GENERAL CONDITIONS
2020

Ref: MHF Cov

MyHEALTH FRANCE

Updated October 2019

Insurance made easy.

For further information about your plan, we can be contacted Monday to Friday from 8.30 am to 6 pm - Paris time.
Tel: +33 (0)1 53 05 30 57 - Fax: +33 (0)1 73 02 93 90 - Email: myhealth.france@april-international.com

TABLE OF CONTENTS

PREAMBLE **P.3**

1. SERVICES AVAILABLE UNDER YOUR PLAN **P.4**
1.1. DIRECT BILLING SERVICE p.4
1.2. ONLINE SERVICES p.4
1.3. WHERE TO SEND YOUR CLAIMS FOR REIMBURSEMENT OR REQUESTS FOR A DENTAL QUOTE p.4

2. DEFINITIONS **P.4**

3. PLAN BENEFITS AND TERRITORIALITY **P.6**
3.1. WHAT IS COVERED BY YOUR PLAN? p.6
3.2. WHERE ARE YOU COVERED? p.6

4. WHO IS COVERED BY THE PLAN? **P.6**

5. EFFECTIVE DATE, DURATION AND CANCELLATION OF THE PLAN **P.6**
5.1. WHEN DOES YOUR PLAN TAKE EFFECT? p.6
5.2. WAITING PERIODS WHICH APPLY TO YOUR PLAN p.6
5.3. DURATION OF COVER AND RENEWAL OF YOUR PLAN p.6
5.4. YOUR COVER COMES TO AN END p.6
5.5. HOW TO CANCEL YOUR PLAN p.7

6. PREMIUMS **P.7**
6.1. HOW IS YOUR PREMIUM CALCULATED? p.7
6.2. PAYMENT METHODS p.8
6.3. WHAT HAPPENS IF THE PREMIUM IS NOT PAID? p.8

7. MAKING CHANGES TO YOUR PLAN **P.8**
7.1. HOW TO MAKE CHANGES TO YOUR PLAN? p.8
7.2. WHAT DO YOU NEED TO TELL US ABOUT? P.8

8. WHAT IS COVERED AND HOW TO ACCESS THE SERVICES **P.8**
8.1. TYPE AND AMOUNT OF REIMBURSEMENT p.8
8.2. PAYMENT OF CLAIMS p.11

9. WHAT IS NOT COVERED BY YOUR PLAN **P.11**
9.1. EXCLUSIONS SPECIFIC TO THE LEVEL 1 PLAN p.11
9.2. EXCLUSIONS SPECIFIC TO THE LEVEL 2, LEVEL 3, LEVEL 4, LEVEL 5 PLANS P.11

10. GENERAL PROVISIONS **P.12**
10.1. WHO INSURES YOUR PLAN? p.12
10.2. LEGAL p.12
10.3. LIMITATIONS p.12
10.4. SUBROGATION p.13
10.5. COMPLAINTS - MEDIATION p.13
10.6. DATA PROTECTION AND FREEDOM OF INFORMATION p.13

NB: The original version of this document is in French. In the event of a dispute, the French version shall prevail over any translation into other languages.

PREAMBLE

The purpose of these general conditions is to describe the benefits and services provided under the optional group insurance plans, MyHealth France, purchased by the Association des Assurés APRIL from Axéria Prévoyance (for the LEVEL 1 plan: agreement 3AMHFFDSNR2018 and for the other plans: agreement 3AMHFFDSR2018).

Axéria Prévoyance is a French public limited insurance company with a capital of €31,000,000, whose head office is located at 90 avenue Felix Faure, 69439 Lyon Cedex 03, FRANCE. It is registered with the Lyon Trade & Companies register under number 350 261 129 and is regulated by the Prudential Supervision and Resolution Authority located at 4 place de Budapest, 75436 Paris Cedex 09. Axéria Prévoyance is also referred to as the "Insurer" in these General Conditions.

The Association des Assurés APRIL is an association formed under the French Act of 1901, located at 69439 LYON Cedex 03, whose purpose is to study, arrange and promote for the benefit of its members, all types of insurance authorised by law, in the form of group insurance where the risk is insured by licenced insurance companies operating under the French Insurance Code, the French Mutuality Code or the French Social Security Code.

The organisation managing these insurance agreements, as the Insurer's delegate, is APRIL International Care France, a French simplified joint-stock company with a capital of €200,000, an insurance intermediary, registered in the Paris Trade and Companies register under number 309 707 727 and with ORIAS under number 07 008 000 (www.orias.fr), whose head office is located at 14 rue Gerty Archimède, 75012 Paris, FRANCE. The company is regulated by the Prudential Supervision and Resolution Authority, located at 4 place de Budapest, 75436 Paris Cedex 09.

The *Member* is the individual who joins the Association and is enrolled in this Plan.

Membership consists of the application form, the general conditions and the *Membership certificate* which specifies the Insurer. The Plan is governed by French law and in particular the French Insurance Code. The language used for the implementation of this plan is French.

