contract. These data are exclusively intended for the medical service of MSH International. The exercise of rights is carried out by email, after the production of an identity document, for the attention of, the medical adviser: medical@msh-intl.com.

9 – Supervisory authority

The Supervisory Authority of the Insurer is the Authority of Prudential Supervision and Resolution, 4 Place de Budapest - CS 92459 - 75436 Paris Cedex 09, France

10 – Limitation clause

The insurer shall not be deemed to provided cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose that insurer to any sanction, prohibition or restriction under United Nations resolutions, or the trade or economic sanctions, laws or regulations of the European Union, France, United States of America or any other applicable law or regulation.

11 – Cumulative Insurance

Reimbursements for expenses incurred by a sickness or an accident cannot exceed the amount of the expenses remaining chargeable to the Insured Member after reimbursements of any kind to which he is entitled. Benefits of the same nature contracted with several insurers produce their effects within the limits of each benefit, regardless of the date of subscription.
Within this limit, if an Insured is covered by a local social security scheme or an insurance policy of the same nature, the Insurer reserves the right to appeal under the conditions of Article 4.

12 - Jurisdiction and contractual language

French courts shall have jurisdiction. The language used in relation to this policy is French. This Information insurance leaflet is a non-contractual translation of the group insurance policy.

Section 2 – Insured parties

13 – Members

Benefits of the policy can be provided to individuals on international mobility, citizens or non-citizens of the European Union, residents in a Member State of the European Union and members of the Policyholder Association, and having subscribed, via the Policyholder Association, this insurance group healthcare policy.

The period of residence abroad is at least six (6) months.

The countries of residence excluded from all coverage areas are United States, United Kingdom, Switzerland, United Arab Emirates, Bahamas.

Members of family are also eligible as Beneficiaries if they fulfil the eligible conditions.

14 – 5- Membership conditions

Ces personnes doivent, au moment de leur affiliation remplir et signer un bulletin individuel d'affiliation incluant un questionnaire de santé validé par le Médecin Conseil de l'Assureur.

The insurance applicants must, at time of their affiliation, completed, dated and signed an individual membership form, including an health form approved by the medical adviser.

A medical examination can be requested at the expense of the Insurer. The Insurer reserves the right to make acceptance conditional upon the production of any additional information it considers necessary.

Adherents previously insured by a health group insurance policy of the Indigo Expat range underwritten through Moncey Insurance and Advice and wishing for equivalent insurance cover, fill out a simplified health questionnaire. In this case, there is no timeout.
For Members wishing to take out equivalent insurance outside the above case, waiting times are

not applied, with the exception of the maternity waiting period.

The health questionnaire fully completed and waiting times are applied for any other new membership.

The Member undertakes to provide evidence of his/her declarations at any time by sending supporting documents corresponding to his/her situation.

14 – 6- Effective date of coverage

14.1 Once the policy relating to this Information insurance leaflet has taken effect, cover is effective for each Insured Member, and their beneficiaries where relevant, who acquire the status of Insured Parties from the first or fifteenth day of the month following the date of receipt of the individual membership form. The effective date of coverage is indicated on the membership certificate.

On the date they join the category of insured person to be insured, as mentioned on the certificate of insurance.

Cover in favour of Beneficiaries of the Member defined in section 3 starts at the same time as those in favour of the principal Insured Party or, later, when the parties concerned fulfil the required conditions.

14.2 Territorial application scope of the cover
Medical expenses must have been incurred during the insurance period in one of the following territorial areas of coverage for which the Insureds defined in the policy are covered, either :

- **Zone 4 : China, Hong Kong, Taiwan + Zones 3, 2, 1**
- **Zone 3 : Brazil, Singapore, Russia + Zones 2, 1,**
- **Zone 2 : Albania, Angola, Andorra, Germany, Argentina, Australia, Austria, Azerbaijan, Bahrain, Barbados, Belgium, Belarus, Bolivia, Bosnia and Herzegovina, Bulgaria, Cambodia, Canada, Chile, Cyprus, Colombia, South Korea, South Korea South, Costa Rica, Croatia, Denmark, Djibouti, Ecuador, Spain, Estonia, Faroe Islands, Finland, France, Georgia, Gibraltar, Greece, Guatemala, Hungary, Indonesia, Ireland, Iceland, Israel, Italy, Japan, Kazakhstan , Kuwait, Latvia, Lebanon, Liechtenstein, Lithuania, Luxembourg, Macedonia, Malaysia, Malta, Morocco, Mexico, Moldova, Monaco, Montenegro, Mozambique, Norway, New Zealand, Nigeria, Oman, Panama, Netherlands, Peru, Poland , Polynesia, Portugal, Qatar, Dominican Republic, Czech Republic, Romania, St. Barthelemy, St. Martin, St. Peter and Miquelon, Serbia, Slovakia, Slovenia, Sweden, Thailand, Turkey, Ukraine, Uruguay, Vanuatu, Vatican, Venezuela, Vietnam and Wallis and Futuna + Zone 1**
- **Zone 1: Worldwide out of country zones 2 to 4**

Nevertheless, during a trip of less than 7 weeks outside the area of coverage, only the costs resulting from an Accident or an Emergency illness are reimbursed, provided the treatment was practised by a general or specialised practitioner or the hospitalisation was a necessity owing to the emergency and took place within twenty-four (24) hours.

In all other cases, express approval by the Insurer is necessary.

The coverage area is specified on the membership certificate.

The countries of residence excluded from coverage are: Bahamas, United Arab Emirates, United States of America, Switzerland, United Kingdom.

15 – Cessation or suspension of cover

15.1 Except in the event of a deliberate reticence, omission or false or inaccurate declaration, once accepted the Insured Party may not be excluded from the Insurance against his/her wishes provided he/she is part of the category of person to be insured under the policy, subject to application of the provisions of article L.141-3 of the French Insurance Code.

In any event, cover ceases:

15.1.1 Pour chaque Adhérent :
- **At the initiative of the Member in the event of annual cancellation of its membership. To do this, the member must inform the Insurer, through the Policyholder, by letter sent by registered mail within 2 months of the renewal date,**
- **As soon as the Insured member ceases to belong to the category of insured persons to which the policy applies, subject to providing written evidence,**
- **In the event of non-payment of premiums, in accordance with the provisions of the French Insurance Code,**
- **In the event of a false declaration in accordance with article 6.**
- **On the date on which the Member ceases to be a member of the Policyholder,**
- **In the event of the death of the Insured member, except in case of Membership application of the deceased Insured's Dependents, on the required conditions in article 16,**
- **At the due date of the insurance year of his 70th birthday**

15.1.2 For all Insured belonging at the category of individuals on international mobility, aforesaid:
- **on the effective termination date of the policy which is the purpose of this Insurance leaflet, by the Policyholder or by the Insurer.**

15.2 The cover in favour of the Beneficiaries cease (or are suspended) on the date they no longer meet one of the conditions stipulated below, and at the same time as those of the Insured Party.

