Terms and Conditions 2026-2027

MyHealth International

Understanding your policy and benefits

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April International
INSURANCE MADE EASY

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Reimbursements from the insurer and from any other public or private body cannot be higher than the amount of expenses actually incurred. Double insurance operates within the limits of each type of cover regardless of the date of purchase. Within these limits You can claim reimbursement from the provider of your choice. YOU RISK TERMINATION OF THE PLAN IF YOU DO NOT DECLARE ANY DOUBLE INSURANCE ARRANGEMENTS. THIS OBLIGATION REMAINS IN FORCE DURING THE ENTIRE DURATION OF THE PLAN. The limiting of reimbursements to the amount of costs actually incurred is determined by the insurer for each service or treatment covered under the plan.

1. Plan definitions

The language used in insurance can be technical so, to help *You* better understand how your plan operates, *We* have provided *You* with definitions of the key terms used.
Whenever the following terms are written in italics and with a capital letter, they have the following meanings

1.1. Common definitions for all benefits:

A **ACCIDENT:** any bodily injury unintentionally sustained by the *Insured* as a result of a sudden and unexpected external event of accidental and unforeseeable nature, occurring during the period of cover. It is your responsibility to provide proof of the *Accident* and to demonstrate the direct causal link between the *Accident* and the expenses incurred.

C **CLAIM:** any event, *Illness* or *Accident* giving rise to cover under the policy while the policy is in force.

COUNTRY OF NATIONALITY: the country for which *You* hold a valid passport or any other official and valid identity document.

COUNTRY OF ORIGIN: the country in which the Insured was residing prior to departure, or their *Country of nationality*, different from the declared *Country of residence.*

COUNTRY OF RESIDENCE: the country in which *You* usually reside, different from your *Country of nationality*, as declared in your Application form.

COVER ZONE: the geographical area in which *You* are covered year-round, as stated on your *Membership Certificate.*

D **DEDUCTIBLE:** the amount that remains payable by *You* in the settlement of a *Claim*.

DEPENDANTS: the *Spouse* and *Dependent child(ren)* who are entitled to the benefits of the policy and are named on the *Membership Certificate*.

DEPENDENT CHILD: your child or your *Spouse's* child, unmarried and financially dependent, up to the age of 21. Children under the age of 28 who are in full-time education are also covered, even if they do not live at the family home, provided they remain within the same area of cover as *You.*

E **EFFECTIVE DATE:** the date on which the policy begins. It is stated on the *Membership Certificate*.

EXCLUDED COUNTRIES: due to events that may occur in certain countries or for regulatory reasons, cover for specific countries or regions is excluded. The full list of *Excluded Countries* is available on our website by clicking here, or upon request by calling +33 (0)1 73 02 93 93 or by email at info.expat@april-international.com. This list of *Excluded Countries* is subject to change.

EXCLUSIONS: items or circumstances not covered under the insurance policy. All insurance policies include *Exclusions* from cover.

F **FRENCH OVERSEAS DEPARTMENTS AND REGIONS:** Guadeloupe, French Guiana, Martinique, Réunion and Mayotte.

I **ILLNESS:** any alteration in the state of health confirmed by a competent *Medical authority*.

INSURANCE YEAR: period of twelve consecutive months starting on the *Effective date* of the plan.

INSURED: refers to the *Principal Insured* and any *Dependants* named on the *Membership Certificate*.

M **MEDICAL CONDITION:** deterioration of the health state or *Illness*.

MEDICAL AUTHORITY: any person holding a valid medical or surgical diploma who is authorised to practice in their specialist field in the country where *You* are staying.

MEDICAL MANAGEMENT: care requiring a medical consultation and/or prescription of medical tests and/or medical treatment.

MEMBER: an individual or legal entity who subscribes to the optional group insurance contract taken out by the contracting association and commits to the corresponding obligations, in particular the payment of *Premiums.* Their contact details are indicated on the *Membership Certificate*. The *Member* subscribes to the contract either for themselves or as the legal representative of an insured person or as the legal representative of the subscriber company.

MEMBERSHIP CERTIFICATE: document which *We* issue to the *Member* confirming their cover under the MyHealth International plan and specifying the *Insured*, the *Effective date* and the benefits and packages selected. The *Membership certificate* corresponds to the policy's specific terms and conditions.

P **PRE-EXISTING CONDITION:** any *Medical condition* or *Illness* that was diagnosed, treated, medically managed, or investigated through medical tests prior to the date of signature of your Application form (including your Health Questionnaire). A condition is considered pre-existing if *You* were aware of it or could reasonably have been expected to be aware of it, at the time of joining the policy.

PREMIUM: the amount paid by the *Member* in exchange for the cover provided by the insurer.

PRINCIPAL INSURED: the natural person admitted to the insurance and on whom the cover provided under the policy is based, referred to as "*You*" in this document**.**

S **SPOUSE:** the husband or wife of the *Principal Insured*, or their declared common-law partner.

SUDDEN ILLNESS: any deterioration in health certified by a competent *Medical Authority*, which occurs suddenly and is unforeseeable.

SYMPTOM: a functional, perceived or observable sign indicating the presence of a condition or *Illness* and allowing it to be identified.

U **US:** APRIL International Care France

1.2. Definitions specific to the Medical Expenses benefit:

A

ACTUAL COSTS: total amount of medical expenses charged to *You*.

C

CAISSE DES FRANÇAIS DE L'ÉTRANGER (CFE): a social protection body with which the *Insured* may be affiliated. Where *CFE* top-up health cover is selected, the benefits shall apply in accordance with the terms, conditions and limits set out in Appendix 10 – "Specific provisions applicable to *CFE* top-up cover", which supplements these Terms and Conditions.

COPAYMENT: a fixed percentage of the covered expenses that remains payable by *You* in the settlement of a *Claim*.

CONFIDENTIAL MEDICAL CERTIFICATE: medical questionnaire which must be completed by your doctor and returned to *Us* before *You* are admitted to hospital (or as soon as possible following an *Accident* or in case of *Medical emergency*) in order to obtain our *Pre-approval*. A penalty of 50% will be applied to your reimbursement if *You* do not follow this procedure.

M

MEDICAL EMERGENCY: any sudden and unforeseen deterioration in health that needs to be certified by a competent *Medical authority* and requires an immediate intervention of a doctor (within 48 hours), postponing of which could lead to serious health problems.

MEDICALLY NECESSARY: medical procedure, which is necessary for the diagnosis or treatment of an *Illness* or accidental bodily injury, based on generally accepted current medical practice. A service or supply will not be considered medically necessary if it is provided only as a convenience to the provider or *Insured member* and/or is not appropriate for *Insured member*'s diagnosed symptoms, and/or exceeds in scope, duration or intensity that level of care which is needed to provide appropriate diagnosis or treatment of an *Illness* or *Medical condition*.

P

PRE-APPROVAL: *Hospitalisation* and medical treatments or procedures costing more than €/US$2,000 are subject to our *Pre-approval* of our Medical Examiner. *You* will have to send Us an itemised estimate of costs and a form called "Pre-approval request" at the latest 5 days before starting the treatment. In the event of *Hospitalisation*, please ask your doctor to complete the form called "Confidential medical certificate". A penalty of 50% will be deducted from your reimbursement if this formality is not respected.

PRE-APPROVAL REQUEST: form to be completed by your doctor in order to obtain our *Pre-approval* before beginning any treatment or procedures

R

REASONABLE AND CUSTOMARY COSTS: medical expenses are considered to be reasonable and customary if they do not exceed the rates normally charged for an identical service or treatment in the location in which they are incurred.

Medical costs vary greatly depending on the country, and even between practitioners and facilities in the same area: some charge higher prices than others, but with the same quality of service. To avoid this type of abuse and using our in-depth knowledge of the local health systems, *We* have been compiling pricing databases for over 30 years. These databases are continually added to and are updated every year. If *We* consider a *Claim* to be inappropriate, *We* reserve the right to reduce the amount *We* will pay or refuse the *Claim*.

W

WAITING PERIOD: period during which no *Claims* will be paid. *The Waiting period* begins on the *Effective date* of the plan, as shown on the *Membership certificate*.

1.3 Definitions specific to the Repatriation Assistance benefit:

A

ACT OF TERRORISM OR SABOTAGE AND ATTACKS: any clandestine action with an ideological and/or political motive carried out by individuals or groups directed against persons or public or private entities in order to:

- Carry out a criminal action intended to harm the lives of others,
- Alarm the population and create an atmosphere of general insecurity,
- Disrupt public transport and the operation of businesses or institutions manufacturing or processing goods or providing services

ASSAULT: any unintentional *Bodily injury* to the *Insured*, resulting from the deliberate, sudden and brutal action of another person or group of persons

B

BAGAGES: the *Insured*'s travel bags and suitcases and the personal effects and items contained in them as well as any items which have been checked in with a carrier.

BODILY INJURY: injury causing a person physical harm.

F

FAMILY MEMBER: your *Spouse*, child, brother, sister, father, mother, parents-in-law, grandchildren, grandparents or your legal guardian residing in your *Country of nationality*.

FRIEND: any individual named by *You* or one of your dependents, residing in your *Country of nationality*.

FORCE MAJEURE: any unpredictable, overwhelming, external event.

M

MEDICAL TEAM: structure adapted to each individual case and defined by the liaison doctor of the Assistance provider.

S

STABILISATION: stabilisation of the state of health of a victim of an *Accident* or person suffering from an *Illness*.

1.4 Definitions specific to the Personal Liability benefit:

C

CONSEQUENTIAL DAMAGE: damage other than physical harm and *Material damage* that is the direct and immediate consequence of *Bodily injury* or *Material damage and consequential financial loss* covered under the plan.

I

INJURY: damage causing a person physical harm.

M

MATERIAL DAMAGE AND CONSEQUENTIAL FINANCIAL LOSS: damage causing harm to the structure or substance of the thing

and resulting from an insured event.

PERSONAL LIABILITY: legal obligation of all people to remedy damage they cause to others.

2. Who is eligible for the policy?

To be eligible under this policy, *You* must:

- reside outside of your *Country of nationality*,
- as at the *Effective Date* of the policy:
  - be between the ages of 16 and 60 for the healthcare, repatriation assistance and personal liability benefits, where your declared *Country of residence* is one of the following: Brazil, Chile, China, Costa Rica, Hong Kong, Japan, Mexico, Singapore, Taiwan, Thailand, the United Arab Emirates, the United Kingdom or the United States;
  - be between the ages of 10 and 74 for the healthcare, repatriation assistance and personal liability benefits in all other countries.

  The minimum age requirement for healthcare, repatriation assistance and personal liability benefits applies only where a child is insured alone under a policy. *You* may insure your children below the minimum age provided *You*-yourself are insured under the same policy.
- have completed the medical formalities required under the policy, including the Health Questionnaire, which must be duly completed and signed no more than 3 months prior to the *Effective date* of the policy.

Your *Dependants* may also be covered under this policy, provided they are named on your *Membership Certificate.*

Adding your *Dependent children* to the plan:

- **If *You* have had Maternity cover for at least 12 consecutive months**:
  - To cover your child at birth with no medical formalities, please send *Us* your application for enrolment, together with **a birth certificate within 30 days** of the birth.
  - **After this period**, newborns are enrolled **subject to the approval of our medical department**:
    - *You* will be asked to complete a **health questionnaire** and provide a **hospital birth report**,
    - The newborn's membership of the plan will only take effect at the earliest on the day after our *Medical Approval*.

  Please note: if an in-depth review is required, the membership will take effect at the earliest on the day of acceptance of the special conditions sent to *You*.
- **If *You* do not have Maternity cover (or if *You* have been covered for less than 12 months)**: please send *Us* your application for enrolment, together with a **health questionnaire** and a **hospital birth report**. The newborn's membership of the plan will only take effect at the earliest on the day after our *Medical Approval*.

  Please note: if an in-depth review is required, the membership will take effect at the earliest on the day of acceptance of the special conditions sent to *You*.

For **newborns born as a result of surrogate motherhood, and for children who are adopted or placed in a foster family or care home**, please note that membership will be subject to a full medical review and a Health questionnaire or medical certificate of good health may be requested; in case of acceptance cover will start on the date of approval subject to the agreement and conditions of approval issued.

Membership is based on the statements provided by *You* and/or the Member, and on the good faith of all parties. Enrolment is subject to our *Medical Approval*. *We* reserve the right to request additional medical information depending on the answers provided in the Health Questionnaire. If *You* (or a family member) present an increased medical or occupational risk, *We* may either accept enrolment under specific terms and conditions, or decline the application.