The term *Insured* means all persons who are entitled to benefits under the MyHealth France Plan. Insured members are listed on the *Membership certificat*e.

The LEVEL 1 plan of insurance agreement n° 3AMHFFDSNR2018 does not meet the criteria for state-approved health insurance. This means it does not fall under the legislative framework of supplementary health insurance plans offering tax and Social Security benefits in accordance with the provisions of Articles L.871-1 and L.862-4 of the French Social Security Code and Articles R.871 and R.871-2 onwards of the French Social Security Code. It does not therefore qualify for the tax regime provided for under Act n° 94-126 of 11/02/1994 known as the "Loi Madelin" or Madelin law.

The LEVEL 2, LEVEL 3, LEVEL 4 and LEVEL 5 plans of insurance agreement n° 3AMHFFDSR2018 meet the criteria for state-approved health insurance. This means they fall under the legislative framework of supplementary health insurance plans which offer tax and Social Security benefits in accordance with the provisions of Articles R.871-1 and R.871-2 onwards of the French Social Security Code.

The benefits cover medical expenses which are reimbursable by French Social Security at, as a minimum, 100% of the Reimbursement rate. Likewise, no exclusions from cover specified in these General Conditions will apply to the requirements to provide cover as set out in articles R.871-1 and R.871-2 of the French Social Security Code. This Agreement also complies with the minimum reimbursement thresholds and maximum cover limits set for State-approved insurance plans known as "Contrats Responsables" and the conditions under which excess fees charged by doctors who have not signed up to the Controlled Pricing System, DPTAM, may be covered.

Under the "100% santé" reform and in application of decree n° 2019-21 of 11th January 2019, expenses incurred for medical services from the "100% santé" basket of care will be fully covered up to the level of the retail prices set under this system and less the reimbursement from the *Statutory scheme*. These expenses will be covered in accordance with the schedule set out in the decree referred to above.

As a result, your benefits and levels of reimbursement will be automatically adjusted in line with the legislative and regulatory developments governing state-approved health insurance.

If *You* wish to benefit from the tax regime provided for under French Act n° 94-126 of 11/02/1994 known as the "Madelin law", *You* must:

- be subject to the income tax regime in respect of Industrial and Commercial Profits or Non-commercial Profits or wages and salaries in application of the provisions of Article 62 of the French General Tax Code; be enrolled in a Statutory French Health Insurance Scheme;
- be up-to-date with the payment of your contributions to the French Health and Old Age Insurance schemes in which *You* are enrolled.

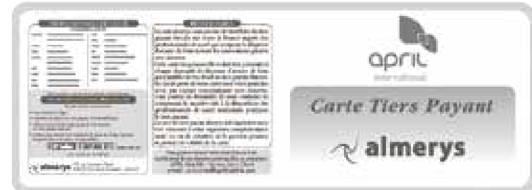
To make the document easier to understand, a definition of each term or expression written in italics and spelled with a capital letter is provided in paragraph 2 (Definitions).

1. SERVICES AVAILABLE UNDER YOUR PLAN

1.1. DIRECT BILLING SERVICE:

You will be provided with a "direct billing" card when you join the plan with a new card being sent out to you at the end of each year if your plan is renewed. With this card your medical expenses are directly covered if your medical care is delivered and billed in France. You are covered up to the level of the benefits provided under this plan and will be responsible for paying any costs over and above these amounts.

The direct billing card can be used for the following:
- pharmacy items,
- outpatient care,
- transportation,
- clinical laboratory services,
- radiology,
- medical auxiliaries,
- specialist doctors.



1.2. ONLINE SERVICES:

At www.april-international.com, get personalised information through the secure "Customer zone" section.

If *You* are the *Principal insured*, *You* can:
- view your reimbursement statements, your benefits or these General conditions,
- view your personal and bank details.

If *You* are the *Member*, *You* can:
- view your personal details and those of your insurance consultant,
- check your *Premiums* and payment method.

1.3. WHERE TO SEND YOUR CLAIMS FOR REIMBURSEMENT OR REQUESTS FOR A DENTAL QUOTE

We have set up an electronic transfer service which means you don't have to send us the reimbursement statements from your *Statutory scheme*. This is because your statements are sent directly to us by French Social Security.

The electronic transfer service is not available if you choose the LEVEL 1 plan.

***We* reserve the right to request any other supporting documents we deem necessary to ensure your medical care is covered under this plan.**

To submit a Claim for reimbursement or request a Dental quote (see paragraph 8.2):
APRIL International Care France - Service Courrier (Mail Service) - 1 rue du Mont - CS 80010 - 81700 Blan - FRANCE

2. DEFINITIONS

Each term defined below has the following meaning when written in italics and spelled with a capital letter:

A

ACCIDENT: any unintentional personal injury suffered by the *Insured*, stemming from the abrupt, sudden, violent, fortuitous and unforeseeable action of an external cause. Under Article L.1353 of the French Civil Code, you are responsible for providing proof of the *Accident* and of the direct cause-and-effect relationship between it and the costs incurred.