The cessation (or suspension) of cover, both for the Insured Party and his/her Beneficiaries, results in the termination of entitlement to services for all procedures and treatments which have occurred since the cessation date

Section 3 – Cover and Benefits

16 – Beneficiaries of cover

The healthcare expenses cover described in the policy which is the object of this Insurance leaflet applies to:

16.1 either the Member only, defined in article 1.

16.2 either the Member and members of his / her family (Beneficiaries), on the date of the event giving rise to coverage:

In this case, the following may be included on the policy:

2.1 The spouse of the insured

- The spouse of the principal Insured not legally separated, or
- fail him/her, the civil union partner (when having registered a PACS or any equivalent civil union partnership)
- The declared common law partner, cohabiting with the Covered Person and who fulfil together the two following conditions:
  - they are both free from matrimonial ties,
  - the cohabitation with the common law partner has been declared by the Insured at the time of enrolment, with production of a certificate legally recognized by a competent authority in his/her Country or a common proof of residence or a statement issued on honour. The cessation of cohabitation must be declared by the Insured.

Only one person shall be considered as a partner/spouse. In the event of divorce or legal separation, termination of partnership or cohabitation, the TPA must be notified in writing by the Insured.

2.2 Children of the Insured :

- The children neither married, nor civil partners of the Insured and / or his Spouse, who live under the same roof of the Insured and who are:
- aged under 18 or
- whatever their age : if they hold an invalidity or disability card issued by the competent local authorities (proof of the disability and its persistence must be provided), or
- or if they fulfill the following conditions:
  - be under 24 years old,
  - not be employees or do not benefit from own resources because of their work (except, if they are students, in case of casual employment for less than three months).

For children who are students, a school certificate is required for any new enrolment and at the start of each subsequent academic year.
If the Insured does not fall under the French tax system, the status of Dependent children defined above is assessed using the criteria of the French tax legislation.

To be considered Insured Parties, the Beneficiaries must be named on the membership certificate. The coverage shall be terminated for the beneficiaries as soon as they no longer fulfil the afore defined conditions and, in any case, at the same date as for the Insured Person. Any change of Insured's situation should be brought to the attention of MSH International.

The Insured must declare his removal. In case of residence in an excluded country, membership ends on the 1st or 15th of the following date (or following the date of receipt of the application).

The benefits are payable for medical care and hospitalisation occurring within the period during which the beneficiary belongs to the above category.

As a result of the death of the Primary Insured Member, the individual membership terminates and a refund of the current year's contribution is made on a pro rata basis if no claims have been repaid. The Insurer reserves the right to request an act of death before any refund of the contribution. Subject to meeting the eligibility conditions, the first Trustee indicated on the Certificate of Membership may apply to become the Primary Insured Member and include the other Trustees in the same individual membership.
If this request is received within 28 days of the death, the Insurer may not add any other specific restrictions or exclusions, in addition to the restrictions or exclusions already applicable prior to death.

17 – Benefits covered

17.1 Available options

The choice of the basic Health is made by the Member at the time of his/her enrolment, as follows:

- **Indigo Expat WeCare 80**
- **Indigo Expat WeCare 90**
- **Indigo Expat WeCare 100**

It can be modified later by this one, the date of effect of the change of formula being postponed to the following annual due date.

The choice of a superior formula is subject to acceptance by the Insurer of a new health questionnaire for the Insured and his / her beneficiaries, and to the application of waiting periods for maternity benefits.

Any change of the formula, once accepted by the Insurer, gives rise to the issue of a new membership certificate. In the case of group memberships

(Principal member, Spouse / Cohabitant / Partner and Minor Children), the choice of formula must be the same for each Member.

17.2 Type of cover

The cover consists in reimbursing healthcare expenses incurred by the Insured from the first euro and limited to the actual costs and reasonable and usual costs.

The treatment must be recognised by local medical authorities and provided by practitioners exercising within a field in which they are qualified (in line with legislative, regulatory and other requirements in respect of professional standards in the country concerned).

In the event of hospitalisation, costs in respect of the following shall be covered:

- Medical hospitalisation in a public or private establishment (except not appointed establishments in France)
- Hospitalisation and surgery. Procedures carried out under general anaesthesia or in relation to trauma surgery and surgical procedures carried out under local anaesthesia are deemed to be surgical procedures,
- Related medical and paramedical costs provided in the context of hospitalisation,
- Transportation of the patient by ambulance.

Emergency local transportation by ambulance is covered, within the same country, in the event of hospitalization, between the patient's home or the site of the Accident and the closest hospital in the same country. It is also covered if the patient's condition requires his/her subsequent transfer from the first establishment to another closer establishment.

For any hospitalisation, the prior approval of the Insurer is required, except in case of emergency as defined in Section 6 of this information leaflet.

In other cases, cover is detailed in the table of benefits set out in annex of this summary of benefits.

17.3 Table of benefits

The Insured are guaranteed to be covered for all the corresponding benefits mentioned in the table of benefits. They will not be covered for benefits that are not mentioned in the table.

The benefits and benefits ceiling mentioned in the table of benefits are expressed in actual costs, by Insured and by calendar year. Refunds for medical expenses are made in in the currency chosen by the Insured up to the maximum indicated in the attached Table of Benefits.

Actual costs: the reasonable and usual cost is assessed according to the rates currently charged by institutions and practitioners, medical practice prevailing in the country where medical care is provided (type of treatment, quality of care and equipment, geographical area and countries). It is subject to coding and pricing standards for referenced acts and treatments in each country.

The unreasonable and unusual nature of the costs incurred may result to a refusal to pay medical expenses or a limitation of the reimbursement (deduct the amount paid in proportion to the rates usually and reasonably charged).

Maximum amounts :

Two maximum annual amounts are indicated in the attached table of benefits :

the maximum annual reimbursement of the Plan, is the maximum amount paid for all benefits, per Insured, per calendar year, and under this insurance plan and under each available option.

Some benefits also have their own maximum annual reimbursement, which can be applied either "per calendar year", "for the duration of coverage of the Insured" or "per event" (travel, per session or pregnancy).

The Insurer, through the TPA, may pay a percentage of the costs for some benefits, for example "65% of actual costs, up to € 5,000". Where the maximum limit applies or where the term "100% of actual costs" is indicated for some benefits, the refund will be subject to the overall limit of the formula, if the latter has one.

17.4 Declaration of medical costs

The declaration form is sent to MSH International accompanied by the supporting documents requested.

The declaration form is accompanied by the supporting documents requested by the Insurer.

No copies, photocopies or duplicates of invoices will be accepted. By way of exception, scanned copies sent by email are permitted for any invoice for an amount less **than €500 per invoice**, provided that the Insured retains the originals.

In this case, the Insured must retain the originals for 24 months from the date of treatment. During this period, the Insurer may ask to receive the originals, failing which the reimbursement paid may be challenged.

To be reimbursed, the Insured person commits to send :

- In case of hospitalization: relevant receipt of the hospitalization (invoices paid, fee notes, hospitalization slip) indicating the name of the establishment and the patient, the date of care and the cost of care,
- In case of illness: detailed invoice, prescriptions
- In case of home birth: a copy of the birth certificate of the child.
- pour le règlement des soins : l'Assuré doit transmettre un relevé d'identité bancaire (soit lors de son adhésion soit à la 1ère demande de remboursement).