3. Geographical scope of your policy

For the Medical expenses and basic Repatriation Assistance benefits:
The benefits apply on an annual basis within the *Country of Residence* stated on your *Membership Certificate*.
The benefits also apply within the *Cover Zone* specified on your *Membership Certificate*.

Two *Cover zones* are available:
Zone 1: Worldwide including the United States
Zone 2: Worldwide excluding the United States

For *Insured* under Zone 2, benefits remain valid in the United States in the event of an *Accident* or *Medical Emergency* during temporary stays, for non-medical reasons, of no more than 60 consecutive days and subject to the limits specified in the Table of Benefits.
For any stay exceeding 60 consecutive days outside the *Cover zone*, the *Insured* must inform *Us* in order to adjust *the Cover zone* and the corresponding *Premium*.

For comprehensive assistance and personal liability benefits:
These benefits apply worldwide on an annual basis (including in your *Country of nationality*), except in *Excluded countries*.

Due to events that may occur in certain countries, cover is excluded in some locations.
The full list of *Excluded countries* is available on our website by clicking here, or upon request by calling +33 (0)1 73 02 93 93 or by email at info.expat@april-international.com. This list of *Excluded countries* is subject to change.

4. What is covered by your policy

4.1. What benefits are covered by your policy?

Application to this policy provides *You*, depending on the selected plan and benefits, with international healthcare cover from the first € or US$ spent.
In this context, *You* and your *Dependants* are covered for *Medically necessary* treatments and procedures, as well as the related costs, services and supplies, where these arise from the occurrence or worsening of a *Medical condition*.
The basic Repatriation Assistance benefit is included in your policy along with the Medical Expenses benefit.
You may apply for the optional Comprehensive Assistance and Personal Liability benefit. This optional benefit may also be purchased separately.

***You* are entitled to the benefits listed below where they are stated on your *Membership Certificate*.**

4.2. Medical Expenses benefits

Healthcare expenses are covered up to the amount incurred and within the limits of *Reasonable and Customary Costs*, taking into account the country or locality in which the treatment is provided.

The MyHealth International policy offers 4 plan levels, each with its own set of benefits and associated healthcare provider networks. To help ensure access to quality care, and to make sure that the treatment provided is appropriate to your health condition and consistent with locally applicable fees, *We* provide access to networks of healthcare professionals who apply *Reasonable and Customary Costs* (see paragraph 4.4.5). **If *You* receive treatment from a facility or healthcare professional who is not part of the network applicable to *Your* level of cover, or who is not recommended by APRIL International, *You* may be liable for a 40% co-payment on the amount of your reimbursement *Claim* if the cost of care exceeds local standards (excluding Life-threatening *Emergencies*).**

You can access information on APRIL International's healthcare provider network:
- **in your Member Guide and via your Member Portal;**
- **or by contacting our teams, who are available to assist *You* with all your healthcare-related queries.**

4.2.1 Type of reimbursement

The reimbursement of medical expenses is covered for all *Medically necessary* treatments and procedures listed in the benefits schedule (see paragraph 4.4.2) which are prescribed by a qualified *Medical authority*.

Reimbursements are made on a benefit-by-benefit basis, according to the selected plan, level of benefits and *Copayment* level, as outlined in the Table of Benefits. For Medical expenses billed in a currency other than Euro or US dollar, the applicable exchange rate will be the one in force on the date the *Claim* occurred. Only expenses relating to services provided during the policy period will be eligible for reimbursement.

The plan, benefits, and the selected *Deductible* or *Copayment* level, as chosen by the *Member*, are stated on their *Membership Certificate* and apply to all insured family members listed on the policy.

Overall limits:
The reimbursement limits are expressed per *Insured* and per *Insurance Year*:
- **Explore Plan:** the overall reimbursement limit is set at €/US$500,000
- **Essential Plan:** the overall reimbursement limit is set at €/US$1,500,000

- **Extensive Plan:** the overall reimbursement limit depends on the country where treatment is received:
  - In China, Hong Kong, Japan, Singapore, or the United States: the limit is €/US$2,000,000
  - In all other countries: unlimited
- **Elite Plan:** the overall reimbursement limit depends on the country where treatment is received:
  - In China, Hong Kong, Japan, Singapore, or the United States: the limit is €/US$4,000,000
  - In all other countries: unlimited

4.2.2 Medical Expenses Table of Benefits

Benefits are expressed per *Insured* and per *Insured Year*, unless otherwise stated.
Healthcare expenses are covered up to the amount incurred and within the limits of *Reasonable and Customary Costs*, considering the country or locality in which the treatment is provided.

	Explore	Essential	Extensive	Elite
Overall limit	**€/US$500,000**	**€/US$1,500,000**	**Countries listed*: €/US$2,000,000** Rest of the world: **Unlimited**	**Countries listed*: €/US$4,000,000** Rest of the world: **Unlimited**
Hospitalisation**				
Hospital Services or Day-patient treatment surgery > Intensive Care Unit charges > All Inpatient Treatment ordered by a Doctor > Diagnostic tests and medicines > Doctor, Surgeon, nursing and Anaesthetist Fees	100%	100%	100%	100%
Hospital Room Type When an insured spends at least one night as an inpatient in a hospital	Semi Private Room	Private Room	Private Room	Private Room
Emergency medical treatment outside the area of cover	€/US$75,000 Up to 60 days	€/US$150,000 Up to 60 days	€/US$300,000 Up to 60 days	100% Up to 60 days
Advanced Medical Imaging (MRI, CT and PET scans) As part of Inpatient or Day-patient	€/US$10,000	€/US$15,000	€/US$20,000	100%
Parental Accommodation When an insured child aged under 18 years is an Inpatient	Not covered	100%	100%	100%
Local Road Ambulance Road ambulance services to and/or from the hospital in case of hospitalisation	100%	100%	100%	100%
Internal Prostheses, Medical Aids and Devices Which are required intra-operatively	100%	100%	100%	100%
Emergency Dental Treatment To restore or repair sound natural teeth within 14 days of accident	100%	100%	100%	100%
Home hospitalisation	100%	100%	100%	100%
Pre- and post-hospitalisation covered by APRIL				
Pre-Hospital Treatment Consultations and treatment received within 30 days prior hospitalisation	€/US$3,000	€/US$5,000	100%	100%
Post Hospital Treatment Consultations and treatment received within 90 days of receiving Inpatient treatment	€/US$5,000	€/US$7,000	100%	100%

	Explore	Essential	Extensive	Elite
Rehabilitation treatment Treatment started within 3 months following hospitalisation, aimed at restoring health and mobility	100% Up to 20 days	100% Up to 20 days	100% Up to 30 days	100% Up to 60 days
External Prostheses, Medical Aids and Devices Which are medically required following Inpatient Care, Day-patient Treatment or Accident and Emergency Room Treatment	80% Up to €/US$2,500	80%	90%	100%
Conditions management				
Cancer treatments (oncology, chemotherapy, radiotherapy) Consultations, diagnostics and treatment received under Inpatient, Day-patient or Outpatient treatment	100%	100%	100%	100%
Cancer related appliances and counselling > Includes wigs / headbands and mastectomy bras for cancer patients > Counselling with registered psychologist., counsellor	Not covered	Not covered	€/US$250	€/US$400
Cancer preventive surgery **(12 months waiting period***)**	Not covered	Not covered	Not covered	€/US$25,000
Organ, Bone Marrow Transplant and Stem Cell Treatment Inpatient only. Acquisition and donor costs are excluded.	100%	100%	100%	100%
Kidney Dialysis Treatment received as an Inpatient or as Day-patient treatment	100%	100%	100%	100%
HIV/AIDS Benefit Treatment received as an Inpatient or as Day-patient treatment	100%	100%	100%	100%
Palliative care Lifetime limits apply, whether provided in a specialised facility or unit.	€/US$25,000	€/US$40,000	100%	100%
Congenital conditions Lifetime limits apply. Treatment received as an Inpatient or as Day-patient treatment	€/US$50,000	€/US$100,000	100%	100%
Psychiatric care Hospital treatment of mental and nervous conditions Inpatient only	Not covered	Not covered	€/US$8,000 Up to 15 days	100% Up to 30 days
Complications of pregnancy (12 months waiting period*)** Complications that arise during the pre-natal stages of pregnancy	Not covered	100%	100%	100%

	Explore	Essential	Extensive	Elite
Outpatient – Optional				
Overall Limit	**€/US$3,000**	**Unlimited**	**Unlimited**	**Unlimited**
TeleHealth In partnership with Teladoc	Unlimited	Unlimited	Unlimited	Unlimited
Doctors fees > General Practitioners > Specialists	100% up to the annual limit	€/US$2,500	€/US$8 000	100%
Drugs and Dressings When prescribed by a Doctor and up to the cost of the generic equivalent where available	100% up to the annual limit	€/US$ 2,000 Limit doubled in case of chronic illness	€/US$ 6,000 Limit doubled in case of chronic illness	100%
Hormone Therapy To relieve the symptoms of premature menopause and when medically prescribed	Not covered	Not covered	€/US$250	€/US$500
Lab, diagnostic tests and scans (X-Rays, MRI, CT and PET Scans) When prescribed by a Doctor	100% up to the annual limit	€/US$5,000	100%	100%
Outpatient Mental Health Treatment Psychiatrists, psychologists and psychotherapists	Not covered	€/US$500 Up to 7 sessions	€/US$1,200 Up to 10 sessions	€/US$4,000 Up to 20 sessions
Complementary Therapies Physiotherapist, orthoptist, podiatrist /chiropodist, speech therapist and occupational therapist	Up to 5 sessions	€/US$1,000 Up to 10 sessions	€/US$1,500 Up to 15 sessions	100%
Alternative medicine Osteopath, chiropractor, homeopath, ethiopath, acupuncture, traditional Chinese medicine, hypnotherapist	Not covered	€/US$500	€/US$1,000	€/US$4,000
Nursing at Home When medically prescribed	Up to 30 days	€/US$2,000 Up to 30 days	€/US$6,000 Up to 60 days	100% Up to 120 days
Medical appliances and mobility aids Including hearing aids when prescribed by a Doctor	Not covered	€/US$2,000	€/US$3,500	€/US$5,000
Prevention				
Adults preventive screening as follows: > Mammography for women aged 40 and above > Pap smear for women aged 19 and above > Prostate screening for men aged 40 and above > Bowel cancer screening for women or men aged 45 and above	100% up to the annual limit	100%	100%	100%
Medical checkup packages Medical and hearing checkup or standalone tests in the absence of a diagnosis	Not covered	€/US$200	€/US$800	€/US$2,000
Child health screening Evaluating medical history, physical and development assessment, school entry health check, hearing check and or diabetic screening > Age 3 and below: max 2 tests per year > Age 4 to 15: max 1 test per year	Not covered	€/US$200	€/US$800	100%

	Explore	Essential	Extensive	Elite
Vaccinations Childhood, mandatory vaccinations, travel-related vaccinations	100% up to the annual limit	100%	100%	100%
Nutrition Consultations with dieticians or nutritionists	Not covered	Not covered	€/US$150	100% Up to 5 sessions
Over-the-counter (OTC) drugs Contraception, vitamins, smoking cessation drugs, non-prescription pharmacy	Not covered	€/US$50	€/US$100	€/US$150
Genetic testing (12 months waiting period*)** When medically prescribed and in the event of a hereditary predisposition to cancer	Not covered	Not covered	Not covered	€/US$1,500
Health or Fitness App Reimbursement for one digital Health or Fitness App of your choice	Not covered	Not covered	Not covered	€/US$50
Maternity** (12 to 24 months waiting period***) – Optional				
Routine Pregnancy and Childbirth (12 months waiting period*)** > Childbirth fees > Homebirth > Pre- & post-natal care including Physician consultation fees, diagnostic, tests, medicines, vitamins and drugs, licensed midwifery and certified doula services, > Pre-natal classes (held by a doctor and midwife) > Neonatal Screening > Elective caesarean section	Not covered	€/US$4,000 per pregnancy	€/US$8,000 per pregnancy	€/US$12,000 per pregnancy
Complications of Childbirth (12 months waiting period*)** > Emergency caesarean section > Medically necessary caesarean section	Not covered	€/US$8,000 per pregnancy	€/US$12,000 per pregnancy	€/US$24,000 per pregnancy
Infertility treatment (24 months waiting period*)** > Drugs, hormone treatment, testing > In vitro fertilisation, artificial insemination Max 4 attempts, lifetime limit	Not covered	Not covered	€/US$1,500 per attempt	€/US$2,500 per attempt

	Explore	Essential	Extensive	Elite
Dental (3 to 6 months waiting period***) – Optional				
Annual limit	€/US$800	€/US$1,000	€/US$2,000 for the first 2 years, boost to €/US$3,000 from 3rd year	€/US$4,000 for the first 2 years, boost to €/US$5,000 from 3rd year
Routine Dental Treatment (3 months waiting period***) > Two dental check-ups or examinations per insurance year > X-Rays > Scale-and-Polish Cleaning > Simple Fillings > Surgical Services, Extractions, Root Canal Treatments > Treatment of tooth decay, periodontics, endodontics	80%	80%	100%	100%
Major Dental Treatment (6 months waiting period***) including dentures, crowns, bridges, inlays, and implants	80%	80%	100%	100%
Orthodontics (3 months waiting period***) treatment must begin before age 16	Not covered	Not covered	€/US$ 1,200	€/US$ 1,700
Optical (6 months waiting period***) – Optional				
Optical Care and expenses Eye examination and visual aids (frames, lenses or contact lenses) – one frame reimbursed every two years when medically prescribed	Not covered	€/US$200	€/US$300	€/US$450
Laser treatment for vision correction (myopia, hypermetropia and astigmatism)	Not covered	Not covered	€/US$300	€/US$1,000

*Country of treatment: China, Hong Kong, Japan, Singapore, United States.
** All *Hospitalisations* are subject to *Pre-Approval*. A 50% penalty will apply if this requirement is not met prior to admission.
*** *Waiting period* waived if you previously held equivalent or higher benefits cancelled less than one month ago, upon presentation of proof of the previous benefits and the corresponding Cancellation Certificate.
**** Subject to *Pre-Approval*.