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

APPROVED FACILITY: a facility licensed to provide medical care to insured persons which has signed an agreement with a French Social Security organisation.

C

CERTIFICATE OF CANCELLATION: document serving as evidence of the end of entitlement to benefits provided by the *Insured's* previous health insurer. This document shows the date of enrolment in the plan, the date of termination, the list of plan beneficiaries and the medical cover to which they are entitled.
CLAIM: event, *Illness* or *Accident* which gives rise to cover when the contract is in effect.

COORDINATED CARE PATHWAY: the coordinated care pathway consists of choosing, and prioritising consultations with, a particular doctor (known as the treating doctor) for your medical care except in emergencies, when you are away from home or where direct access to a specialist is authorised (ophthalmologists and gynaecologists and, for patients under 26, psychiatrists and neuropsychiatrists). The coordinated care pathway applies to patients from the age of 16 and, by following it, your reimbursements will not be subject to penalties

CO-PAYMENT: share of costs remaining payable by you after the reimbursement from your *Statutory scheme*.

COUNTRY OF NATIONALITY: the country shown on your passport or on any other official identity document under the heading "nationality".

D **DAILY HOSPITAL CHARGE:** the patient's contribution to costs payable in connection with their *Hospitalisation*.

DEPENDENT CHILD: your child or that of your *Spouse*:
- under 21 years of age,
- under 26 years of age, in full-time education.

The children are considered dependent when they fulfil the conditions listed above even if they carry out a professional activity temporarily (seasonal work...) or part-time (odd jobs...) provided that they can prove that they do not have any top-up healthcare cover from this activity.

DPTAM (CONTROLLED PRICING SYSTEM): generic term for the various systems designed to control excess fees charged by health professionals in the approved sector. This includes doctors who have signed up to the the Access to Care Agreement (CAS) or who have chosen the Controlled Pricing Option (OPTAM / OPTAM-CO).
By consulting a doctor who has signed up to a 'DPTAM', your medical treatment, procedures and consultations will be reimbursed by French Social Security at a higher rate.

'DPTAM'-REGISTERED DOCTOR: doctor who has signed up to a Controlled Pricing System (DPTAM).

NON 'DPTAM'-REGISTERED DOCTOR: doctor who has not signed up to a Controlled Pricing System (DPTAM).

E **EFFECTIVE DATE:** date on which the policy takes effect. It is specified on the *Membership certificate*.

EXCESS: (Article L322-2 of the French Social Security Code): fixed amount which is not reimbursed by French Social Security. This Excess, which is payable by the *Insured*, applies to pharmacy items, medical auxiliaries and medical transportation with the exception of emergency transportation. The Excess is not reimbursed under this plan.

F **FLAT RATE:** the price set for a generic drug. This is the rate on which reimbursements of generic drugs are calculated by your *Statutory scheme*.

FRENCH SOCIAL SECURITY REIMBURSEMENT RATE (SSRR): statutory rate of reimbursement used by French Social Security for treatments, procedures or prescriptions performed or issued by health professionals. It varies depending on the sector to which the health professional or hospital belongs. Where generic medicines exist, the reimbursement rate is the *Flat rate* corresponding to the price of the generic version.

H **HOSPITALISATION:** a (medical or surgical) stay in a (public or private) hospital during which you are allocated a bed following an *Accident,* an *Unforseen illness* or an *Illness*.

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

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

INSURED: all individuals covered by the benefits under this plan. That is, *You* and the members of your family who meet the conditions of insurance. They are specified on the *Membership certificate*. The members of your family are your *Spouse* and *Dependent children*.

M **MEDICAL AUTHORITY:** person holding a medical or surgical diploma which is valid in the country where *You* are staying.

MEMBER: individual or company who is a member of this group plan effected by "l'Association des Assurés APRIL" and who pays the *Premium*.

MEMBERSHIP CERTIFICATE: document serving as proof of insurance, which *We* issue to the *Member* confirming their cover under the MyHealth France plan and specifying the *Insured*, the *Effective date* and the cover and options selected. The *Membership certificate* reflects the special conditions of the plan.

P **PREMIUM:** sum paid by the *Member* in exchange for the cover granted by the insurer.

PRINCIPAL INSURED, "YOU": individual accepted by the insurer.

R **RECOMMENDED RATE:** Reimbursement rate used by the *Statutory scheme* agreed between French Social Security and the professional associations of various types of practitioner for doctors in the non-approved sector.

S **SPOUSE:** husband or wife of the *Principal insured*, from whom they are neither divorced nor legally separated, or the partner of the *Principal insured* by means of a Civil Partnership in force on the date of the *Claim* (article 515-1 of the French Civil Code). The *Principal insured's* de facto spouse will be considered to be a *Spouse* if documentary proof is provided.

STANDARD RATE: Reimbursement rate used by the *Statutory scheme* agreed between French Social Security and the professional associations of various types of practitioner for doctors in the approved sector.