Any other receipt to complete the file may be requested.

The Insurer, via MSH International, reserves the right to ask any Insured or his /her dependents that they provide with all the necessary information for the processing of their personal data and claims. To do this, the Insurer can access their medical files with all the legal obligations of confidentiality attached to them.

ANY INFORMATION SUPPLIED BY AN INSURED WHICH PROVES TO BE ERRONEOUS, FALSIFIED OR EXAGGERATED OR ANY FRAUDULENT ACTIONS OR DELIBERATE MISCONDUCT BY AN INSURED SHALL INCUR THE DIRECT LIABILITY OF THE LATTER AND REPAYMENT OF THE SUMS UNDULY PAID BY THE INSURER BASED ON THIS INCORRECT DATA.

Any adherent who does not respond to requests for complementary parts and / or that does not return the fully filled management forms will see his suspended application, except the exceptional agreement of the insurer.

18 - Prior agreement

The reimbursement of expenses is subject to the prior approval of the Insurer except in the event of a clear Emergency (see. Definitions), for all the benefits mentioned in the attached table of benefits with an asterisk (1) or (2).

Unless in case of an Emergency, each admission to a Hospital must be notified to the Insurer according to the Table of benefits and at least 15 days prior to the effective admission. The approval of the Insurer shall be communicated within five (5) working days of receipt of the request.
The agreement is deemed to be obtained if it has not been responded within five (5) days from the date of receipt of the application.

In the absence of a request for prior agreement, hospitalization or any other treatment for which this agreement is necessary, the Insurer reserves the right to refuse the request for reimbursement.

If thereafter the treatment proves medically justified, the TPA reimburses **80% of hospital expenses and 50% of the amount due for any other similar services that should have been reimbursed.**

Prior agreement is not required in the event of an emergency as defined in this Insurance leaflet. Nevertheless, the Insurer should be advised within 48 hours, or as soon as possible in the event of force majeure as defined by jurisprudence. Provisions relating to reasonable and customary costs in countries where the care is provided apply under all circumstances.

19 – Limitation to actual costs

In accordance with article 9 of law no. 89-1009 of 31 December 1989 and decree no. 90-769 of 30 August 1990, reimbursement or compensation of costs incurred for an illness, childbirth or an accident may not exceed the costs remaining payable by the Insured Party following all types of reimbursement to which he/she is entitled.

Cover of the same kind taken out with several insurers shall be effective within the limit of each cover, irrespective of the date they were taken out. In this limit, the beneficiary of the Agreement may obtain additional payment by sending details of the reimbursements made by the other organization(s).

For application of the arrangements, the limitation of expenses for which the Insured is still liable is determined by the Insurer for each of the treatments or expense items.

L'Assureur réserve la possibilité de demander la justification des frais, et peut aussi demander communication des règlements effectués au même titre par application de tout autre régime de complémentaire santé ou contrat d'assurance dont bénéficieraient les intéressés.

In case of undue payments: the beneficiary of the benefit commits to repay to the Insurer, as soon as possible, the undue claims. Therefore, the Insurer can make compensation between these amounts and any other benefits due by the Insurer to the Insured.

Section 4 – Excluded risks and benefits

20 – Excluded risks

The costs incurred are not paid by the insurer if they follow the following facts:

- **A DISEASE OR ACCIDENT WHICH IS THE VOLUNTARY FACT OF THE INSURED, VOLUNTARY MUTILATION OR A SUICIDE ATTEMPT,**
- **THE CONSEQUENCES OF A CIVIL OR NON-CIVIL WAR, AN INSURRECTION, A RIOT, AN ATTACK, A COMMOTION OR ACTS OF TERRORISM, WHATEVER THE PLACE OF THESE EVENTS AND THEIR PROTAGONISTS, EXCEPT IF THE COVERED PERSON DOES NOT TAKE AN ACTIVE PART IN SUCH EVENT**
- **ANY INTENTIONAL ACTION WHICH MAY ENTAIL THE BENEFIT OF THE POLICY AND ANY CONSEQUENCE OF A CRIMINAL PROCEEDING WHICH THE INSURED PERSON IS THE SUBJECT,**

A CLAIM ARISING DIRECTLY OR INDIRECTLY FROM THE DECAY OF AN ATOMIC NUCLEUS,

The Insurer reserves the possibility of modifying the coverage for one or several specific territories, subject to a fifteen days prior notice sent to the Policyholder Association. The latter may refuse this modification and terminate its contract by sending the Insurer a registered letter with acknowledgment of receipt within thirty days from the date of receipt of the Amendment sent by the Insurer. The termination takes effect on the first day of the calendar quarter following the notification of refusal. The Policyholder Association must warn the Member of the termination.

21 – Excluded Benefits

Are not covered by the Contract, except if the Benefits are indicated in the Table of Benefits:

Acquisition of an organ
Expenses for the acquisition of an organ including, but not limited to, donor search, typing, harvesting, transport and administration costs.

Behavioural and personality disorders
Treatment for conditions such as conduct disorder, attention deficit hyperactivity disorder, autism spectrum disorder, oppositional defiant disorder, antisocial behaviour, obsessive-compulsive disorder, phobic disorders, attachment disorders, adjustment disorders, eating disorders, personality disorders or treatments that encourage positive social-emotional relationships, such as family therapy, unless indicated otherwise in the Table of Benefits.

***Complementary treatment* with the exception of those treatments indicated in the Table of Benefits.**

***Complications caused by conditions not covered under your plan*: expenses incurred because of complications directly caused by an illness, injury or treatment for which cover is excluded or limited under your plan.**

***Consultations performed by you or a family member*: as well as any drugs or treatments prescribed, by you, your spouse, parents or children.**

Dental veneers and related procedures, unless medically necessary.

***Developmental delay*: unless a child has not attained developmental milestones expected for a child of that age, in cognitive or physical development. We do not cover conditions in which a child is slightly or temporarily lagging in development. The developmental delay must have been quantitatively measured by qualified personnel and documented as a 12-month delay in cognitive and/or physical development.**

***Drug addiction or alcoholism: c*are and/or treatment of drug addiction or alcoholism (including detoxification programmes and treatments related to the cessation of smoking), instances of death, or the treatment of any condition that in our reasonable opinion is related to, or a direct consequence of, alcoholism or addiction (e.g. organ failure or dementia).**

Experimental or unproven treatment or drug therapy: any form of treatment or drug therapy which in our reasonable opinion is experimental or unproven, based on generally accepted medical practice, unless the Insurer has given its specific consent.

Costs related to complications directly caused by an illness or injury that is not covered or partially covered, according to the terms and conditions of your insurance policy; the costs of complications directly caused by an illness or injury that is not covered, or is partially covered by the terms of this information leaflet.

Chemical contamination and radioactivity
Treatment for any medical conditions arising directly or indirectly from chemical contamination, radioactivity or any nuclear material whatsoever, including the combustion of nuclear fuel.