4.2.3 How *Deductibles* and *Copayment* apply?

Deductibles:

Healthcare benefits are offered with no *Deductible* by default. However, *You* may choose one of the following annual *Deductible* levels: €/US$500, €/US$1,000, €/US$2,500, or €/US$5,000 (available under the Extensive and Elite plans only).
If *You* have chosen an annual *Deductible*, all expenses incurred up to the selected *Deductible* amount will remain payable by *You*. The *Deductible* applies per *Insurance Year* and per *Insured*, and across all selected healthcare benefits.
In order to track the portion of the *Deductible* already used, *You* must submit all invoices for healthcare expenses incurred, whether or not they exceed the *Deductible*.
When calculating the portion of the *Deductible* used, *We* apply the benefit limit stated in the Table of Benefits for the relevant type of treatment, based on your selected plan.
If the treatment type is excluded under your policy, the associated costs will not be taken into account in the calculation of the *Deductible*.

Please note: if a *Deductible* is selected or if *You* are covered under the Explore plan, *You* will not be eligible for the Caremark card (pharmaceutical direct billing in the United States).

***Copayment* options of 30%, 20% and 10%:**

The Outpatient benefit (including Prevention) is provided with 100% reimbursement of *Actual Costs*. However, *You* may choose to be covered at 70%, 80% or 90% of *Actual Costs* for this benefit.

These *Copayment* options do not apply to the Hospitalisation, Optical/Dental and Maternity benefits, which are always provided with 100% reimbursement of *Actual Costs*.

4.2.4 Definitions relating to Medical Expenses benefits

C **CANCER PREVENTIVE SURGERY:** a surgical procedure carried out to prevent breast (mastectomy) or ovarian (oophorectomy) cancer, when prescribed by a doctor. Cover is provided where a close family member (parent, child or sibling) has been diagnosed with breast or ovarian cancer, or where a *Genetic test* confirms a hereditary cancer risk.

CHILDBIRTH COMPLICATIONS: includes medically necessary surgical births. Any complications and care provided to the newborn are covered under the *Hospitalisation* benefit following enrolment in the policy (see paragraph 2 for enrolment conditions).

CONGENITAL CONDITION: any anomaly, disease or malformation present in utero, at birth or related to heredity. A *Congenital condition* may be identified at birth or diagnosed later in life.

CHRONIC CONDITION: any disease, pathology or bodily impairment that persists for more than six months or requires medical care (such as follow-up consultations or treatment) at least once per year. A *Chronic condition* also presents one or more of the following characteristics:

- it is likely to recur on a regular basis;
- it does not benefit from any recognised curative treatment to date;
- it is generally considered not to respond favourably to treatment;
- it requires palliative treatment;
- it results in permanent disability.

D **DAY HOSPITALISATION:** *Hospitalisation* lasting less than 24 hours during which a bed is assigned to *You*, without an overnight stay in the hospital.

G **GENETIC TESTING:** testing for the BRCA1 and BRCA2 genes (linked to breast, ovarian, prostate and pancreatic cancer), and for familial adenomatous polyposis (FAP) linked to colorectal cancer. Cover is provided when prescribed by a qualified physician and when a first-degree relative (parent, child or sibling) has either been diagnosed with breast cancer or FAP or received a test result indicating a hereditary cancer predisposition syndrome.

H **HOME NURSING:** nursing care provided immediately after or instead of *Hospitalisation* or *Day Hospitalisation*. This care is covered if the treating physician determines that a nurse is medically required to visit your home at least once per day. These services require *Pre-Approval* from our Medical Officer.

HOME HOSPITALISATION (HAD): full-time *Hospitalisation* provided at the patient's home following a stay in hospital. It must be arranged by a coordinating physician in consultation with the hospital previously involved in the patient's care. The coordinating physician may provide care directly or call upon colleagues to carry out complex medical or technical procedures. The physician also organises interventions by other healthcare professionals (e.g. nurses, physiotherapists) and may arrange for the use of monitoring or life-support equipment (e.g. respiratory aid, vital signs monitoring). The delivery of medication, including chemotherapy, at the patient's bedside is included. These services require prior approval from our *Medical Officer*.

HORMONE THERAPY: medical consultations and prescribed treatments, including patches or implants, where necessary to relieve the symptoms of early menopause, provided the onset and treatment occur before the age of 40.

HOSPITALISATION: a stay of more than 24 hours in a public or private hospital, following an *Accident* or *Illness*.

M **MEDICALLY ASSISTED REPRODUCTION:** includes all necessary investigations to determine the cause of infertility, such as hysterosalpingography, laparoscopy or hysteroscopy. Also covered are treatments such as in vitro fertilisation (IVF) in cases of diagnosed infertility. Cover is limited to four attempts per policy lifetime. An attempt is defined as the retrieval of an ovum and the implantation of a fertilised ovum into the *Insured's* uterus.

O **OUTPATIENT SURGERY:** a surgical procedure performed in a surgical centre, hospital, day care unit or outpatient department that does not require overnight *Hospitalisation* for medical reasons.

P **PREGNANCY COMPLICATIONS:** complications affecting the mother's health only. Only the following complications occurring during the prenatal phases of pregnancy are covered: ectopic pregnancy, gestational diabetes, preeclampsia, miscarriage, threatened miscarriage, stillbirth and hydatidiform mole.

PRIVATE ROOM: a single-occupancy hospital room used exclusively by the *Insured* during *Hospitalisation*. Luxury rooms or rooms with hotel-style services are not covered.

T **TRAVEL-RELATED VACCINATIONS:** vaccinations that are mandatory or recommended based on the *Country of residence*. Covered vaccines include: Rotavirus (gastroenteritis), Cholera, Tick-borne encephalitis, Japanese encephalitis, yellow fever, Typhoid fever, Hepatitis A, Hepatitis B, Leptospirosis, Meningitis, Rabies, Tuberculosis, and Monkeypox (MPox).

4.2.5 What to do in the event of *Hospitalisation*?

All *Hospitalisations* (including Maternity) are subject to *Pre-Approval* from our Medical Officer.
To obtain this *Pre-Approval*, *You* must have a form entitled *Confidential Medical Certificate* completed by your practitioner **no later than 5 days before admission to hospital.**

In the event of an emergency *Hospitalisation*, please contact *Us* as soon as possible so that *We* can provide *You* with this form. The form must include the reason for *Hospitalisation*, the dates and nature of the condition, and the date of onset of *Symptoms* or the circumstances of the *Accident* (in which case an *Accident* report must also be provided).
It must be submitted to our Medical Officer, along with any other relevant medical documents necessary to assess your case.

If this *Pre-Approval* process is not followed, but the *Hospitalisation* is nonetheless deemed *Medically necessary*, **a 50% penalty will be applied to the reimbursement of your invoice** (except in cases of *Accident* or *Medical emergency*).

Your healthcare network in case of *Hospitalisation* (excluding *Emergencies*):
Under the MyHealth International policy, **the plan selected** (as stated on your *Membership Certificate*) **provides access to a specific network of healthcare providers.**
This arrangement is designed to guarantee access to high-quality care at negotiated rates, and applies only in the case of planned *Hospitalisation*. All facilities in our network are rigorously audited by our medical teams according to strict quality and safety criteria.

When planning a *Hospitalisation*, *You* must ensure that the facility is part of the healthcare network corresponding to your selected plan. In this case, your expenses will be covered at 100%, subject to the limits of the policy.
The updated list of partner healthcare providers is available by clicking here, in your Member Portal or upon request from Our teams at +33 (0)1 73 02 93 93.

If *You* receive care outside this network (except in the case of a *Medical Emergency* or a duly justified exceptional circumstance), **a 40% co-payment will apply to the reimbursement of your invoice**.
This system is designed to direct *You* to trusted healthcare facilities in order to ensure cost control and consistent quality of care worldwide.

4.2.6 How to request *Pre-Approval* before certain procedures or treatments?

Any medical expense equal to or exceeding €/US$2,000 related to Maternity, as well as series-based treatments listed in the Table of Benefits, is subject to *Pre-Approval* from our Medical Officer (valid for 6 months).
Before incurring such expenses, *You* must submit a prescription from your doctor along with a detailed quotation, no later **than 5 days before the scheduled date of treatment**.
In the case of pregnancy, please provide *Us* with a document confirming your pregnancy.

If this *Pre-Approval* procedure is not followed, **a 50% penalty will be applied to the reimbursement of your invoice**, except in the event of a *Medical Emergency*.

4.2.7 Conditions for submitting a *Claim*

You must retain the **original invoices (and any other supporting documents) for a period of two years** from the date on which *You* submitted your *Claim*.
In all cases, please attach the following documents to your *Claim*:

- invoices or fee notes for expenses paid by *You*, medical prescriptions and dated prescriptions clearly stating your full name and date of birth, the type of *Illness*, the nature and diagnosis, dates of consultations and treatments, along with proof of payment. Prescriptions must clearly indicate the names and prices of the medicines and specify the local currency;
- if the treatment required *Pre-Approval*, the corresponding *Pre-Approval* form duly approved by our Medical Department;
- in the case of *Hospitalisation*, *You* must also include the hospital report and the *Confidential Medical Certificate* completed by your doctor. Please also ensure that the invoice clearly indicates the cost of the *Private Room*.

We reserve the right to request any additional documentation *We* deem necessary to verify that the treatment is covered under the terms of the policy. In the event of a disagreement regarding the reimbursement amount, please notify *Us* within six months from the date the benefit statement was issued.

All reimbursements are subject to compliance with the provisions set out in paragraph 4.2.

4.3. Repatriation Assistance benefits

2 levels of cover are available:

- Basic repatriation assistance: **included in your Medical expenses cover,**
- Comprehensive repatriation assistance: available as an option.

How to benefit from repatriation assistance?
It is essential to obtain Pre-Approval from the Assistance provider to benefit from the following cover.

Conditions of application

Assistance provider shall only provide medical assistance after emergency services have been deployed under the authority of a competent *Medical Authority*.

From the very first call, the *Medical Team* will contact the local attending physician in order to intervene in the most appropriate manner given the condition of the patient.

If any of the assistance services listed below are arranged directly by *You* or your relatives, no reimbursement shall be made unless the Assistance provider was informed in advance, gave its explicit consent, and issued a case reference number. In such cases, expenses will only be reimbursed upon presentation of supporting documents and within the limit of the costs that would have been incurred had the Assistance provider arranged the service itself.

The Assistance provider shall not be held liable for any delay or failure in the provision of services in the event of strikes, riots, civil unrest, reprisals, restrictions on the free movement of people and goods, *Acts of terrorism or sabotage*, acts of war (declared or undeclared), civil war, nuclear disintegration, ionising radiation, or any other case of *Force majeure* or unforeseeable circumstances.

4.3.1. Basic Repatriation Assistance

The terms and levels of cover apply per *Insured*, within the limits specified for each benefit.