STATUTORY FLAT-RATE CONTRIBUTION TO COSTS (Article L322-2 of the French Social Security Code): Flat-rate charge which is not reimbursed by French Social Security. This flat-rate contribution to costs, payable by the *Insured*, applies to consultations, treatments and procedures performed by doctors and clinical laboratory services. It is not reimbursed under this plan.
STATUTORY SCHEME: the French health insurance scheme in which *You* are enrolled.

U **UNFORESEEN ILLNESS:** any sudden and unpredictable deterioration in the state of health confirmed by a competent *Medical authority*.

US/WE: APRIL International Care France.

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*.

3. PLAN BENEFITS AND TERRITORIALITY

3.1. WHAT IS COVERED BY YOUR PLAN?

Depending on the plan you selected, Membership provides you with the reimbursement of your medical expenses on top of the benefits paid by the French *Statutory scheme* to which *You* belong. The plan *You* selected is specified on the *Membership certificate*.

3.2. WHERE ARE *YOU* COVERED?

You are covered for a year at a time in France. Benefits can also be claimed during temporary stays of up to 90 consecutive days in the event of *Unforeseen* illness anywhere in the world, as well as in your *Country of nationality* if you are covered by your *Statutory scheme*.
As a result of heightened tension in certain countries, prior confirmation must be obtained from *Us* that the cover is valid there. The complete list of excluded countries is available at www.april-international.com or by calling +33 (0)1 53 05 30 57 or by email at myhealth.france@april-international.com. This list is subject to change.

4. WHO IS COVERED BY THE PLAN?

To be covered by the insurance, *You* must:
- be living in France, outside your *Country of nationality*, for the entire duration of the plan,
- be enrolled in a French *Statutory scheme*.

The members of your family may also benefit from cover under this plan (if they are specified on your *Membership certificate*), as long as they comply with the above cited conditions, i.e.:
- your *Spouse*,
- your *Dependent children*.

Membership rests on your declarations and those of the *Member* and on the good faith of all parties and is subject to our approval.

5. EFFECTIVE DATE, DURATION AND CANCELLATION OF THE PLAN

5.1. WHEN DOES YOUR PLAN TAKE EFFECT?

On the date specified on the *Membership certificate* and, at the earliest, on the 16th of the month or the first day of the month following receipt of the Application form completed and signed, subject to the suspensory condition of payment of the *Premium* due and our acceptance of the application evidenced by the issuing of a *Membership certificate* specifying the cover selected.

5.2. WAITING PERIODS WHICH APPLY TO YOUR PLAN:

There are no *Waiting periods*.
Expenses incurred in respect of prescribed treatments or procedures must be received during the period of cover.

The dental cover, orthodontics, and dentures from the "Free pricing" basket (excluding medical care and dentures from the "100% santé" basket) as described in the benefits schedule, are limited to 100% of the *French Social Security Reimbursement Rate* during the first (6) six months following the *Effective date*.
This cover limit may not apply if *You* can provide evidence that you **previously had cover of the same type and at the same level** as the benefits provided under the MyHealth France plan and if this cover was **cancelled less than one (1) month** from the *Effective date* of this plan.

5.3. DURATION OF COVER AND RENEWAL OF YOUR PLAN

Membership of this plan is effective for a period ending on 31st December of the year during which it came into effect. It is renewed automatically on 1st January of each year for a period of one year and for as long as the agreements remain in force.
Your medical expenses cover is life-long from the date of membership, that is, the insurer may not cancel your plan other than in the cases listed in paragraph 5.4.

5.4. YOUR COVER COMES TO AN END

a) if the *Member* cancels at the annual renewal date of 31/12 by registered letter at least 2 months before this date (sent before the 31/10).
b) if the *Premium* is not paid (see paragraph 6.3);
c) in the event of cancellation of the plan by the insurer or by "l'Association des Assurés APRIL" on the annual due date (in this case the Association will inform each *Member*);
d) when *You* no longer meet the conditions of insurance (see paragraph 4);
e) if *You* are no longer living in France. Supporting documentation must be produced (for example, a certificate showing that you are no longer covered by the statutory scheme or a copy of your new contract of employment).

f) if *You* make a false declaration, in accordance with the provisions below.

In the event of termination by the insurer or the Association as per paragraph c) above, the insurer agrees to maintain medical expenses cover equivalent to that in force on the date of termination.

Penalties for false declaration:

Any omission, concealment or false declaration, whether intentional or not, identified by APRIL in the information provided to them will result in the application of the penalties provided for in Articles L 113-8 and L 113-9 of the French Insurance Code, with the insurance contract being rendered null and void in cases of intentional misrepresentation.

Article L113-8 of the French Insurance Code:
Irrespective of the ordinary causes of nullity and subject to the provisions of article L132-26, the insurance contract is rendered null and void in the event of intentional concealment or false declaration on the part of the *Insured*, if this concealment or false declaration changes the subject of the risk or decreases the insurer's assessment of that risk, even if the risk which the *Insured* omitted or distorted has no impact on the *Claim*.
The Insurer is then entitled to retain the *Premiums* paid and to payment of all due premiums by way of damages.