Failure to seek or follow medical advice : treatment required as a result of failure to seek or follow medical advice.

Family therapy and counselling: costs in respect of a family therapist or counsellor for out-patient psychotherapy treatment.

Fees for the completion of a Claim Form: medical practitioner fees for the completion of a Claim Form or other administration charges.

***Medical error:* treatment required as a result of medical error.**

***Intentionally caused diseases or self-inflicted injuries: c*are and/or treatment of intentionally caused diseases or self-inflicted injuries, including a suicide attempt.**

Speech therapy related to developmental delay, dyslexia, dyspraxia or expressive language disorder.

Participation in war or criminal acts
Treatment for any illnesses, diseases or injuries, as well as instances of death resulting from active participation in war, riots, civil disturbances, terrorism, criminal acts, illegal acts or acts against any foreign hostility, whether war has been declared or not.

Plastic surgery: any treatment carried out by a plastic surgeon, whether or not for medical/psychological purposes and any cosmetic or aesthetic treatment to enhance your appearance, even when medically prescribed. The only exception is reconstructive surgery necessary to restore function or appearance after a disfiguring accident, or as a result of surgery for cancer, if the accident or surgery occurs during your membership.

Loss of hair and hair replacement: investigations into, and treatment of, loss of hair and any hair replacement unless the loss of hair is due to cancer treatment.

Pre- and post-natal classes.

***Pre-existing conditions (including any pre-existing chronic conditions)* which are indicated on a Special Conditions Form that is issued prior to policy inception (if relevant) and conditions**

which have not been declared on the relevant application form. In addition, conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered.

Products sold without prescriptions: **products that can be purchased without a doctor's prescription, except where a specific benefit covering these costs appears in the Table of Benefits.**

Stays in a cure centre, **bath centre, spa, health resort and recovery centre, even if the stay is medically prescribed.**

Sterilisation, sexual dysfunction and contraception: **investigations into, treatment of and complications arising from sterilisation, sexual dysfunction (unless this condition is as a result of total prostatectomy following surgery for cancer) and contraception including the insertion and removal of contraceptive devices and all other contraceptives, even if prescribed for medical reasons. The only exception in relation to costs for contraception is where contraceptives are prescribed by a dermatologist for the treatment of acne.**

Surrogacy: **treatment directly related to surrogacy whether you are acting as surrogate, or are the intended parent.**

Treatment in the USA **if we know or suspect that cover was acquired for the purpose of travelling to the USA to receive treatment for a condition, when the symptoms of the condition were apparent to the insured person prior to acquiring cover. If any claims have been paid by us in these circumstances, we reserve the right to seek reimbursement from the insured person of any amounts which have already been paid in claims.**

Treatment outside the geographical area of cover **unless for emergencies or authorised by us, unless it is an emergency, or we have authorized treatment.**

Travel costs to and from medical facilities **(including parking costs) for eligible treatment, except any travel costs covered under local ambulance, medical evacuation and medical repatriation benefits.**

Triple/Bart's, Quadruple or Spina Bifida tests, except for women aged 35 or over.

Tumour marker testing, unless you have previously been diagnosed with the specific cancer in question, in which case, cover will be provided under the Oncology benefit.

Vessel at sea: medical evacuation/repatriation from a vessel at sea to a medical facility on land.

Genetic testing, except: where specific genetic tests are included a) within your plan; where DNA tests are directly linked to an eligible amniocentesis i.e. in the case of women aged 35 or over; testing for genetic receptor of tumours, which is covered.

Home visits **unless they are necessary following the sudden onset of an acute illness, which renders the insured incapable of visiting their medical practitioner, physician or therapist.**

Infertility **treatment including medically assisted reproduction or any adverse consequences thereof, unless you have a specific benefit for infertility treatment, or have selected an Out-patient Plan (whereby you are covered for non-invasive investigations into the cause of infertility within the limits of your Out-patient Plan).**

Obesity treatment
Investigations into, and treatment of obesity.

Orthomolecular treatment
For the orthomolecular treatment, please refer to Orthomolecular definition.

Injuries caused by professional sports: treatment or diagnostic procedures for injuries arising from an engagement in professional sports.

Treatments not indicated in your Table of Benefits
The following treatments, expenses, procedures or any adverse consequences or complications relating to them, unless otherwise indicated in your Table of Benefits:

- **Complications of pregnancy.**
- **Dental treatment, dental surgery, periodontics, orthodontics and dental prostheses with the exception of oral and maxillofacial surgical procedures, which are covered within the overall limit of your Core Plan.**
- **Dietician / nutritionists fees**
- **Emergency dental treatment.**
- **Expenses for one person accompanying an evacuated/repatriated person.**
- **Health and wellbeing checks including screening for the early detection of illness or disease.**
- **Home delivery.**
- **Infertility treatment.**
- **In-patient psychiatry and psychotherapy treatment.**
- **Laser eye treatment.**
- **Medical repatriation.**
- **Organ transplant.**
- **Out-patient psychiatry and psychotherapy treatment.**
- **Out-patient treatment.**
- **Paramedical treatments**
- **Prescribed glasses and contact lenses including eye examination.**
- **Prescribed medical aids.**
- **Preventive treatment.**
- **Rehabilitation treatment.**

- **Routine maternity and complications of childbirth.**
- **Travel costs of insured family members in the event of an evacuation/repatriation.**
- **Travel costs of insured family members in the event of the repatriation of mortal remains.**
- **Travel costs of insured members to be with a family member who is at peril of death or who has died.**
- **Vaccinations.**

Sleep disorders: **treatment of sleep disorders, including insomnia, obstructive sleep apnoea, narcolepsy, snoring and bruxism.**

Termination of pregnancy**, except in the event of danger to the life of the pregnant woman.**

Vitamins or minerals : **products classified as vitamins or minerals (except during pregnancy or to treat diagnosed,**
clinically significant vitamin deficiency syndromes) and supplements such as special infant formula and cosmetic products, even if medically recommended, prescribed or acknowledged as having therapeutic effects. Costs incurred as a result of nutritional or dietary consultations are not covered, unless a specific benefit is included within your Table of Benefits;

In general, and except for dental prostheses or contact lenses, reference is made to the rules for accepting claims from the French Social Security.

No claims will be paid, directly or indirectly, in contravention of any restrictions imposed for example by the United Nations, the Office of Foreign Assets Control from the U.S. Department of the Treasury or the European Union, in respect of countries subject to sanctions.

Sumptuary, unreasonable and unusual nature of the costs incurred may result to a refusal to pay medical expenses or a limitation of the reimbursement (deduct the amount paid in proportion to the rates usually and reasonably charged).

Section 5 – Premiums

22 – Calculation and payment of premiums

22.1 Premium calculation

Premiums for each insurance year are calculated based on the age of each affiliate members at the date of affiliation and then at the renewal date of membership, formula and coverage area.

The newborn child (with the exception of multiple births and adopted children placed in foster care) is automatically covered from birth without medical formality and provided that the Insurer is informed within four weeks of the date of birth and that one of the biological parents or foster parents has been covered by the Insurer for at least six consecutive months. The continuation of this coverage is then subject to membership and payment of the membership premium.