Medical Repatriation

In the event of an *Accident* or a *Sudden Illness*, the doctors at the Assistance provider will contact the attending physicians on site and take decisions based solely on the medical information provided and the requirements dictated by your health condition.

If the Assistance provider's *Medical Team* recommends your repatriation, the Assistance provider will organise and cover the costs of the repatriation, based exclusively on the medical necessity as determined by its *Medical Team*.

The destination of the repatriation may be:

- the most suitable hospital facility;
- the hospital closest to your home in your *Country of nationality* (or *Country of origin*, if different), or to your main residence in your declared *Country of residence*;
- your home in your *Country of nationality* (or *Country of origin*, if different), or your main residence in your declared *Country of residence*.

If *You* are hospitalised in a facility outside the hospital area of your usual home in your *Country of nationality* or declared Country of residence, Assistance provider will organise and cover the cost of your return following certified medical *Stabilisation* and will arrange transport to your main residence in your declared *Country of residence* or to your home in your *Country of nationality*.

Repatriation may be carried out using a light medical vehicle, ambulance, train, scheduled flight, or air ambulance. The final decision regarding the hospital destination, timing, need for medical escort and means of transport rests exclusively with Assistance provider's *Medical Team*.

Any refusal of the solution proposed by the *Medical Team* shall result in the cancellation of the assistance cover. **Assistance provider may request that *You* use your travel ticket if it can be used or changed accordingly.**

Repatriation of other insured family members in the event of the *Insured*'s Medical Repatriation

If the *Insured* is medically repatriated, the Assistance provider will organise the return to their home of any insured family members travelling with them.

Assistance provider will cover the cost of a one-way transport ticket in economy class by air or first class by train, provided that the means of transport initially planned for their return journey cannot be used or modified.

Accompanying Children

If *You* are repatriated and are unable to care for your *Dependent Children* under the age of 18, who are also covered under the policy, the Assistance provider will arrange and cover a return transport ticket in economy class by air or first class by

train for a person of your choice, to accompany your children back to your *Country of nationality*.

Repatriation of the body in the event of death and coffin costs

In the event of death, the Assistance provider will organise and cover the cost of repatriating the body or ashes from the place of death to the place of burial in the *Insured*'s *Country of nationality, Country of residence, or Country of origin* (if different). Assistance provider will also cover the costs related to post-mortem preparation, placing in the coffin, and all arrangements necessary for transport.

Coffin costs related to the transport organised by the assistance service will be **covered up to a maximum of €/US$2,000**.

Funeral expenses, ceremony costs, local transportation, and burial or cremation fees remain the responsibility of the *Insured*'s family. The selection of service providers involved in the repatriation process is the sole responsibility of the Assistance provider.

4.3.2. Comprehensive Repatriation Assistance

Compassionate visit in the event of *Hospitalisation*

If your *Medical condition* does not allow or require repatriation and your local *Hospitalisation* exceeds six (6) consecutive days, Assistance provider will arrange and cover a round-trip transport ticket (economy class air fare or first-class train ticket) for one *Family Member* to visit you.

This benefit is only granted if no adult *Family Member* is already present on site. Assistance provider **will also arrange and cover hotel accommodation (room and breakfast only) for up to ten (10) nights, limited to €/US$100 per night**. No reimbursement will be provided for any other type of temporary accommodation.

Care of *Dependent Children* under the age of 18

In the event of the *Insured's Hospitalisation* where *Dependent Children* cannot be cared for by a *Family Member* or on their own, the insurer shall cover:

- home-based childcare, **up to a maximum of 20 hours**;
- the benefit is capped at **€/US$500** in total for the service.

Return or care of domestic pets in the event of the *Insured*'s repatriation

If the *Insured* and all *Family Members* are repatriated to their *Country of nationality* (or *Country of origin*, if different) or *Country of residence*, the Assistance provider will arrange and cover the return of domestic pets. The method and feasibility of transport will be determined solely by the Assistance provider. **Coverage is limited to €/US$500,** regardless of the number of pets. Assistance provider cannot be held liable if repatriation cannot be arranged due to local legislation or restrictions. This benefit does not apply to wild animals.

Pet Boarding: If the Insured is hospitalised and no arrangements can be made for pet care, the insurer will cover pet boarding costs in a suitable facility during the hospital stay, **up to €/US$500, regardless of the number of animals**.

Home Help

The insurer shall cover the cost of a home help to assist with household tasks, either upon discharge from hospital, during *Hospitalisation*, or during home confinement.

Coverage is limited to ten (10) hours of service within the month following the *Hospitalisation* or return home, with a maximum of €/US$250

Search and rescue costs

The purpose of this cover is to provide You with the reimbursement of search and rescue costs incurred by the intervention, in a public or private location, of fully equipped, specialised teams, including the use of a helicopter.

This cover tops up or takes over from any other similar cover You may have.

In all cases, cover is capped at a maximum of €/US$5,000 per person and €/US$15,000 per event.

Repatriation in the event of an *Act of Terrorism or sabotage* or an *Attack* or *Assault*

If the *Insured* is the victim of *a Terrorist Act, Sabotage, Attack or Assault* resulting in *Bodily Injury* or psychological trauma, Assistance provider shall organise repatriation to the *Country of nationality* (or *Country of origin,* if different). The method and timing of repatriation, and the means of transport used, shall be determined and selected by the Assistance provider.

Return in case of *Attack*, Political Unrest or Natural Disaster

If *You* are advised by the local authorities of your declared *Country of residence* or by those of your *Country of nationality* to leave your place of stay due to an *Attack*, political unrest or a natural disaster (such as an earthquake or flood), you may benefit from the early return benefit. To claim reimbursement, you must submit all relevant supporting documents to the insurer upon return to your *Country of nationality*. **Reimbursement shall be up to the cost of an economy-class air ticket or**

first-class train ticket, limited to €/US$1,500
This benefit applies only outside your *Country of nationality* and is not valid in *Excluded countries*.

Return of *Insured* family members
In case of repatriation of the *Insured*'s remains, Assistance provider shall arrange the return of Insured family members travelling with the deceased.
Assistance provider shall provide a one-way economy-class air ticket or first-class train ticket, provided that the initially planned return transport is unusable or cannot be modified.

Accommodation costs following an *Accident* or *Illness*
Following a *Hospitalisation* of more than six (6) days outside your declared *Country of residence*, the insurer shall cover hotel accommodation expenses, in case immediate return is not possible, **up to €/US$150 per night for a maximum of seven (7) nights.**

Return after medical *Stabilisation* to the declared *Country of residence*
Once medical repatriation has occurred and *You* are deemed fit to resume your professional activity, Assistance provider, with the agreement of its *Medical Team*, will organise your return to your declared *Country of residence.*
Assistance provider will cover the cost of a one-way economy-class air ticket or first-class train ticket.

Presence of a *Friend* or Relative in case of death
If the presence of a *Family Member* or close *Relative* is required to identify the deceased *Insured* and arrange for the repatriation or cremation, the Assistance provider shall provide a round-trip economy-class air ticket or first-class train ticket. This benefit only applies if the *Insured* was alone at the time of death. Assistance provider shall also arrange and cover hotel accommodation (room and breakfast only) **for up to four (4) consecutive nights, limited to €/US$50 per night. Any alternative temporary accommodation is not eligible for reimbursement.**

Sourcing and delivery of medication not available locally
In the event that indispensable medicines or their equivalents cannot be obtained locally and were prescribed before departure by your treating doctor in your *Country of nationality* (or in your *Country of origin*, if different), Assistance provider will source them in France.
If they are available, they will be sent as soon as possible subject to the constraints of local legislation and available means of transport.
This service is available for one-off requests. It does not apply, under any circumstances, to long-term treatments that require regular deliveries or requests for vaccines. *You* are responsible for the cost of the medication unless it is covered under your medical expenses cover. *You* agree to reimburse the amount plus any custom clearance charges within a maximum period of 30 days from the shipment date.

Legal assistance abroad (except in your *Country of nationality*)
Following an unintentional infraction of the laws and regulations of your *Country of residence*, and for all non-criminal acts, Assistance provider will intervene, on written request, if legal action is taken against *You*. This benefit does not apply to matters related to your professional activity. Assistance provider will cover the local legal fees **up to a maximum of €/US$1,500 per event.**

Advance of criminal bail abroad (except in your *Country of nationality*)
Assistance provider may advance the bail amount required by local authorities to secure your release or to prevent incarceration.
This advance is arranged through a legal representative, up to a maximum of €/US$15,000 per event.
You must repay this advance to the Assistance provider:
- Upon refund of the bail in the event of dismissal or acquittal;
- Within 15 days of the enforceable judgment in case of conviction;
- In any case, within three months from the date of the payment.

Travel Assistance
While travelling abroad, in case of loss or theft of your personal belongings (identity documents, payment methods, *Baggages*) or travel tickets, and after reporting the incident to local authorities, the Assistance provider shall support you in completing the necessary formalities. Assistance provider is not authorised to block payment methods on your behalf. If replacement documents are issued in your *Country of nationality*, Assistance provider will arrange for their expedited delivery. Assistance provider may provide an advance of **up to €1,500/US$ per event to allow *You* to purchase essential items**.
In case of loss or theft of a travel ticket, the Assistance provider may send a non-negotiable replacement ticket and advance

the associated costs.
These advances may be made in exchange for a guarantee provided by you or by a third party. Reimbursement of all advances must be made within 30 days from the date the funds were made available.

Flight Delay, Cancellation or Denied Boarding
If, at any airport:
- The *Insured*'s confirmed scheduled flight is delayed by four (4) hours or more from its initially scheduled departure time.
- The *Insured*'s confirmed scheduled flight is cancelled.
- The *Insured* is denied boarding due to overbooking and no alternative means of transport is provided within six (6) hours.

The *Insured* shall be compensated up to €300/US$ for all expenses related to meals, refreshments, hotel accommodation and/or return transfers to and from the airport or terminal.
This benefit is not applicable in the following cases:
- Where flight confirmation was required, and the *Insured* failed to confirm the flight unless prevented from doing so by strike action or *Force Majeure*.
- Where the delay results from strike action or risks of civil or international war known to the *Insured* prior to departure.
- In the event of the temporary or permanent withdrawal of the flight authorisation, imposed by civil aviation authorities, airport authorities, or similar bodies in any country.

Missed Connection
If the *Insured* misses the departure of a scheduled connecting flight due to the late arrival of a previous scheduled flight, and no alternative transport is provided within six (6) hours of arrival at the connection point, the Assistance provider shall reimburse hotel, meal, or refreshment expenses incurred, up to €300/US$.
The "Flight Delay, Cancellation or Denied Boarding" and "Missed Connection" benefits may be claimed cumulatively.

Reimbursement of trip expenses
The purpose of this benefit is the reimbursement, on a pro rata basis, of trip abroad outside your *Country of residence,* expenses which have already been paid but not used (excluding travel and accommodation costs) in the event of an early return home following the *Insured*'s medical repatriation to their *Country of nationality* organised by the Assistance provider.
The maximum amount of the daily allowance is €/US$250 per day, with an overall cover limit of €/US$5,000 per *Insurance year*.
The benefit is proportional to the number of unused days of the trip. To calculate the benefit, expenses in respect of administration, visa, insurance, tips and reimbursement or compensation paid by the organiser of the trip or any other organisation to which *You* paid the expenses in question will be deducted. This benefit is available outside your *Country of residence*.

Enforced stay abroad
In case of an event classed as *Force majeure* by the public authorities of the country in which *You* are temporarily staying outside your *Country of residence* and which prevents *You* from returning permanently to your *Country of residence*, the assistance provider will cover the additional costs involved in extending your stay up to a maximum of **€/US$100 per night (food and accommodation only), for a maximum of 14 nights.**
Cover only takes effect after the public authorities of the country in which *You* are temporarily staying have declared a state of *Force majeure* and with the prior agreement of the assistance provider. All costs incurred without the prior agreement of the assistance provider as well as all costs incurred due to an extended stay which is not due to an event classed as *Force majeure* will not qualify for any benefits.

Urgent message transmission
If *You* are materially unable to transmit an urgent message and *You* so request, the Assistance provider shall transmit, by the quickest means available, your messages or news to family members, close relations, or your employer, free of charge. Messages remain the responsibility of their authors, who must be identifiable, and the Assistance provider shall act solely as an intermediary.
Messages can also be transmitted in reverse under the same conditions.