Article L 113-9 of the French Insurance Code:
Omissions or inaccurate declarations made by the *Insured* whose bad faith has not been established will not render the insurance null and void. If this is discovered before any *Claims* have been made, the insurer has the right either to uphold the insurance contract subject to a *Premium* increase being accepted by the *Insured*, or to terminate the insurance ten days after notification has been issued to the *Insured* by registered letter. The portion of the *Premium* paid in respect of the time when the insurance is no longer in place will be refunded. If it is only discovered once a *Claim* has been made, compensation is reduced in proportion to the *Premium* rates paid against the *Premium* rates which would have been due if the risks had been fully and accurately reported.

5.5. HOW TO CANCEL YOUR PLAN

Signing the Application form does not constitute a binding agreement for the *Member* in the following cases:

If the *Member* purchased the insurance as a result of door-to-door canvassing:
The following provisions under article L.112-9-I of the French Insurance Code apply: *"Any person who is canvassed at their home or residence or place of work, even if this visit was 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 letter during a period of 14 calendar days from the date of entering into the agreement without requiring to specify the reasons for the cancellation or being subject to penalties. (…). As soon as they become aware of any circumstances giving rise to a claim under the insurance contract, the policyholder loses this right to cancel*".

If the *Member* has entered into a distance contract (by telephone or internet):
The *Member* may cancel their membership within 14 days of receipt of the *Membership certificate* and the General conditions.

In all cases, in order to exercise this right to cancel:
The *Member* must notify us of their decision to cancel their plan by means of a clearly-worded statement within the timescales specified above.

To do this, simply complete the cancellation form available on page 15 or send a letter to APRIL International Care France - Service Courrier (Mail Service) - 1 rue du Mont - CS 80010 - 81700 Blan using the following template:

"*I, the undersigned, M……..(first name, last name, address) wish to cancel my membership of the "MyHealth France" plan number …........…................. Signed in (town)... on ....………..……………………………………….. Signature …..............................…………………………………………*"

Cover comes to an end on the date of receipt of the letter of cancellation. *We* will refund the *Member* the *Premiums* already paid with the exception of those corresponding to the period of cover which has already passed.

If any benefits have already been paid under this plan, the *Member* will no longer have the right to cancel.

6. PREMIUMS

6.1. HOW IS YOUR PREMIUM CALCULATED?

The *Premium* increases on 1st January of each year in line with the age of eachh *Insured*. The age of the *Insured* used to calculate the first year's *Premium* is the age of the *Insured* on the *Effective date* of the plan. For each following year, the age of the *Insured* used to calculate the *Premium* is the age of the *Insured* on 1st January of that year.

Taxes currently payable by the *Member* are included in the *Premium*. Any change in the level of these taxes will be reflected in the amount of the *Premium*.

If several persons are enrolled in the same plan, the total premium will be the sum of the premiums of all persons insured under this plan.
The *Premium* may increase on 1st January of each year depending on the claims history of the insured group. The composition of the group takes into account the age of each *Insured*, cover and level of cover selected.

The *Insured's* state of health and their level of medical expenditure are not taken into account for the calculation of the *Premium*. If the *Member* requests an amendment to the level of cover initially selected, the age used for the calculation of the *Premium* will be the age of the *Insured* on the date when the amendment takes effect.

6.2. PAYMENT METHODS:

Premiums are payable in advance in euros, annually by bank card or SEPA direct debit from a bank account in euros located in one of the SEPA countries or monthly by SEPA direct debit, depending on the payment method chosen by the *Member* on their membership Application form.

6.3. WHAT HAPPENS IF THE PREMIUM IS NOT PAID?

If the *Premium* remains unpaid 10 days after its due date, *We* will serve the *Member* with formal notice of suspension of cover. The plan will then be suspended 30 days later. Following a further period of 10 days, *We* will terminate the plan. Legal action may be taken to secure payment of any unpaid *Premiums*.
Once formal notice has been served, the *Premium* due for the entire year is immediately payable under the French Insurance Code. Please note that failure to pay the *Premiums* and the subsequent termination of the plan do not cancel the debt. *We* will take appropriate action to obtain payment of the *Premium* due and will have recourse to a debt recovery firm specialising in international debts. The *Member* is liable for any administration charges incurred as a result of any action taken by *Us* or by our service providers.
If the amount stated on the letter of formal notice is paid after suspension of the plan but before termination, the plan will be revived at noon on the day after the *Premium* is paid.
No expenses incurred during the period of suspension of cover will be reimbursed under the plan, even once the *Premium* has been paid.

7. MAKING CHANGES TO YOUR PLAN

7.1. HOW TO MAKE CHANGES TO YOUR PLAN

The *Member* may switch to a different plan from the one they initially chose (with effect at the earliest on the 1st of the month following receipt of their request and effective for a minimum period of 12 consecutive months). If they require any further information, the *Member* should contact their insurance advisor from whom they purchased their plan.