In order to add a newborn, the Member makes a request to MSH International accompanied by a photocopy of the birth certificate.

22.2 Payment of the premiums by the Insured member

Premiums are paid by the Insured in advance in euros (€) to MSH International, to whom the Association has delegated the collection and collection of contributions, by direct debit, transfer, or bank card on the internet. The amount of the contribution is indicated according to the procedure defined in the membership form.

22.2 Non-payment of the premiums

In the event of non-payment of the premium or a fraction of the premium, a registered letter shall be sent to the Member of the policy at least thirty (30) days after the renewal date, a letter of formal notice is sent, informing him/her that at the end of a period of forty-five (45) days after the date of the later, non-payment of the premium shall result in cancellation of the policy which is the object of this Insurance leaflet, without further notice
The Insurer may terminate the Policy after ten (10) days after this period.

22.3 Revision

Annual revision and indexation of premiums
Premium rates may be amended at each annual renewal date based on changes in demographics, regulations, parameters used by the French social security, examination of health questionnaires and the policy's results. The new contribution amounts apply on the renewal date of the membership.

If a new pricing is established by the Insurer, it shall be sent to the Policyholder Association four (4) months before the planned renewal date. **The Policyholder Association must inform the Insured member three (3) months before this pricing comes into force.**

In the event of disagreement, **the Insured member** may ask for its membership certificate to be cancelled by sending a letter sent by registered mail **within two (2) months from notification by the Policyholder Association.** Cancellation shall be effective from the first day of the month following receipt of the letter sent by registered mail by the Insurer

Section 6 – Definitions

The terms and expressions used in this Insurance leaflet have the following meanings:

Accident: Accident: all bodily harm not intentionally caused by the Member and/or his/her Spouse and that was caused exclusively and directly by the sudden and unforeseeable effect of an external

cause. The cause and symptoms of the injury must be medically and objectively definable, be subject to diagnosis and require therapy.

Prescribed ancillary nursing care refers to services medically prescribed and carried out by a qualified nurse at home or in an appropriate medical centre on an Out-patient basis. This includes but is not limited to, acts such as dressing changes or insulin injections. Only acts that are deemed to be medically necessary will be covered.

Acquisition of an organ: expenses for the acquisition of an organ including, but not limited to, donor search, typing, harvesting, transport and administration costs.

Insured person: is you and your dependants as stated on your Insurance Certificate.

Acute: refers to sudden onset.

Diagnostic tests are investigations such as x-rays or blood tests, undertaken in order to determine the cause of the presented symptoms.

Family history: when exists where a parent, grandparent, sibling, child, aunt or uncle has been previously diagnosed with the medical condition in question.

Direct family history: when exists where a parent, grandparent, sibling or child has been previously diagnosed with the medical condition in question.

Surgical appliances and materials are those which are required for the surgical procedure. These include artificial body parts or devices such as joint replacement materials, bone screws and plates, valve replacement appliances, endovascular stents, implantable defibrillators and pacemakers.

Dependant is your spouse or partner (including same sex partner) and/or unmarried children (including any step, fostered or adopted children) financially dependent on the policyholder up to the day before their 18th birthday; or up to the day before their 24th birthday if in full time education, and also named in your Insurance Certificate as one of your dependants.

Medical auxiliaries: nurses, caregivers and other state-certified medical staff.

Insurer: MFPrévoyance, Société Anonyme with a Management Board and Supervisory Board with capital of € 81,773,850, governed by the Insurance Code, RCS 507 648 053, 4 Place Raoul Dautry, 75716 Paris Cedex 15, France.

Beneficiary: the insured person to whom the benefits paid by the Insurer in respect of this policy are due in the event of occurrence of the risk.

Health and wellbeing checks including screening for the early detection of illness or disease are health checks, tests and examination, performed at an appropriate age interval, that are undertaken without any clinical symptoms being present. Checks are limited to:

- Physical examination.
- Blood tests (full blood count, biochemistry, lipid profile, thyroid function test, liver function test, kidney function test).
- Cardiovascular examination (physical examination, electrocardiogram, blood pressure).
- Neurological examination
- Cancer screening:

Insurance Certificate is a document outlining the details of your cover and is issued by us. It confirms that an insurance relationship exists between you and us.

Hospital accommodation refers to standard private or semiprivate accommodation as indicated in the Table of Benefits. Deluxe, executive rooms and suites are not covered. Please note that the hospital accommodation benefit only applies where no other benefit included in your plan covers the required in-patient treatment. In this case, hospital accommodation costs will be covered under the more specific in-patient benefit, up to the benefit limit stated. Psychiatry and psychotherapy, organ transplant, oncology, routine maternity, palliative care and long term care are examples of in-patient benefits which include cover for hospital accommodation costs, up to the benefit limit stated, where included in your plan.

Out-patient surgery is a surgical procedure performed in a surgery, hospital, day-care facility or out-patient department that does not require the patient to stay overnight out of medical necessity.

Dental Surgery: dental surgery includes the surgical extraction of teeth, as well as other tooth related surgical procedures such as apicoectomy and dental prescription drugs. All investigative procedures necessary to establish the need for dental surgery such as laboratory tests, X-rays, CT scans and MRI(s) are included under this benefit. Dental surgery does not cover any surgical treatment that is related to dental implants.

Complications of childbirth refer only to the following conditions that arise during childbirth and that require a recognised obstetric procedure: post-partum haemorrhage and retained placental membrane. Complications of childbirth are only payable where your cover also includes a routine maternity benefit. Where your cover includes a routine maternity benefit, complications of childbirth shall also refer to medically necessary caesarean sections.

Oral and maxillofacial surgical procedures refer to surgical treatment performed by an oral and

maxillofacial surgeon in a hospital as a treatment for: oral pathology, temporomandibular joint disorders, facial bone fractures, congenital jaw deformities, salivary gland diseases and tumours. Please note that surgical removal of impacted teeth, the surgical removal of cysts and orthognathic surgeries for the correction of malocclusion, even if performed by an oral and maxillofacial surgeon, are not covered unless a Dental Plan has also been selected.

Preventative surgery refers to prophylactic mastectomy or prophylactic oophorectomy. We will pay for preventative surgery when an insured person:
• Has a direct family history of a disease which is part of a hereditary cancer syndrome, for example, breast cancer or ovarian cancer, and
• Genetic testing has established the presence of a hereditary cancer syndrome.

Contraception: use of agents, contraceptives, methods or procedures to reduce the likelihood of conception or avoid it.

Complications of childbirth refer only to the following conditions that arise during childbirth and that require a recognised obstetric procedure: post-partum haemorrhage and retained placental membrane. Complications of childbirth are only payable where your cover also includes a routine maternity benefit. Where your cover includes a routine maternity benefit, complications of childbirth shall also refer to medically necessary caesarean sections.

Complications of pregnancy relate to the health of the mother. Only the following complications that arise during the pre-natal stages of pregnancy are covered: ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, threatened miscarriage, stillbirth and hydatidiform mole.