Loss, damage or destruction of personal *Baggage*
The insurer shall cover, during travel undertaken by the Insured, the loss, partial or total destruction or damage of personal *Baggage*.
This benefit applies only in the following situations:
- if the loss, damage or destruction occurs while the *Baggage* is in the custody of a carrier and has been duly checked-in;
- If the loss, damage or destruction results from a catastrophic event such as fire, flood, structural collapse, or an *Act of Terrorism*.

Benefit Limit:
The Insurer shall reimburse *Baggage* up to **€/US$1,000.**

How to claim the benefit:
You must report the *Claim* in writing to the Insurer via https://www.chubbclaims.com/ace/fr-en/welcome.aspx within five (5) working days following the event. After this period, the Insurer reserves the right to reject the claim. A list of supporting documents will be required.

Fraudulent use of a SIM card by a third party
The insurer will cover the cost of the fraudulent use of a mobile phone by a third party if the phone is stolen in an *Assault* during your stay outside your *Country of nationality*, providing the phone was used in this way before the *Insured* made the request to block the SIM card and within forty-eight (48) hours of the date and time of the theft.

Specific cases involving mobile phones, smartphones and personal tablets
The Insurer shall reimburse the Insured up to €500/US$ per event for mobile phones, smartphones or tablets stolen as a result of assault or snatching outside your *Country of nationality*, upon submission of supporting documents. **This benefit is limited to one *Claim* per *Insurance Year* and per *Insured*.**
Depreciation scale:
- Twenty percent (20%) during the first year (starting from the date of purchase)
- Forty percent (40%) during the second year
- No reimbursement shall be made after the second year

In all cases, the Insured must provide the initial or replacement purchase invoice(s) for the device.

Early return home in the event of the death or *Hospitalisation* of a *Family member*
Assistance provider will provide *You* with a round-trip ticket by air in economy class or by train in 1st class in the event of the death or *Hospitalisation* for more than 5 days of a *Family member* in your *Country of nationality* (or in your *Country of origin* if different). The outward trip must take place within 8 days of the death or *Hospitalisation*.
This benefit can be claimed when the death or *Hospitalisation* occurs after their departure.
Assistance provider reserves the right, prior to the provision of its services, to request proof of the covered event (hospital certificate, death certificate etc.). This benefit cannot be used more than once per *Insurance Year* for the same causal event. A causal event is the event or situation causing the use of the benefit. This means that one and the same *Illness* of a *Family member* cannot give rise to several early returns home within the same *Insurance year*.
In order to claim this benefit, *You* must contact the Assistance provider to obtain their prior agreement. Otherwise, the Assistance provider has the right to refuse to reimburse any tickets which *You* may have bought Yourself.

Translation of legal and administrative documents
When *You* are abroad or in case of medical repatriation, if *You* have serious difficulty understanding legal or administrative documents in the local language, the Assistance provider will arrange and cover the cost of translating these documents into your native language. Assistance provider will provide cover up to a maximum of **€/US$500 per *Insurance year***. Assistance provider will not be held responsible for the consequences of poor translations or misunderstandings on your part.

Limitations of the Comprehensive Assistance benefit
Where the Assistance provider organises and covers the cost of a repatriation or transport, *You* may be asked to prioritise the use of your own travel ticket. If the Assistance provider arranges and pays for your return, *You* must return the unused portion of your travel ticket to the Assistance provider.

Psychological Support
Assistance provider provides the *Insured* with psychological support. A clinical psychologist offers the *Insured*, with full confidentiality, medico-psychological assistance to enable them to open up and clarify the situation they are facing. The psychologist helps identify, assess, and mobilise the Insured's personal, family, social, and medical resources to navigate this difficult time.
This service is provided over the phone. Upon a simple call, an appointment is scheduled at the Insured's convenience with psychologist, who will call back to initiate the support process. If necessary, the caller may be connected directly with a psychologist, subject to the availability of a psychologist. **Sessions are conducted confidentially and in accordance with applicable professional ethical standards. The support provided is limited to a maximum of three (3) sessions.**
The team of clinical psychologists can be reached at **+33 (0)1 41 61 23 25**, allowing the Insured to speak with qualified professionals. Depending on the situation and the beneficiary's preferences, an appointment may also be arranged with a state-certified psychologist near the beneficiary's place of residence. The choice of practitioner rests with the Insured and

any consultation fees are at their own expense.
Additionally, in the event of the Insured's death, the Assistance provider provides psychological support to the *Spouse* and/or the *Insured's Dependants*, even if they are not enrolled under the policy. This support is also limited to a maximum of three (3) sessions.

4.4. Personal Liability benefit (Private capacity)

Purpose of the insurance:

This benefit covers the financial consequences of any damage for which *You* and the Insured members of your family are held liable in a private capacity, including during the commute to and from work. The benefit is available if the liability for damage **caused to a third party** falls on You or any person for whom *You* are responsible.

Upper limits on cover:

- Bodily injury, material damage and consequential financial loss: **up to €/US$7,500,000 per *Claim* and per *Insurance year*** including: Material damage and consequential financial loss: **up to €/US$750,000 per *Claim* and per *Insurance year*. *Deductible* of €/US$150 per *Claim*.**
- Damage resulting from fire, explosion and water, caused to third parties in buildings which **You** have rented or borrowed for the organisation of family ceremonies: **up to €/US$150,000 per *Claim* and per *Insurance year*. *Deductible* of €/US$150 per *Claim*.**

How to make a *Claim*?

As soon as *You* become aware of any circumstances that may give rise to a *Claim* under the plan, *You* must inform the insurer, using the following address: France.DeclarationsRC@Chubb.com within a period of no more than 15 days. Details of the circumstances surrounding the *Claim* and their consequences should also be provided.

Special provisions

Disputes:

In the event of a dispute regarding the measures to be taken to settle a disagreement, the matter may be submitted to a third party designated by mutual agreement or, failing that, to the President of the Tribunal de Grande Instance of Paris acting in summary proceedings. Expenses incurred in the implementation of this option will be covered by the insurer. However, the President of the Tribunal de Grande Instance of Paris may decide otherwise if *You* have implemented this option under improper conditions.
If *You* undertake litigation at your own cost and obtain a solution that is more favourable than that proposed by the insurer or by the third party mentioned above, the insurer will reimburse the costs which You incurred up to the cover limit.
When the procedure described above is put in motion, the time limit on appeals is suspended for all legal proceedings covered by the insurance and which *You* may undertake, until the third party tasked with proposing a solution has disclosed its content.

Choice of legal representation

In the event of legal or administrative action requiring the involvement of a lawyer or any other person qualified by law or current regulations to represent your interests, *You* have free choice and the insurer will pay the fees directly.
If *You* do not know a lawyer, the insurer may make one available to *You*. This free choice is also applicable if there is a conflict of interest between *You* and the insurer.

Procedure - Transactions

In the event of proceedings involving liability covered by this insurance, the insurer reserves the right, under the limits of the cover, to direct the proceedings and exercise all appeals before civil, commercial or administrative jurisdictions.

Should You not allow this option to be exercised, the insurer will have the right to terminate your insurance cover.
In the case of proceedings before a criminal court and if the victim(s) have not been compensated, the insurer will have the right, with your agreement, to take responsibility for your criminal defence or to take part in the proceedings. In the absence of such an agreement, the insurer may, nevertheless, defend your civil interests. The insurer can also exercise all appeals on your behalf, including an appeal in cassation, when criminal interests are no longer involved. Otherwise, the insurer can only exercise them with your agreement. *You* are prohibited, within the limits of the insurance, from reaching a settlement with the injured parties.
Any admission of liability or transaction carried out without the involvement of the insurer will not be enforceable; the acknowledgment of a material fact is not considered to be an admission of liability.

5. What is excluded from your policy?

5.1. General *Exclusions* applicable to all benefits

In addition to the *Exclusions* specified under each benefit, the following consequences and circumstances are excluded from all benefits:

- *Pre-existing Medical Conditions* ;
  - *Accidents* or *Illnesses* that predate the signature date of the Application form, unless they were declared AND accepted at the time of application;
  - any complication resulting from *Medical conditions* not covered under your Policy;
  - costs incurred or treatments prescribed prior to the *Policy Effective Date* and/or during the *Waiting Period*.

  For reference, *Pre-existing Conditions* are defined as any *Medical condition* or pathology diagnosed, or medically treated, or investigated through medical examinations and/or treated before the date of signing your application (including the Health Questionnaire). A *Pre-existing Condition* is considered to be any such illness or symptomatic condition of which You were aware, or could reasonably have been aware, at the time of application to the policy.

- Intentional Acts;
  - any reimbursement in the event of an intentional false declaration by the *Insured*;
  - acts committed intentionally by the *Member* or the *Insured* and/or breaches of the law in the country where the *Insured* is staying;
  - voluntary participation by the Insured in fights, civil unrest, terrorist acts, riots or assaults, regardless of the location or persons involved (except in cases of legitimate self-defence);
  - attempted suicide, self-harm or self-inflicted injuries or *Illnesses*;
  - use of drugs or narcotics without a medical prescription;
  - alcohol abuse or intoxication of the *Insured* (blood alcohol level exceeding the legal limit defined by road traffic laws in force at the time of the *Claim* in the country where it occurred);
  - road traffic *Accidents* involving a two-wheeled motor vehicle where the *Insured* was not wearing a helmet;
  - voluntary termination of pregnancy, except in the case of therapeutic abortion;
  - engagement in any high-risk professional activity excluded by the insurer.

- Participation in sports:
  - participation in sports on a professional basis, as part of a sports studies programme or as part of professional sporting competitions;
  - participation in the following sports:
    - Mountain sports: mountaineering, rock climbing (except on artificial walls with safety measures), bouldering, hiking above 3,000 metres, ski jumping, bobsleigh, skeleton, canyoning, rafting, skiing (alpine, cross-country, snowboarding) outside designated, open and marked trails;
    - Aerial sports: aerobatics, gliding, parachuting, microlight flying, hang-gliding, paragliding, skysurfing, hot air ballooning;
    - Water sports: scuba diving, hydro speed, kitesurfing, jet skiing;
    - Combat and self-defence sports;
    - Motor sports: driving of cars, motorbikes, karts or quad bikes;
    - Hunting.

    However, participation in these sports for leisure, initiation or "discovery" purposes is covered, provided it is supervised by a professional duly certified by the relevant State authorities.
  - extreme sports, even when practised for leisure or on an introductory basis: bungee jumping, potholing, extreme canoeing or kayaking (on rivers of class above V, or class above II, or more than two nautical miles from the coast), sailing (transoceanic, solo navigation more than 20 nautical miles from shelter), base jumping;
  - aviation accidents, unless the *Insured* is travelling solely as a passenger and is on board an aircraft for which both the owner and the pilot hold all required licences and authorisations.

Compliance with Economic and Trade Sanctions:

Where the provision of cover or payment of a benefit or *Claim* under this policy would breach resolutions of the United Nations or economic and trade sanctions, laws or regulations of the European Union, the United Kingdom, France, national legislation, or the United States of America, such cover or payment shall be null and void.

5.2. *Exclusions* applicable to the Medical Expenses benefits

In addition to the General *Exclusions* applicable to all benefits, as outlined in paragraph 5.1 above, the following are excluded from the Medical Expenses benefit, including their consequences and related outcomes:

- Any expenses incurred for treatments or procedures prescribed prior to the *Effective Date* of the policy or during the *Waiting Periods*;
- Comfort / Cosmetic / Alternative care:
  - cosmetic treatments and aesthetic surgery aimed at improving physical appearance (including when medically prescribed), unless required to restore function or appearance following a disfiguring Accident or as part of cancer-related surgery, provided the *Accident* or surgery is also covered by APRIL International;
  - septoplasty, rhinoplasty and surgery related to nasal septum deviation, except in the event of an *Accident* covered by APRIL or in exceptional cases accepted by the insurer;
  - any care, assessments, treatments, follow-up, stays or services for weight control purposes, including bariatric surgery;
  - treatments and accommodation costs in health resorts, wellness or fitness centres, convalescent facilities or rest homes, spas, thermal resorts and any other establishments not recognised as medical care providers (hospital/clinic), even where such treatment or stay is medically prescribed;
  - ancillary expenses that do not have a direct medical purpose during Hospitalisation, such as telephone, television and internet charges, newspapers, transportation costs and meals provided to visitors, except where otherwise provided for in the Table of Benefits.
- Treatments or care not recognised by the Medical Authority in the country where they take place or carried out in unauthorised facilities:
  - medical or surgical expenses not prescribed by a physician recognised by a competent Medical authority;
  - treatments, consultations, medication or care self-prescribed by the *Insured* or prescribed by their spouse, child or parent;
  - experimental treatments whose effectiveness has not been proven and recognised by the competent public health authority of the country in which they are provided.
- Pharmaceuticals:
  - parapharmaceutical products;
  - vitamins, food supplements and minerals, except for iron, folic acid and vitamin D when medically prescribed in the event of a confirmed deficiency;
  - expenses related to the purchase of medications or treatments used outside their authorised indication for use, or prescribed for purposes that are not *Medically necessary* (e.g. aesthetic weight loss or physical performance enhancement);
- Transport expenses:
  - search and transport costs for organ transplantation.
- Other *Exclusions*:
  - care, treatments and consultations provided in a hospital setting where they could have been covered on an outpatient basis;
  - care, treatments and consultations (including telehealth) provided by healthcare professionals located outside the selected Area of Cover, except in the event of an *Accident* or a *Medical Emergency* and subject to the limits set out in the Table of Benefits. This exclusion does not apply to the teleconsultation service provided by APRIL;
  - procedures and treatments related to gender reassignment;
  - expenses related to the organ donor;
  - growth hormones;
  - treatments for disorders of sexual function, such as impotence or any other sexual dysfunction, regardless of the cause;
  - all expenses related to sleep disorders;
  - expenses incurred for the completion of reimbursement claim forms or other administrative costs (such as handling fees or admission fees);
  - the consequences and effects of civil or foreign war, insurrection, rebellion, riot, military coup or any usurpation of power, martial law, or acts of any authority constituted unlawfully, regardless of where such events occur and irrespective of the parties involved, in particular where the Insured Person has exposed themselves to danger by entering an area officially recognised as strongly discouraged by the French Government or by the government of the country of expatriation, or has participated in or shown a clear disregard for their own safety.