7.2. WHAT DO YOU NEED TO TELL US ABOUT?

The *Insured* and the *Member* must inform us in writing of any change in status, situation or contact details **(otherwise all correspondence sent to the last known address will be deemed to have been served)**. *We* must also be informed of any change of occupation.

8. WHAT IS COVERED AND HOW TO ACCESS THE SERVICES

Double insurance:

Reimbursements from the French *Statutory scheme*, 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.

8.1. TYPE AND AMOUNT OF REIMBURSEMENT:

Medical expenses are covered within the limits of *Actual costs*.

All medically justified healthcare expenses for treatments and procedures listed in the benefits schedule which are prescribed by a qualified *Medical authority* and covered by the *Statutory scheme* will be reimbursed. *We* intervene only to provide you with a supplement to your *French Statutory health insurance scheme* (unless otherwise stated in the benefits schedule).

For medical care received in France, the conditions required for the provision of cover are those set out with reference to the French Social Security general classification of procedures.

For medical expenses billed in a currency other than the euro, the exchange rate will be applied when the treatment is received. Only expenses related to treatment received during the period of cover will be reimbursed.

There are five healthcare plans depending on the level of cover required: LEVEL 1, LEVEL 2, LEVEL 3, LEVEL 4 and LEVEL 5.

Expenses are reimbursed item by item under the chosen plan (which is specified on your *Membership certificate*) and in accordance with the benefits schedule.

The benefit amounts listed below are expressed as a percentage of the Social Security (SS) Reimbursement Base (RB) or as a % of actual costs. They include the portion covered by the French Statutory Health Insurance Scheme (except for the cover limits for Dental care where the package shown in the benefit schedule is in addition to the benefits from the *Statutory Scheme*). APRIL reimbursements are therefore calculated less the SS reimbursement.

The covered amount varies based on whether or not the doctor has signed up to a *Controlled Pricing Scheme* (*DPTAM*), with the exception of the LEVEL 1 plan, as specified in the benefits schedule.

Upper limits:

The cumulative amount of reimbursements paid by the insurer is limited, per *Insured* and per *Insurance year*, to the amount specified in the benefits schedule for each option, less any compensation or benefits of the same type paid by your *Statutory scheme* or any public or private organisation in France or abroad (other than the upper limits for Dental care where the package specified in the benefits schedule is added to the benefits provided by your *Statutory scheme*).

		PLAN				
TREATMENT OR PROCEDURE		**LEVEL 1**	**LEVEL 2**	**LEVEL 3**	**LEVEL 4**	**LEVEL 5**
HOSPITALISATION* (Medical and surgical hospitalisation, home hospitalisation and maternity)						
Room and board		300% of the *SSRR*	100% of the *SSRR*	300% of the *SSRR*	150% of the *SSRR*	300% of the *SSRR*
Daily hospital charge		100% of *Actual costs*	100% of *Actual costs*	100% of *Actual costs*	100% of *Actual costs*	100% of *Actual costs*
Medical and surgical fees and expenses	*"DPTAM"-registered doctors*	300% of the *SSRR*	100% of the *SSRR*	300% of the *SSRR*	170% of the *SSRR*	300% of the *SSRR*
	Non "DPTAM"-registered doctors	300% of the *SSRR*	100% of the *SSRR*	200% of the *SSRR*	150% of the *SSRR*	200% of the *SSRR*
Private room **(maximum 30 days per year)**		€50 /day	€25/day	€50 /day	€25/day	€75/day
Cost of staying in hospital with a child under 12 **(maximum 30 days per year)**		€25/day	€25/day	€25/day	€25/day	€50 /day
Patient transportation costs reimbursed by the *Statutory scheme*		300% of the *SSRR*	100% of the *SSRR*	300% of the *SSRR*	150% of the *SSRR*	300% of the *SSRR*
OUTPATIENT CARE						
Medical fees: Consultations/Visits - GPs and specialists Specialist treatment or procedures, surgery and technical medical procedures, including on an outpatient basis	*"DPTAM"-registered doctors*	–	100% of the *SSRR*	100% of the *SSRR*	170% of the *SSRR*	220% of the *SSRR*
	Non "DPTAM"-registered doctors	–	100% of the *SSRR*	100% of the *SSRR*	150% of the *SSRR*	200% of the *SSRR*
Radiology	*"DPTAM"-registered doctors*	–	100% of the *SSRR*	100% of the *SSRR*	170% of the *SSRR*	220% of the *SSRR*
	Non "DPTAM"-registered doctors	–	100% of the *SSRR*	100% of the *SSRR*	150% of the *SSRR*	200% of the *SSRR*
Medical auxiliaries and diagnostic tests		–	100% of the *SSRR*	100% of the *SSRR*	150% of the *SSRR*	200% of the *SSRR*
Medicines reimbursed by the *Statutory scheme*		–	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*
Spa therapies covered by the *Statutory scheme*		–	100% of the *SSRR*	100% of the *SSRR*	150% of the *SSRR*	200% of the *SSRR*