Laser eye treatment refers to the surgical improvement of the refractive quality of the cornea using laser technology, including necessary pre-operative investigations.

Waiting period: is a period of time commencing on your policy start date (or effective date if you are a dependant), during which you are not entitled to cover for particular benefits.

Dietician fees relate to charges for dietary or nutritional advice provided by a health professional who is registered and qualified to practice in the country where the treatment is received. If included in your plan, cover is only provided in respect of eligible diagnosed medical conditions.

Prescribed medical aids refers to any device which is prescribed and medically necessary to enable the insured person to function to a capacity consistent with everyday living where reasonably possible. This includes:
• Biochemical aids such as insulin pumps, glucose meters
and peritoneal dialysis machines.
• Motion aids such as crutches, wheelchairs, orthopaedic supports/braces, artificial limbs and prostheses.
• Hearing and speaking aids such as an electronic larynx.
• Medically graduated compression stockings.
• Long term wound aids such as dressings and stoma supplies.
Costs for medical aids that form part of palliative care or long term care (see palliative care and long term care definitions) are not covered.

Occupational therapy refers to treatment that addresses the individual's development of fine and gross motor skills, sensory integration, coordination, balance and other skills such as dressing, eating, grooming, etc. in order to aid daily living and improve interactions with the physical and social world. A progress report is required after 20 sessions.

Expatriate on international mobility: a natural person temporarily residing outside his country of origin.

Costs incurred for a parent accompanying a child insured at the hospital: hospital accommodation costs of a parent during the entire period of hospitalization of a child insured for treatment covered by the policy. If a hospital bed is not available, the Insurer will pay the equivalent of a room in a three-star hotel. Miscellaneous expenses such as meals, phone calls or newspapers are not covered. The age limit applied is indicated in the table of Benefits.

Delivery costs: medical expenses (including double room) incurred for vaginal delivery. Any complication, including cesarean section if medically necessary, will be covered by the "Complications of Pregnancy and Childbirth" benefits.

Organ transplant is the surgical procedure in performing the following organ and/or tissue transplants: heart, heart/valve, heart/lung, small intestine, liver, pancreas, pancreas/kidney, kidney, bone marrow, parathyroid, skin/muscular/skeletal and cornea transplants. Expenses incurred in the acquisition of organs are not reimbursable.

Pregnancy refers to the period of time, from the date of first diagnosis, until delivery.

Midwife fees refer to fees charged by a midwife or birth assistant, who, according to the law of the country in which treatment is given, has fulfilled the necessary training and passed the necessary state examinations.

Hospital is any establishment which is licensed as a medical or surgical hospital in the country where it operates and where the patient is permanently supervised by a medical practitioner. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.

Day-care treatment is planned treatment received in a hospital or day-care facility during the day, including a hospital room and nursing, that does not medically require the patient to stay overnight and where a discharge note is issued.

Emergency hospitalization: in case of emergency hospitalization, the insurer reimburse the medical expenses in accordance with the corresponding table of Benefits and the contractual conditions. The Insurer has taken out a contract with a third party for assistance and repatriation which, according to the contractual provisions, will cover the costs of transport in case of emergency hospitalization.

Prescribed physiotherapy refers to treatment by a registered physiotherapist following referral by a medical practitioner. Physiotherapy is initially restricted to 12 sessions per condition, after which the treatment must be reviewed by the referring medical practitioner. Should further sessions be required, a new progress report must be submitted to us after every set of 12 sessions, which indicates the medical necessity for any further treatment. Physiotherapy does not include therapies such as Rolfing, Massage, Pilates, Fango and Milta therapy.

Prescribed glasses and contact lenses including eye examination refers to cover for a routine eye examination carried out by an optometrist or ophthalmologist (one per Insurance Year) and for lenses or glasses to correct vision.

Serious illness: Any illness that causes fear for life in the short or medium term, such as: cancer, AIDS, amyotrophic lateral sclerosis, multiple sclerosis, heart disease, neurological or respiratory severe, severe renal failure, diabetes with serious complications.

Unexpected illness: sudden illness that must not have a cause and effect relationship with the reason of illness or hospitalization prior to the date of departure on the move.

Maternity - Delivery: medically necessary expenses incurred during pregnancy and delivery including the benefit items indicated in the corresponding table of B. In case of caesarean delivery not justified by a medical necessity will be covered within the limit of the management of a "natural" delivery performed in the same hospital and within the limit of the corresponding benefits ceiling.

Doctor: Doctor authorized to practice medicine, in accordance with the laws of the country in which the care is administered, within the limits provided for by the license which has been granted to him.

Prescribed drugs refers to products prescribed by a physician for the treatment of a confirmed diagnosis or medical condition, or to compensate vital bodily substances including, but not limited to, insulin, hypodermic needles or syringes. The
prescribed drugs must be clinically proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country. Prescribed drugs do not legally have to be prescribed by a physician in order to be purchased in the country where the insured person is located; however, a prescription must be obtained for these costs to be considered
eligible.

Medical necessity refers to medical treatment, services or supplies that are determined to be medically necessary and appropriate. They must be:
a) Essential to identify or treat a patient's condition, illness or injury.
b) Consistent with the patient's symptoms, diagnosis or treatment of the underlying condition.
c) In accordance with generally accepted medical practice and professional standards of medical care in the medical community at the time. This does not apply to complementary treatment methods if they form part of your cover.
d) Required for reasons other than the comfort or convenience of the patient or his/her physician.
e) Proven and demonstrated to have medical value. This does not apply to complementary treatment methods if they form part of your cover.
f) Considered to be the most appropriate type and level of service or supply.
g) Provided at an appropriate facility, in an appropriate setting and at an appropriate level of care for the treatment of a patient's medical condition.
h) Provided only for an appropriate duration of time.
In this definition, the term "appropriate" means taking patient safety and cost effectiveness into consideration. When specifically applied to in-patient treatment, medically necessary also means that diagnosis cannot be made, or treatment cannot be safely and effectively provided on an outpatient basis.

Speech therapy: refers to treatment carried out by a qualified speech therapist to treat diagnosed physical impairments, including, but not limited to, nasal obstruction, neurogenic impairment (e.g. lingual paresis, brain injury) or articulation disorders involving the oral structure (e.g. cleft palate).

Orthoptics: Specific therapy to synchronize eye movement when there is a lack of coordination between the eye muscles.

Orthodontics is the use of devices to correct malocclusion and restore the teeth to proper alignment and function.

Orthomolecular treatment refers to treatment which aims to restore the optimum ecological environment for the body's cells by correcting deficiencies on the molecular level based diagnosis or medical condition or to compensate vital bodily substances. The prescription drugs must be clinically proven to be effective for the condition and recognised by the pharmaceutical regulator in a given country.