5.3. *Exclusions* which apply to Repatriation Assistance benefits (basic and comprehensive options)

In addition to the *Exclusions* which apply to all cover as listed in paragraph 5.1 above, costs resulting from the following facts or events are not covered under the repatriation assistance benefits (they will not give rise to any compensation whatsoever nor to any intervention on the part of the Assistance provider):

- any interventions and/or reimbursements related to medical visits, check-ups, or preventive screening;
- benign conditions or *Medical conditions* which can be treated locally and that do not prevent the Insured from

continuing their journey;
- convalescence, conditions in the process of being treated and not yet stabilised and/or requiring further planned treatment;
- *Illnesses* which had been identified prior to departure and which were at risk of aggravation or relapse;
- congenital *Illnesses* or deformities;
- conditions requiring Hospitalisation in the 6 months prior to departure;
- any consequences of a condition which required repatriation (check-ups, further treatment, recurrences);
- pregnancy, except in the event of unforeseen complications that could endanger the life of the mother and/or the unborn child;
- childbirth and its complications;
- travel undertaken for diagnosis and/or treatment;
- the consequences of the failure of, unfeasibility of, or reaction to any vaccination or treatment required or mandatory for travel;
- the consequences of civil or foreign war on French territory.

The following are not covered:
- regular transportation required because of the *Insured*'s health.
- events arising from the *Insured*'s participation as a competitor in sporting competitions, bets, games, contests, rallies or their preparatory trials;
- the consequences of any neuropsychic, psychological or psychosomatic disorder, any manifestation justifying neuropsychiatric treatment, and in particular nervous depression or anxiety.

The insurer will not be held liable for any failure or delay in the performance of their obligations resulting from *Force majeure* such as civil or foreign war, revolution, riot, strike, seizure or coercion by public force, official prohibitions, piracy, explosion of devices, nuclear or radioactive effects, epidemics, climatic or natural impediments including storms, hurricanes, earthquakes.

The following are excluded from the search and rescue cover:
- Search and rescue costs resulting from a failure to observe the rules of caution laid down by the site operators and/or regulatory provisions governing the activity being practised by the *Insured*;
- Search and rescue costs resulting from the practice of a professional sport, participation in an expedition or competition, unless otherwise expressly stipulated.

Exclusions which are specific to the loss, damage or destruction of personal *Baggage*:
- dentures and optical or other prostheses, glasses and contact lenses;
- cash, personal papers, business documents, administrative documents, traveller's cheques, credit cards, airline tickets, travel tickets and vouchers;
- damage caused by normal wear and tear, depreciation or inherent defects of the *Baggage*;
- damage caused by mites or vermin or by cleaning, repairs or restoration or misuse of the *Baggage* by the *Insured*;
- damage resulting from confiscation, seizure or destruction on the orders of an administrative authority;
- valuables, jewellery and furs;
- keys or other similar objects (for example, magnetic cards or badges);
- any *Baggage* or personal effects left unattended by the *Insured*;
- mobile phones;
- it and audio-visual equipment, cameras, video cameras or hi-fi equipment entrusted to a carrier;
- costs which may be compensated under another insurance plan or costs for which the *Insured* has been compensated.

The Assistance provider can only intervene in the following circumstances:
- can only intervene within the limits of the agreements given by the local authorities;
- can under no circumstances replace local emergency rescue services or cover any costs incurred as a result of their intervention;
- will not be held responsible for any failure or difficulty in carrying out their obligations as a result of cases of *Force majeure* or events such as riots, civil war, foreign war, popular movements, revolution, strikes, seizure of control or restrictions enforced by the forces of law and order, official prohibition, piracy, detonation of an explosive device, nuclear or radioactive fallout or adverse weather conditions;
- is not obliged to intervene in cases where the *Insured* has deliberately violated the laws in force in the countries through which they are travelling or in which they are temporarily staying outside their *Country of nationality*.

5.4. *Exclusions* which apply to the Personal liability (private capacity) cover:

In addition to the *Exclusions* which apply to all cover as listed in paragraph 5.1 above, the following are not covered:

- **damage resulting from any professional activity whatsoever or the exercise of the functions of elected offices;**
- **driving any motorised or animal-drawn vehicle;**
- **the consequences of any *Material damage* or *Bodily injury* suffered by the *Insured*;**
- ***Material damage* caused by fire, explosion, or water damage having begun or occurred in the buildings or premises of which the *Insured* is the owner, tenant or of which they have private use in any capacity whatsoever;**
- **noise and disturbances caused by neighbours;**
- **damage caused by asbestos (including asbestos fibres or dust), lead (including by lead-containing particles), toxic moulds or fungal contamination and pollution damage in the USA/Canada;**
- **damage resulting from the use of automobiles or motor vehicles, sail or motor boats, aircraft or saddle animals of which the *Insured* or the persons for whom they are civilly liable have ownership, control or custody;**
- ***Material damage* to property resulting from fire, explosion or water damage if it occurs on premises of which the *Insured* is the owner or occupier or tenant. However, Damage occurring which occurred in a hotel room rented by the *Insured* (or their employer) for a period of less than thirty consecutive days remain covered on the express condition that the *Insured* has not taken up residence there;**
- **non-*Consequential financial loss*;**
- **all consequences of contractual commitments made by the *Insured* insofar as the resulting obligations exceed those which would be binding under common law;**
- **legal compensation commonly described as 'Punitive' or 'Exemplary Damages' and generally defined as compensation over and above actual damages which may be awarded to victims by courts in the *US* or Canada if they consider that the person having caused the Damage has demonstrated 'anti-social' or 'more than negligent' behaviour and 'wilful ignorance of its consequences';**
- **the consequences of any neuropsychic, psychological or psychosomatic disorder, any manifestation requiring neuropsychiatric treatment, and in particular nervous depression or anxiety.**

The following are also excluded from cover:

- ***Damage* to property, including animals, which the *Insured* is driving or riding or of which they have custody or use even when entrusted to them on a voluntary basis;**
- ***Damage* resulting from a professional or remunerated activity as well as the holding of public office or a position in a trade union);**
- ***Damage* resulting from the *Insured*'s involvement in an Act of Terrorism or Sabotage, an Attack, a Riot or a Popular movement;**
- ***Damage* resulting from non-accidental pollution;**
- ***Damage* to goods, objects, products or animals sold by the *Insured*;**
- ***Damage* caused by horses or other equines, by dogs in category 1 or 2 as defined in article 211-1 of the French Rural Code, and by wild animals;**
- **all financial consequences of *Personal liability* incumbent on the *Insured* in their capacity as an employer due to an occupational *Accident* or occupational *Illness* affecting one their employees in the performance of their duties;**
- ***Damage* resulting from the *Insured*'s social management of their employees or ex-employees, job applicants, their dependents and the social partners;**
- **direct or indirect effects of changing the structure of the atomic nucleus, climatic events such as storms and hurricanes, earthquakes, floods, tidal waves or other disasters unless these are covered under compensation for natural disasters.**

6. Policy *Effective date*, duration, and cancellation

6.1. When does your policy start?

Your application date corresponds to the *Effective date* of cover, as indicated on your Application Form. It will commence at the earliest on the day following receipt of the complete application file (including the completed and signed Application Form and Medical Questionnaire for all *Insured*), subject to payment of the first *Premium*. If your application requires a medical assessment, your policy will start no earlier than the date of medical acceptance.

Your *Effective Date* appears on the *Membership Certificate*, made available via secure access to your Member Portal and your Easy Claim app.

6.2. *Waiting periods* applicable to your policy:

Benefits shall take effect for each *Insured* on the *Effective Date* of cover, subject to the application of the following *Waiting Periods* for the Medical Expenses benefits:

- 3 months for routine dental care expenses,
- 6 months for major dental care and optical expenses (contact lenses, frames, lenses, and laser eye surgery),
- 12 months for maternity-related expenses, genetic testing, and preventive cancer surgery,
- 24 months for medically assisted reproduction expense.

Any expenses incurred for treatment or acts prescribed before the *Effective Date* of the policy, before the date of subscription to a new option, or during the applicable *Waiting Periods* are definitively excluded from cover and shall not give rise to any reimbursement.

Waiting Periods* may be waived upon review (excluding maternity), if *You* can provide evidence that *You* benefited from healthcare cover at least equivalent to the MyHealth International policy during the month preceding the policy's *Effective Date.

This waiver is subject to our approval following a review of the Certificate of Termination *You* will have provided, along with the details of the previous healthcare benefits.

6.3. Duration of cover and renewal of your policy:

Membership to this policy is effective for a period of 12 months. It shall be renewed automatically on each anniversary date for a further one-year period, unless terminated by either party on the anniversary date, by registered letter with acknowledgement of receipt or by registered electronic letter, giving two months' notice.

The Terms and Conditions and the Table of Benefits in force on the renewal date shall apply throughout the following *Insurance year.*

Should the Terms and Conditions or benefit levels be modified, *You* will be informed three months before the anniversary date of your policy. *We* undertake to inform the *Member* of any *Premium* changes two months prior to their effective date. If your policy is not terminated within thirty days of the communication of said changes, it shall be renewed based on the new conditions, subject to receipt of the corresponding *Premium* payment.

6.4. When does your policy end:

a) in the event of termination by the *Member* on the annual renewal date (policy anniversary), with a 60-day notice period;
b) in the event of mid-year termination by the *Member*, at any time after 12 months of membership. Termination will take effect 30 days after receipt of the cancellation request;
c) 30 days after receipt of the new policy conditions:
   To exercise the right to cancel, the *Member* may notify APRIL International Care France :
   - by ordinary or registered post to the following address: Service Courrier – 1 rue du Mont – CS 80010 – 81700 Blan – FRANCE
   - via the form available in your Member Portal, by selecting the reason "Request to cancel my policy"
   - or by email to care@april-international.com ;
d) in the event of non-payment of Premiums (refer to paragraph 7.3) ;
e) in the event of termination of the agreement by the insurer or by the APRIL Members' Association on the annual renewal date (in which case the Association undertakes to inform each *Member*);
f) as soon as *You* no longer meet the conditions for eligibility (refer to paragraph 3). Termination will occur at the end of the current period and no later than 30 days after receipt of the notification, subject to provision of supporting documentation;
g) when *You* are no longer considered an expatriate, upon presentation of an official document confirming this status (for example, a certificate of affiliation to the Social Security scheme of your Country of Nationality or a copy of your new employment contract).

Sanctions in the event of misrepresentation

Whether relating to the declarations to be made upon enrolment or those to be made during the term of the policy, any intentional misrepresentation, omission, or inaccurate statement in the declaration of risk shall result in the application of the appropriate measures, depending on the circumstances.

Furthermore, any omission, concealment, intentional or unintentional misrepresentation when declaring a *Claim*, failure to disclose other concurrent insurance policies, use of inaccurate supporting documents, or any attempt to defraud, shall expose the Insured and the *Member* to a forfeiture of benefits and termination of membership under the policy.