TREATMENT OR PROCEDURE	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	LEVEL 5
DENTAL (Cover limited to 100% of the SSRB for the first 6 months except for “100% Santé” baskets)					
Treatment reimbursed by the Social Security	–	100% of the *SSRR*	100% of the *SSRR*	150% of the *SSRR*	300% of the *SSRR*
Treatment and dentures from the “100% Santé” basket which are reimbursed by the Social Security[1]	–	100% of real costs			
Dentures from the “Controlled pricing” and “Free pricing” baskets which are reimbursed by the Social Security[1]	–	100% of the *SSRR*	100% of the *SSRR*	150% of the *SSRR*	300% of the *SSRR*
Orthodontics covered by the Social Security	–	100% of the *SSRR*	100% of the *SSRR*	150% of the *SSRR*	300% of the *SSRR*
Cover limit for dentures in the “Controlled pricing” and “Free pricing” baskets which are reimbursed by the Social Security Except for treatment and dentures from the “100% Santé” basket which are reimbursed by the Social Security[1]	–	–	–	€250 per year Above this limit: 100% of the *SSRR*	€500 per year Above this limit: 100% of the *SSRR*
VISION CARE					
Category A glasses from the “100% Santé” basket[2]: 1 frame + 2 lenses, including lens matching and adjustments to the frames	–	100% of real costs			
Category B glasses from the “free pricing” basket[2]: 1 frame + 2 lenses	–	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*
Mixed glasses: combination of category A and B lenses and frames[2]	–	Cover of category B glasses up to 100% of the *SSRB* and Category A items up to the level of *Actual costs*			
HEARING AIDS					
Hearing aids - Until 31/12/2020	–	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*
Hearing aids from 01/01/2021	–	Cover of one device per ear every four years, from the date of the previous purchase			
Category 1 devices from the “100% Santé” basket[3]	–	100% of real costs			
Category 2 devices from the “Free pricing” basket and accessories up to €1,700/year - less the Social Security reimbursement[3]	–	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*
OTHER BENEFITS					
Preventive screening under the decree of 08/06/2006	–	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*
Unforeseen medical expenses incurred abroad and reimbursed by the statutory scheme	100% of the *SSRR* Hospital charges only	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*
Medical equipment: Orthopedic appliances and costs (excluding hearing devices and vision care accessories)	–	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*	100% of the *SSRR*
Direct billing certificate	–	yes	yes	yes	yes

*** €18 flat-rate charge covered**

[1] As set out in the regulation. The cost of dentures from the "100% Santé" basket is fully covered under your plan less the reimbursement from the statutory scheme and up to the amount of the fees charged for this type of treatment or procedure in application of decree No. 2019 -21 of 11 January 2019.

[2] As set out in the regulation. Lenses and frames reimbursed at a higher rate (from the "100% Santé" basket) will be fully covered under your plan less the reimbursement from the statutory scheme and up to the level of the retail price set for this type of treatment or procedure. Lenses and frames which are not reimbursed at a higher level (from the "Free-pricing" basket) will be covered less the reimbursement from the statutory scheme and up to the level set by decree No. 2019-21 of 11 January 2019
In both cases, cover applies to costs incurred for the purchase of one pair of glasses consisting of two lenses and a frame per two-year period from the replacement of the previous glasses or a period of one year for children under 16 or if there is a change in the prescription. It is possible to replace the glasses earlier in one of the cases listed under article L165-1 of the French Social Security Code

[3] As set out in the regulation. Hearing devices which are reimbursed at a higher rate (from the "100% Santé" basket) will be fully covered under your plan less the reimbursement from the statutory scheme and up to the level of the retail price set for this type of treatment or procedure. Cover applies to costs incurred for the purchase of a hearing aid per 4-year period as of the last invoice.

8.2. PAYMENT OF CLAIMS:

Depending on the plan selected, the following documents must be sent to us following the payment from your *Statutory scheme*:
- the original reimbursement statements from the *Statutory scheme* (if *You* are not using the electronic transfer service, if *You* did not show your Carte Vitale or if *You* opted for the LEVEL 1 plan),
- the reimbursement statements issued by other insurance providers.

The plans available under the MyHealth France cover, with the exception of the LEVEL 1 plan, meet the criteria for state-approved health insurance. This means they fall under the legislative framework of supplementary health insurance plans which offer tax and Social Security benefits in accordance with the provisions of Articles L871-1 and L862-4 and the following of the French Social Security Code and R871-1 and R871-2 and the following of the French Social Security Code.
As a result, medical expenses which qualify for a Social Security reimbursement are guaranteed to be at least 100% of the Social Security reimbursement base (Social Security reimbursement included). This Plan also complies with the minimum reimbursement thresholds and the maximum cover limits set for State-approved insurance plans known as "Contrats Responsables" and the conditions under which excess fees charged by doctors who have not signed up to the Controlled Pricing System, DPTAM, may be covered.