Orthodontic treatment is covered only in cases of medical necessity, and for this reason, at the point of claiming, we will ask you to submit supporting information to determine that
your treatment is medically necessary and therefore eligible for cover. The supporting information required (depending on your case) may include, but is not limited to, the following documents:
Medical report issued by the specialist, • stating the

diagnosis (type of malocclusion) and a description of the patient's symptoms caused by the orthodontic problem.
• Treatment plan indicating the estimated treatment duration, estimated cost and type/material of the appliance used.
• The payment arrangement agreed with the medical provider.
• Proof that payment has been made in respect of the orthodontic treatment.
• Photographs of both jaws clearly showing dentition prior to treatment.
• Clinical photographs of the jaws in central occlusion from frontal and lateral views.
• Orthopantomogram (panoramic x-ray).
• Profile x-ray (cephalometric x-ray).

Only cover orthodontic treatment where the standard metallic braces and/or standard removable appliances are used. Cosmetic appliances such as lingual braces and invisible aligners are covered up to the cost of metallic braces, subject to the "Orthodontic treatment and dental prostheses" benefit limit.

Periodontics refers to dental treatment related to gum disease.

Chronic condition is defined as a sickness, illness, disease or injury that either lasts longer than six months or requires medical attention (check-up or treatment) at least once a year.
It also has one or more of the following characteristics:
• Is recurrent in nature.
• Is without a known, generally recognised cure.
• Is not generally deemed to respond well to treatment.
• Requires palliative treatment.
• Requires prolonged supervision or monitoring.
• Leads to permanent disability.

Pre-existing conditions are medical conditions or any related conditions for which one or more symptoms have been displayed at some point during your lifetime, irrespective of whether any medical treatment or advice was sought. Any such condition or related condition about which you or your dependants could reasonably have been assumed to have known, will be deemed to be pre-existing. Pre-existing conditions which have not been declared on the relevant application form are not covered. Plus, conditions arising between completing the relevant application form and the start date of the policy will equally be deemed to be pre-existing. Such pre-existing conditions will also be subject to medical underwriting and if not disclosed, they will not be covered. Please refer to the "Notes" section of your Table of Benefits to confirm if pre-existing conditions are covered.

Country of origin: country for which the insured has a valid passport or country of residence of the insured.

Primary country of residence: The country in which you and your dependents (if any) live for more than six months of the year.

Dental prostheses: include crowns, inlays, on lays, adhesive reconstructions/restorations, bridges, dentures and implants as well as all necessary and ancillary treatment required.

Psychiatry and psychotherapy is the treatment of mental disorders carried out by a psychiatrist or clinical psychologist. The condition must be clinically significant and not related to bereavement, relationship or academic problems, acculturation difficulties or work pressure. All day-care or inpatient admissions must include prescription medication related to the condition. Psychotherapy treatment (on an inpatient or out-patient basis) is only covered where you or your dependants are initially diagnosed by a psychiatrist and referred to a clinical psychologist for further treatment. In addition, out-patient psychotherapy treatment (where covered) is initially restricted to 10 sessions per condition, after which treatment must be reviewed by the referring psychiatrist. Should further sessions be required, a progress report must be submitted to us, which indicates the medical necessity for any further treatment.

Treatment / care refers to a medical procedure needed to cure or relieve illness or injury.

Palliative care: refers to ongoing treatment aimed at alleviating the physical/psychological suffering associated with progressive, incurable illness and maintaining quality of life. It includes in-patient, day-care or out-patient treatment following the diagnosis that the condition is terminal, and treatment can no longer be expected to cure the condition.
We will also pay for physical care, psychological care as well as hospital or hospice accommodation, nursing care and prescription drugs.

Long-Term Care: refers to care over an extended period of time after the acute treatment has been completed, usually for a chronic condition or disability requiring periodic, intermittent or continuous care. Long term care can be provided at home, in the community, in a hospital or in a nursing home.

Dental care: includes the annual report, simple fillings related to caries, devitalisation's and prescription drugs for dental care.

Routine medical care: treatments performed by a doctor, therapist or specialist in his medical or surgical practice and which does not require the admission of the patient to a hospital.

Therapist: is a chiropractor, osteopath, Chinese herbalist, homeopath, acupuncturist, physiotherapist, speech therapist, occupational therapist or oculomotor therapist, who is qualified and licensed under the law of the country in which treatment is being given.

Infertility treatment: refers to treatment for the insured person including all invasive investigative procedures necessary to establish the cause for infertility such as hysterosalpingogram, laparoscopy or hysteroscopy. If your Table of Benefits does not

have a specific benefit for infertility treatment, cover is limited to non-invasive investigations into the cause of infertility, within the limits of your Out-patient Plan, (if selected) and this does not apply to members of the Channel Islands Plan, for whom investigation into infertility is excluded. If, however, there is a specific benefit for infertility treatment, the cost for infertility treatment will be covered for the insured member who receives the treatment, up to the limit indicated in the Table of Benefits. Any costs exceeding the benefit limit cannot be claimed under the cover of the spouse/partner (if included in the policy). In the case of InVitro Fertilisation (IVF), cover is limited to the amount specified in the Table of Benefits

Hospital treatment: treatment received in a hospital requiring the insured's medical care during the night.

Complementary treatment: refers to therapeutic and diagnostic treatment that exists outside the institutions where conventional Western medicine is taught. Refer to your Table of Benefits to confirm whether any of the following complementary treatment methods are covered: chiropractic treatment, osteopathy, Chinese herbal medicine, homeopathy, acupuncture and podiatry as practiced by approved therapists.

Preventive treatment refers to treatment that is undertaken without any clinical symptoms being present at the time of treatment. An example of such treatment is the removal of a pre-cancerous growth.

Local Ambulance: ambulance transport required for an emergency or out of medical necessity, to the nearest available and appropriate hospital or licensed medical facility.

Emergency in-patient dental treatment refers to acute emergency dental treatment due to a serious accident requiring hospitalisation. The treatment must be received within 24 hours of the emergency event. This benefit does not extend to follow-up dental treatment, dental surgery, dental prostheses, orthodontics or periodontics. If cover is provided for these benefits, it will be listed separately in the Table of Benefits.

Emergency: constitutes the onset of a sudden and unforeseen medical condition that requires urgent medical assistance. Only treatment commencing within 24 hours of the emergency event will be covered.

Vaccinations: refer to all basic immunisations and booster injections required under regulation of the country in which treatment is being given, any medically necessary travel vaccinations and malaria prophylaxis. The cost of consultation for administering the vaccine, as well as the cost of the drug, is covered.