***We* reserve the right to take legal action to recover any loss or damage suffered as a result.**

***You* will be required to reimburse all benefits unduly paid to *You* under the policy**

6.5. How to cancel your policy?

Signing the Application does not constitute a binding commitment for the *Member*.

If the *Member* enrolled following a doorstep solicitation:

Any individual who has been solicited at their home, residence or workplace, even at their own request, and who signs, in this context, an insurance proposal or contract for purposes not falling within the scope of their commercial or professional

activity, has the right to cancel it by sending a registered letter with acknowledgement of receipt within fourteen (14) full calendar days from the date the contract was concluded, without having to provide any reason or bear any penalty. (...)
As soon as the policyholder becomes aware of a Claim involving the policy's coverage, they may no longer exercise this right of cancellation.

If the *Member* enrolled remotely (by telephone or online):
The *Member* has the option to cancel their membership within a period of fourteen (14) days from the date the contract was concluded.

In all cases, to exercise this right of cancellation:
The *Member* must notify *Us* of their decision to cancel their policy by making an unambiguous declaration within the time limits specified above.
To do so, they may complete the cancellation form available on page 29 or send a letter to APRIL International Care France, drafted as follows:
«I, the undersigned, Mr/Mrs..... (full name and address), hereby cancel my membership under the 'MyHealth International' policy no. .....
Done at ..... on ..... Signature ..... »
In the event of cancellation, the *Member* shall only be liable for the payment of the *Premium* corresponding to the period during which the risk was covered, this period being calculated up to the date of cancellation. *We* shall refund the balance to the *Member* no later than thirty (30) days following the cancellation date.
However, the full *Premium* shall remain payable if the *Member* exercises their right of cancellation while a *Claim* involving the policy's coverage has occurred during the cancellation period.

7. *Premiums*

Membership under this policy does not exempt *You* from paying any contributions due to the statutory health scheme to which *You* may be subject.

7.1. Calculation and revision of *Premiums*

At the time of application, the *Premium* is calculated based on the age of each *Insured* at the policy *Effective Date* and the declared *Country of residence*.
The amount of the *Premium* is specified in the invoice, including all applicable taxes. Any change in the applicable tax rates will automatically lead to a corresponding adjustment of the *Premium*.

During the policy year, the *Premium* may be adjusted based on the age of each Insured (on the policy renewal date), the *Country of residence*, the *Cover zone* and country of treatment, the selected plan and options, and the policy currency. ***You* must notify *Us* of any change in your personal situation as soon as you become aware of it. The *Premium* may be recalculated accordingly.**
The *Premium* may also be adjusted to reflect medical inflation and/or the claims experience of the insured group or other risk-related factors likely to affect the financial balance of the insurance policy.

In the event of a mid-year *Premium* adjustment, *We* will inform you of the revised *Premium* amount. *You* will then have a period of 30 days from the date of this notification to cancel your policy by registered letter with acknowledgement of receipt or by registered electronic letter.

Note: The composition of the insured group is determined based on the year of application, the age of each *Insured*, their geographic zone of residence, the composition of the insured family, the currency, and the level of cover selected.

7.2. Payment Methods:

Premiums are payable in advance in EUR or USD, annually, semi-annually, quarterly or monthly depending on the payment method chosen by the *Member*:

- Bank card
- PayPal
- Bank transfer (bank charges are borne by the *Member*)
- SEPA direct debit (only available for accounts in euros domiciled in SEPA countries) not available in USD.

Monthly payments are only available by SEPA direct debit.

The currency selected at the time of application determines the management currency of your policy, both for the payment of your *Premiums* and for the reimbursement of your *Claim*.

7.3. What happens in case of non-payment of *Premiums*?

If a *Premium* is not paid within 60 days of its due date, *We* will send a formal notice to the *Member* by registered letter. This will result in the suspension of cover by post or by registered electronic letter. After an additional 10-day period, the policy will be automatically terminated. We also reserve the right to take legal action to recover any outstanding *Premiums*.
If a formal notice is issued due to non-payment, the Premium becomes immediately due for the entire *Insurance year*, in accordance with the French Insurance Code.
Please note that non-payment and cancellation of the policy for non-payment do not extinguish the outstanding debt. *We* will take all necessary measures to recover the unpaid *Premiums* and may call upon an international debt collection agency. Any administrative fees arising from our actions or those of our service providers will be payable by the *Member*.

8. Changes to your policy

8.1. How to amend your policy?

The Member may request to modify the coverage zone, benefits, plan level, currency or options initially selected under the conditions set out below.
Such a request may be subject to review by the insurer. The *Insured* and their *Dependants* may also be required to complete new medical formalities as specified in the policy:

- In case of a change to the annual *Deductible* amount, *Copayment* level, or contract currency
  - the change will take effect on the next annual renewal date, subject to acceptance by the insurer.
- In case of a change to the type of coverage, benefits, *Cover zone* or plan level
  - the change will take effect at the end of the current policy period following receipt of the modification request, subject to acceptance by the insurer.
  - any upgrade in benefits or plan level, or move to a higher *Cover zone*, will be effective for a minimum period of 12 consecutive months.
  - any downgrade to a plan offering lower reimbursement limits is only possible after a minimum period of 12 consecutive months under the previous plan, except in the case of a change in family situation or change of *Country of residence*.
  - the packages (e.g. dental, optical, etc.) cannot be carried over when changing the health benefits plan during the policy term.

8.2. What information must *You* provide to *Us*?

The *Member* and the *Insured* must inform *Us* in writing of any change in status, personal circumstances, *Country of residence*, or contact details **(by default, any communication sent to the last known contact details shall be deemed valid)**, as well as any change in professional activity or cessation of professional activity.
Such changes may impact the *Premium*.

9. General provisions

9.1. Who insures your policy?

This policy has been taken out by the APRIL Policyholders' Association (Association governed by the French Law of 1901, located at 12 rue Juliette Récamier – 69452 LYON Cedex 06), whose purpose is to study, underwrite, and promote all types of insurance policies on behalf of its *Members*, to create a spirit of international solidarity among them, to provide them with appropriate information and management tools, and to represent them before any insurance company. The Association's statutes are available in the appendix to this document.

- **for Medical Expenses benefits:**
  under group insurance contracts with optional membership taken out with Groupama Gan Vie (Healthcare agreements 329/200468/00010, 219/200467/00010, 329/200468/55555 and 219/200467/55555 for first-euro/US dollar policies. Healthcare agreements 219/200467/10010 and 329/200468/10010 for *CFE* top-up policies), a public limited company with capital of €1,371,100,605 (fully paid-up), registered with the Paris Trade and Companies Register under number 340 427 616 (APE code: 6511Z), located at 8–10 rue d'Astorg, 75383 Paris Cedex 8, FRANCE;
- **for Repatriation Assistance and Private Liability benefits:**
  optional group assistance agreements with Chubb European Group SE (agreements FRBOTA73507, FRBOTA73508, FRBOTA73509 and FRBOTA73510), a company governed by the French Insurance Code, with a share capital of EUR

896,176,662, having its registered office at La Tour Carpe Diem, 31 Place des Corolles, Esplanade Nord, 92400 Courbevoie, France, registered with the Nanterre Trade and Companies Register under number 450 327 374 (APE code: 660E).

9.2. Legal framework

The authority responsible for overseeing the insurers for all benefits is the Autorité de Contrôle Prudentiel et de Résolution (ACPR), located at 4 place de Budapest, CS 92459, 75436 Paris Cedex 09, FRANCE. APRIL International Care France is also subject to the ACPR.
Membership of the MyHealth International policy consists of the Application form, the present General Conditions, and the *Membership Certificate*. It is governed by French law, in particular the French Insurance Code.
The benefits and levels of reimbursement of this policy will be automatically updated in line with legislative and regulatory changes governing contracts under French law.

9.3. Limitation period

Any legal action arising from this membership is inadmissible after a period of two (2) years from the date on which the event giving rise to it occurred, in accordance with the following provisions:
1° In the event of misrepresentation, omission, or false or inaccurate declaration of the risk, the limitation period starts from the day on which the insurer became aware of it;
2° In the event of a *Claim*, from the day on which the interested parties became aware of it, provided they can prove they were unaware until that time.
When the *Member's* action against the insurer is based on a third party claim, the limitation period only starts from the day the third party brought legal action against the *Member* or was compensated by the *Member*.
The limitation period is interrupted by any of the ordinary causes of interruption under the French Civil Code, as well as by the appointment of experts following a *Claim*.
It may also be interrupted by the sending of a registered letter (or electronic registered letter) with acknowledgement of receipt:

- **from the insurer to the *Member* concerning payment of contributions,**
- **or from the *Member* to the insurer concerning payment of benefits.**

No agreement between the parties to the insurance contract may alter the duration of the limitation period or add to the causes of its suspension or interruption.
The ordinary causes of interruption of the limitation period provided for by the French Civil Code are:

- **acknowledgement by the debtor of the right of the person against whom time was running;**
- **initiation of legal proceedings;**
- **a conservatory measure taken in accordance with the Civil Enforcement Procedures Code or an enforcement action;**
- **summons issued to one of the joint debtors through legal proceedings or enforcement action, or recognition by the debtor;**
- **summons issued to the principal debtor or their acknowledgement, in cases involving prescription applicable to guarantors.**

9.4. Subrogation

The insurer does not waive its rights to subrogation and may exercise recourse against any liable third party.

If *You* are the victim of a road traffic *Accident* involving a motor vehicle, *You* must, under penalty of forfeiture, inform the liable party's insurer of the identity of your health insurer acting as third-party payer, if they request it.

9.5. Verification and control

The insurer reserves the right to request all documents necessary to accurately assess benefits, including medical certificates, surgical reports and/or a second opinion by the insurer's appointed physician.

9.6. Complaints – Mediation

Quality of service is at the heart of our commitments, but if *You* wish to make a complaint about the services provided by our company, *You* can contact our complaints department as follows:

- APRIL International Care France - Service Courrier - 1, rue du Mont - CS 80010 - 81700 Blan - FRANCE
- Our offices: APRIL International Care France - 14, rue Gerty Archimède - 75012 PARIS - FRANCE
- Email: reclamation.expat@april-international.com

Processing times: *You* will receive a dated copy of your *Claim*. An acknowledgement of receipt will be sent to *You* within 10 working days of the date your *Claim* was sent. *You* will receive a reply within 2 months.

Referral to the Mediation officer: If *You* are not satisfied with the response provided, or 2 months have elapsed since *You* sent your first written complaint, *You* may refer the matter to the relevant Mediation officer at the following address:

- La Médiation de l'Assurance - TSA 50110 - 75441 Paris Cedex 09 - FRANCE,
- Email: le.mediateur@mediation-assurance.org

If the plan was taken out remotely via the Internet, *You* may also refer the matter to the competent mediator by lodging a complaint on the European Commission's platform for dispute resolution, accessible at the following address

- http://ec.europa.eu/consumers/odr/

We would like to inform *You* that the data collected for the processing of your *Claim* is processed electronically by our company for the purposes of monitoring the processing of *Claim*s and may only be communicated to the insurer, their reinsurers and the APRIL holding company, as well as to our partner service providers for the implementation of your cover. The information collected is essential for the registration, management and execution of subscriptions by APRIL International Care France, the insurers or their agents. *You* have the right to access, rectify, object to and delete your personal data (see paragraph 9.7).

9.7. Data Protection

In the course of our relationship, *We* are required to collect personal data about *You*. Information on how the data is processed and how You can exercise your rights in respect of this data can be found in the Data Protection Notice provided to *You*. This document is also available from our advisors and on our website www.april-international.com.

10. Appendix: Specific provisions applicable to *CFE* top-up cover

Article 1 – Purpose of this Appendix

If *You* are affiliated with the *CFE*, the Insurer's reimbursement shall be made as a top-up to the benefits paid by this social protection scheme, in accordance with the terms of the policy and this Appendix, as described below.

Article 2 – "Who is eligible for cover under the policy?"

In addition to the provisions of Section 4.2 – "Who is eligible for cover under the Policy?", where the benefits are selected as *CFE* top-up cover, enrolment is subject to the *Insured* being effectively affiliated with the *CFE* under the sickness and maternity schemes for the duration of the policy. Affiliation with the *CFE* is stated on the *Insurance Certificate.*

Article 3 – "What benefits are covered under your policy?"

In addition to the provisions of Section 4.1 – "What benefits are covered under your policy?", enrolment in this policy provides *You*, depending on the plans and benefits selected, with international health insurance as a top-up to the *CFE*.

Article 4 – "Nature and amount of reimbursements"

4.1 Reimbursement principles

Reimbursements by APRIL International shall be made:

- **after deduction of reimbursements made by the CFE;**
- **up to the amount of the expenses actually incurred;**
- within the benefit limits stated in Section 4.2.2 – "Healthcare benefits table". **These limits include the contribution paid by the *CFE*.**

In addition to the provisions of Section 4.2.1 – "Nature of reimbursements", in the case of *CFE* top-up cover, only healthcare expenses covered by the *CFE* are eligible for cover. **However, *We* provide cover from the first euro solely for certain benefits that are not covered by the *CFE* but are included in the Benefits Table, provided that they have been selected:**

- hospital room;
- accommodation for an accompanying parent;
- consultations with psychotherapists and psychologists;
- complementary medicine: consultations with an occupational therapist;
- alternative medicine: consultations with an osteopath, chiropractor, etiopath, acupuncturist, traditional Chinese medicine practitioner or hypnotherapist;
- consultations with dietitians and nutritionists;
- self-medication allowance;
- health check-up;
- dental implants;
- periodontology and endodontics;
- contact lenses not covered by the *CFE*;
- genetic testing;
- health or fitness application;
- laser surgery.

4.3 Operation of Deductibles and Co-payment

The *Deductibles* described in Section 4.2.3 – "Operation of Deductibles and Co-payment" are not available in the case of *CFE* top-up cover.

Article 5 – "What is excluded from your policy"

In addition to the *Exclusions* detailed in Section 5.2 – "Exclusions applicable to the Healthcare Expenses Benefit", the following are excluded:

- **any medical or surgical expenses that are not covered by the *CFE*, unless otherwise provided for under Article 4.1 above of this Appendix.**

Article 6 – "When does your policy start?"

In addition to the provisions of Section 6.1 – "When does Your Policy start?", the *Effective date* of the *CFE* top-up benefits is subject to the *Insured Person*'s entitlement to *CFE* benefits having effectively commenced.

The benefits only cover expenses incurred after both the policy *Effective Date* and the commencement of entitlement to *CFE*

benefits. The *Waiting Periods* provided for under the policy shall continue to apply.

Article 7 – "When does your policy end?"

In addition to the provisions of Section 6.4 – "Your policy benefits end", the benefits shall end for each *Insured Person* as soon as they are no longer affiliated with the *CFE*.

Article 8 – "Payment methods:"

In addition to the provisions of Section 7.2 – "Payment methods", where *CFE* top-up cover is selected, the "US dollar" currency is not available.

If You want to waive your insurance, You can use the tear-off form below and send it to APRIL International Care France – Service Courrier (Mail service) 1, rue du Mont - CS 80010 - 81700 Blan – FRANCE

CANCELLATION

Article L.112-9 of the French insurance code

Article L.112-9: "Any person who is canvassed at their home or residence or place of work, or by means of distance communication such as telephone or internet, even at their own request, and who signs an insurance proposal or contract for a purpose which is not related to their commercial or professional activity, may cancel this agreement by sending a registered letter with acknowledgement of receipt or by electronic registered letter within a period of fourteen (14) days from the day on which *You* entered into the insurance contract, without requiring to specify the reason for the cancellation or being subject to penalties."

Conditions: If *You* wish to cancel your insurance, please fill in and sign this tear-off slip. *You* should then send it in a sealed envelope by registered letter with proof of receipt to the above address. It must be sent no later than 14 days from the day following the day on which *You* entered into the insurance contract or, where the deadline expires on a Saturday, Sunday or a bank holiday or other non-working day, on the next working day.

I, the undersigned, wish to cancel my application for insurance under the following plan:

Plan name: MyHealth International Ref. NMHI26

Policy number: .....
Client reference number: .....
Date of signature of Application form: .....
Member's last name: .....
Member's first name: .....
Member's date of birth: .....
Member's address: .....
Postcode:.....Town:.....Country: .....
Telephone number: .....
Name of the insurance consultant: .....
Address of the insurance consultant: .....
Postcode:.....Town:.....Country:.....
Telephone number: .....

Date and *Member's* signature:

APRIL International Care France
14 rue Gerty Archimède - 75012 Paris - FRANCE
www.april-international.com
S.A.S. with a share capital of €200,000 – Paris Trade and Companies Register No. 309 707 727
Insurance intermediary registered with ORIAS under number 07 008 000 (www.orias.fr)
Supervised by the Autorité de Contrôle Prudentiel et de Résolution (ACPR)
4 place de Budapest - CS 92459 - 75436 PARIS CEDEX

april International
INSURANCE MADE EASY

Excerpt from the statutes of the Association des Assures APRIL

The complete Articles of Association and Rules of Procedure can be viewed online under the following link.

Updated on 17 April 2018

Article 2. Purpose

The purpose of this association is:

- the study, research, underwriting and development of all types of insurance, assistance and service products, particularly in the areas of health, health and retirement provision, with the aim of optimising the conclusion of supplementary or additional insurance policies or insurance policies from the first pound for its members, which, if necessary, supplement the benefits resulting from compulsory insurance, in particular through the conclusion of group insurance contracts with voluntary or compulsory membership;
- raising its members' awareness of key prevention issues so that they can maintain their health on the one hand and obtain preferential terms from insurance companies on the other, taking into account the responsible behaviour of its members in the area of health;
- to carry out statistical studies and analyses of its members' everyday behaviour in the area of social security;
- to establish measures for prevention, support, guidance and assistance for insured persons through a solidarity fund.

Article 5. Composition

The association is composed of members who are divided into:

- Members;
- Members who are self-employed;
- Collective members are companies, organisations or other legal entities that have signed one of the agreements concluded by the association on behalf of their employees.

To become a member of the association, one must be eligible for insurance under one of the agreements concluded by the association and have duly paid their membership fee.

Membership becomes effective from the date of receipt of the application for membership and payment of the membership fee, subject to acceptance of membership of the insurance agreement by the insurer. If membership is not accepted, the membership fee will be refunded within thirty days of notification of rejection by the insurer at the latest.

By resolution of the Board of Directors, the following are also members, but without voting rights:

- natural or legal persons who render or have rendered special services to the association, known as honorary members;
- natural or legal persons who make a donation or bequest to the association, known as supporting members.

Article 6. Loss of membership

Membership shall expire:

- upon death, disappearance or absence in the case of natural persons;
- upon liquidation or dissolution by mutual agreement or by court order in the case of legal persons;
- upon expulsion by the Board of Directors for violations of these Articles of Association or if the behaviour has proven to be contrary to the financial and moral interests of the Association;
- upon loss of insured status in one of the agreements concluded by the association (termination, cancellation, waiver);
- by notice of termination sent by registered letter with acknowledgement of receipt to the president at the association's registered office. This letter must be accompanied by a copy of the letter issued by the administrative office of the contract(s) confirming its/ their termination; these terminations must comply with the conditions set out in the information sheets that serve as the general terms and conditions of the contract(s).

In any case, the membership fee due for the year in which membership is lost shall remain with the association.

Article 8. Provisions applicable to members

All membership of the association is subject to insurance contracts concluded between the association and insurance companies. The content of these contracts, which specify in particular the conditions and consequences of termination of the contracts by the association or the insurance company, is provided to members upon joining the association and signing the contract in the form of an information brochure, which serves as the general terms and conditions.

Article 9. Funds of the association

The association's funds consist of:

- the contributions of its members;
- the income from its assets;
- the amounts charged in return for the services provided by the association;
- legally approved subsidies or payments;

- all other funds not prohibited by law.

Article 11. Solidarity fund

A solidarity fund shall be established for the purpose of financing measures to support, accompany and assist members.

The amount of the annual contribution from the Solidarity Fund shall be determined by the Board of Directors, which shall also determine the guidelines, tasks and functioning of the Fund.

The various solidarity actions of the association, as well as the conditions for access and allocation, shall be laid down in the rules of procedure.

Article 13. General meetings

1. General meetings

1.1 Ordinary General Meeting

At least once a year, the members shall be convened to an ordinary general meeting under the conditions set out below.

The Ordinary General Meeting shall hear:

- the annual report prepared by the Board of Directors, which shall concern in particular the functioning of the insurance contracts concluded by the Association. This report shall be made available to members upon request;
- the auditor's reports;
- the statement of accounts;
- the financial report.

After deliberating and voting on the various reports, the Ordinary General Meeting approves the annual financial statements (calendar year) and decides on all other items on the agenda.

It ensures the renewal of the members of the Board of Directors in accordance with the provisions of Article 12 of these Articles of Association.

1.2 Extraordinary General Meeting

It shall be convened under the conditions set out below.

The Extraordinary General Meeting decides on matters falling within its sole competence: amendments to the Articles of Association, mergers or dissolutions.

2. Convening

2.1 Convening of the Ordinary and Extraordinary General Meeting

The members of the association in accordance with Article 5 who are members at the time of the convening and have duly paid their membership fees shall meet at least once a year for an ordinary general meeting and, if necessary, for an extraordinary general meeting. The members of the association pursuant to Article 5 who are members at the time of the convocation and have duly paid their membership fees shall meet at least once a year for an ordinary general meeting and, if necessary, for an extraordinary general meeting.

The ordinary and extraordinary general meetings shall be composed of all members of the association who have duly paid their membership fees.

The convocation shall be made by name and shall be validly effected at the discretion of the Board of Directors:

- either by letter or email sent at least sixty calendar days before the date of the general meeting;
- or by announcement in a publication addressed to all members.

General meetings are convened by the president of the association or, in the case of extraordinary general meetings, at the request of at least 10% of the members. In the latter case, invitations to the extraordinary general meeting must be sent within eight days of the request being submitted, and the extraordinary general meeting must take place within thirty days of these invitations being sent.

The invitations must include the date, time, place and agenda set by the Board of Directors.

Motions signed by at least one hundred members shall also be included on the agenda, provided that they are sent by registered mail to the president of the association at least forty-five days before the date set for the general meeting.

Only resolutions of the general meeting on items on its agenda are valid.

Furthermore, the invitations must state that, if a quorum is not reached, they shall be deemed invitations to a second general meeting.

3. Voting rights

3.1 Voting rights at ordinary and extraordinary general meetings

Each member has one voting right and one vote at the ordinary and extraordinary general meetings.

Members who are legal entities are represented by their legal representative.

Each member who is a natural person has the right to authorise another member or their spouse. A single member may not hold more than 5% of the voting rights. The proxy granted is valid for a single general meeting or for two if a quorum is not reached at the first meeting or if two meetings – one ordinary and one extraordinary – take place on the same day.

Blank proxies returned to the association shall be transferred to the president or his representative on the board of directors and shall entitle the holder to vote on the adoption of the draft resolutions submitted or approved by the board of directors.

3.1.1 Ordinary General Meeting

Resolutions of the Ordinary General Meeting shall be passed by a majority of the votes cast.

All resolutions shall be passed by a show of hands. However, if at least one quarter of the members present so request, a secret ballot shall be held.

A secret ballot is mandatory for the election of members of the Administrative Board.

3.1.2 Extraordinary General Meeting

Resolutions must be passed by a two-thirds majority of the members present or represented.

Resolutions must be passed by a two-thirds majority of the members present or represented.

4. Conduct of meetings

Meetings are chaired by the President of the Association, who may delegate his duties to the Vice-President or, if the latter is unable to attend, to another member of the Executive Board.

The deliberations shall be recorded in a special register and signed by the President and the Secretary. The minutes may be inspected at the association's registered office.

An attendance list certified by the President and the Secretary shall be kept.

Within the scope of the powers conferred on them by these Articles of Association, all members concerned, including those who are absent, are bound by the resolutions of the meetings.

4.1 Holding of ordinary and extraordinary general meetings

The ordinary and extraordinary general meeting shall only have a quorum if at least one thousand members are present or represented. If the general meeting does not reach this quorum at the first convocation, a second general meeting shall be convened. This shall have a quorum regardless of the number of members present or represented.

If a quorum is not present, the second general meeting may be held immediately after the first with the same agenda.

Upon resolution of the President, ordinary and extraordinary general meetings may be held remotely and may result in an electronic vote.

APRIL International Care France
14 rue Gerty Archimède - 75012 Paris - FRANCE
www.april-international.com

S.A.S. with a share capital of €200,000 – Paris Trade and Companies Register No. 309 707 727
Insurance intermediary registered with ORIAS under number 07 008 000 (www.orias.fr)
Supervised by the Autorité de Contrôle Prudentiel et de Résolution (ACPR)
4 place de Budapest - CS 92459 - 75436 PARIS CEDEX 09 -