Appendix 1: Table of Benefits Indigo Expat WeCare – First Euro (1st Euro)

Hospitalisation benefits	**Indigo Expat OnePack 80**	**Indigo Expat OnePack 90**	**Indigo Expat OnePack 100**
Maximum	1 500 000 €/year/member	1 500 000 €/year/member	1 500 000 €/year/member
In-patient benefits[1]- please refer to note 2 for more information on Treatment Guarantee			
Hospital accommodation – Private room [1]	maximum 300 € per day	maximum 350 € per day	maximum 400 € per day
Hospital accommodation – Semi private room [1]	Full refund	Full refund	Full refund
Intensive care[1]	Full refund	Full refund	Full refund
Prescription drugs and materials[1] (in-patient and day-care treatment only) (prescription drugs are those which legally can only be purchased when you have a doctor's prescription)	Full refund	Full refund	Full refund
Surgical fees, including anaesthesia and theatre charges[1]	Full refund	Full refund	Full refund
Physician and therapist fees[1] (in-patient and day-care treatment only)	Full refund	Full refund	Full refund
Surgical appliances and materials[1]	Full refund	Full refund	Full refund
Diagnostic tests[1] (in-patient and day-care treatment only)	Full refund	Full refund	Full refund
Organ transplant[1]	Full refund	Full refund	Full refund
Psychiatry and psychotherapy[1] (in-patient and day-care treatment only) (10 month waiting period applies)	€30 per day, max.30 days	€40 per day, max.30 days	€50 per day, max.30 days
Accommodation costs for one parent staying in hospital with an insured child under 18[1]	Full refund	Full refund	Full refund
Emergency in-patient dental treatment	Full refund	Full refund	Full refund
Other benefits - please refer to note 2 for more information on Treatment Guarantee			
Day-care treatment[2]	Full refund	Full refund	Full refund
Kidney dialysis[2]	Full refund	Full refund	Full refund
Out-patient surgery[2]	Full refund	Full refund	Full refund
Nursing at home or in a convalescent home[2] (immediately after or instead of hospitalisation)	maximum €2,500	maximum €2,500	maximum €2,500
Rehabilitation treatment[2] (in-patient, day-care and out-patient treatment; must commence within 14 days of discharge after the acute medical and/or surgical treatment ceases)	maximum €2,500	maximum €2,650	maximum €2,750
Local ambulance	Full refund	Full refund	Full refund
Emergency treatment outside area of cover (for trips of a maximum period of six weeks)	Full refund, max. 42 days	Full refund, max. 42 days	Full refund, max. 42 days
CT and MRI scans (in-patient and out-patient treatment)	Full refund	Full refund	Full refund
PET[2] and CT-PET[2] scans (in-patient and out-patient treatment)	Full refund	Full refund	Full refund
Oncology[2] (in-patient, day-care and out-patient treatment) - Purchase of a wig, prosthetic bra or other external prosthetic device for cosmetic purposes	Full refund €200, per lifetime	Full refund €200, per lifetime	Full refund €200, per lifetime
In-patient cash benefit (per night) (where treatment has been received free of charge)	€150, max. 25 nights	€150, max. 25 nights	€150, max. 25 nights
Emergency out-patient treatment (where these benefit amounts are reached, any additional costs may be reimbursed within the terms of any separate Out-patient Plan)	maximum €750	maximum €750	maximum €750
Emergency out-patient dental treatment (where these benefit amounts are reached, any additional costs may be reimbursed within the terms of any separate Dental Plan)	maximum €750	maximum €750	maximum €750
Palliative care[2]	Full refund	Full refund	Full refund
Long term care[2]	Full refund, max. 90 days per lifetime	Full refund, max. 90 days per lifetime	Full refund, max. 90 days per lifetime

Out-patient Plan Benefits	Indigo Expat OnePack 80	Indigo Expat OnePack 90	Indigo Expat OnePack 100
Maximum plan benefit	No limit	No limit	No limit
Out-patient benefits			
Medical practitioner fees and prescription drugs (Prescription drugs are those which legally can only be purchased when you have a doctor's prescription)	80% refund	90% refund	Full refund
Specialist fees	80% refund, max. €180 per visit	90% refund, max. €190 per visit	Full refund, max. €200 per visit
Diagnostic tests	80% refund	90% refund	Full refund
Vaccinations	80% refund	90% refund	Full refund
Chiropractic treatment, osteopathy, homeopathy, Chinese herbal medicine, acupuncture and podiatry (max. 12 sessions per condition for chiropractic treatment and max. 12 sessions per condition for osteopathic treatment, subject to the benefit limit)	80% refund, max. €350	90% refund, max. €360	Full refund, max. €375
Prescribed physiotherapy, speech therapy, oculomotor therapy and occupational therapy[2]	80% refund, max. 15 visits	90% refund, max. 18 visits	Full refund, max. 20 visits
Health and wellbeing checks including screening for the early detection of illness or disease. Checks are limited to: • Physical examination • Blood tests (full blood count, biochemistry, lipid profile, thyroid function test, liver function test, kidney function test) • Cardiovascular examination (physical examination, electrocardiogram, blood pressure) • Neurological examination (physical examination) • Cancer screening - Annual pap smear - Mammogram (every two years for women aged 45+, or earlier where a family history exists) - Prostate screening (yearly for men aged 50+, or earlier where a family history exists) - Colonoscopy (every five years for members aged 50+, or 40+ where a family history exists) - Annual faecal occult blood test • Bone densitometry (every five years for women aged 50+) • Well child test (for children up to the age of six years, up to a maximum of 15 visits per lifetime)	80% refund, max. €350	90% refund, max. €375	Full refund, max.€400
Infertility treatment (18 month waiting period applies)	80% refund, max. €1,500	90% refund, max. €1,500	Full refund, max. €1,500
Psychiatry and psychotherapy (18 month waiting period applies)	80% refund, max. 10 visits	90% refund, max. 10 visits	Full refund, max. 15 visits
Prescribed medical aids	80% refund, max. €1,000	90% refund, max €1,000	Full refund, max. €1,000
Prescribed glasses, contact lenses and laser eye treatment, including eye examination	80% refund, max. €475	90% refund, max. €500	Full refund, max. €535
Dental treatment	80 % refund, max. €2,750	80 % refund, max. €2,750	80 % refund, max. €2,750
Dental surgery			
Periodontics			
Orthodontic treatment and dental prostheses (10 month waiting period applies)	80 % refund, max. €1,500	80 % refund, max. €1,500	80 % refund, max. €1,500

Option: Maternity plan

The Indigo Expat Maternity Plan is optional. It is available to couples and families, i.e. a spouse/partner must also be insured under the policy if the Maternity Plan is selected.

Maternity Plan Benefits	**Indigo Expat OnePack 80**	**Indigo Expat OnePack 90**	**Indigo Expat OnePack 100**
Routine maternity[2] (in-patient and out-patient treatment) (10 month waiting period applies)	max. €6,500	max. €6,750	max. €6,950
Complications of pregnancy and childbirth[2] (10 month waiting period applies)	Full refund	Full refund	Full refund

Notes (precisions)**:**

(1) and (2) : certain treatments and costs require submission of a Treatment Guarantee Form in advance.
Following approval by MSH International, cover for these required treatments or costs can then be guaranteed. In the Table of Benefits, benefits which require pre-approval through submission of a Treatment Guarantee Form are indicated by either a 1 or a 2. If Treatment Guarantee is not obtained for the benefits listed with a 1, we reserve the right to decline a claim. If the respective treatment is subsequently proven to be medically necessary, we will pay only 80% of the eligible benefits. If Treatment Guarantee is not obtained for the benefits listed with a 2, we reserve the right to decline a claim. If the respective treatment is subsequently proven to be medically necessary, we will pay only 50% of the eligible benefits.

Note from the translator: Translation from an original document in French. In case of any discrepancies or misinterpretations resulting from the translation process, the original document in French will always prevail. The translator is not responsible for the contents of this document