The insurer reserves the right to request any medical certificates and post-operative reports from you in order to carry out an accurate assessment of the benefits and the reimbursement of services.

Your applications for reimbursement should be sent to *Us* at the following address:

APRIL International Care France
Service Courrier (Mail Service)
1 rue du Mont
CS 80010
81700 Blan
FRANCE

Reimbursements will only be made if the instructions set out in paragraph 8 above are followed.

9. WHAT IS NOT COVERED BY YOUR PLAN

9.1. EXCLUSIONS SPECIFIC TO THE LEVEL 1 PLAN:

The following are not covered under the plan:
- private room and visitor's bed in case of psychiatric *Hospitalisation*;
- stays in geriatric care, specialist care facilities, medical-social facilities, residential care for dependent seniors and special education centres;
- stays in hospitals and similar facilities for dependent seniors and in long-stay centres;
- cosmetic treatments, cures of any kind (other than those included in the benefits schedule) and thalassotherapy.

9.2. EXCLUSIONS SPECIFIC TO THE LEVEL 2, LEVEL 3, LEVEL 4 AND LEVEL 5 PLANS

The LEVEL 2, LEVEL 3, LEVEL 4 and LEVEL 5 plans meet the criteria for state-approved health insurance which means they will never cover:
- *Statutory flat-rate* contribution to costs (excluding the flat-rate contribution which the *Statutory scheme* may require to be paid by insured persons who have received treatment or undergone procedures charged at a rate which is equal to or

higher than the upper limit set under French Social Security regulations) and the medical *Excesses* which remain payable by the insured;
- reductions in the French Social Security reimbursement and excess fees resulting from a failure to follow the *Coordinated care pathway*;
- private room and visitor's bed in case of psychiatric *Hospitalisation*;
- stays in specialist care facilities, medical-social facilities and residential care for dependent seniors;
- cures of any kind (other than those listed in the benefits schedule), cosmetic treatments and thalassotherapy;
- any expenses which are not reimbursed by the *Statutory scheme*, unless otherwise stated in the benefits schedule.

10. GENERAL PROVISIONS

10.1. WHO INSURES YOUR PLAN?

The purpose of these General conditions is to describe the benefits and services provided under the MyHealth France group insurance agreements entered into by the 'Association des Assurés APRIL' with Axéria Prévoyance (for the LEVEL 1 plan: agreement 3AMHFFDSNR2018, for the other plans: agreement 3AMHFFDSR2018).

Axéria Prévoyance is a French public limited company with a capital of €31,000,000, whose head office is located at 90, avenue Félix Faure, 69439 Lyon Cedex 03, FRANCE, registered in the Lyon Trade and Companies Register under number 350 261129.

The 'Association des Assurés APRIL' is an association formed under the French Act of 1901, 69439 LYON Cedex 03, whose purpose is to study, arrange and develop for the benefit of its members, all types of insurance authorised by law, in the form of group insurance where the risk is insured by licenced insurance companies operating under the French Insurance Code, the French Mutuality Code or the French Social Security Code.

The organisation managing these agreements, as the insurer's delegate, is APRIL International Care France, a French simplified joint-stock company with a capital of €200,000, an insurance intermediary, registered in the Paris Trade and Companies register under number 309 707 727 and with ORIAS under number 07 008 000 (www.orias.fr), whose head office is located at 14 rue Gerty Archimède, 75012 Paris, FRANCE.

10.2. LEGAL:

The insurer's supervisory authority is the Prudential Supervision and Resolution Authority, located at 4 place de Budapest, 75436 Paris Cedex 09, FRANCE.

APRIL International Care France is subject to the Prudential Supervision and Resolution Authority, located 4 place de Budapest, 75436 Paris Cedex 09, FRANCE.

Membership of the MyHealth France plan is evidenced by the Application form, the current General conditions and the *Membership certificate*. It is subject to French legislation and in particular to its Insurance Code.

The benefits and levels of reimbursement provided will be automatically adjusted in line with legislative and regulatory developments governing insurance contracts under French law.

MyHealth France plans, with the exception of LEVEL 1, meet the criteria for state-approved health insurance. This means they fall under the framework of supplementary health insurance plans which offer tax and social benefits in accordance with the provisions of Articles L871-1, R871-1 and R871-2 of the French Social Security Code.

The benefits provided under the LEVEL 2, LEVEL 3, LEVEL 4 and LEVEL 5 plans cover at least 100% of the Social Security *Reimbursement rate*. Likewise, no exclusions from cover under the LEVEL 2, LEVEL 3, LEVEL 4 and LEVEL 5 plans specified in these General conditions will apply to the requirements to provide cover set out in articles R871-1 and R871-2 of the French Social Security Code.

The benefits provided under the LEVEL 2, LEVEL 3, LEVEL 4 and LEVEL 5 plans comply with the minimum reimbursement thresholds and the cover limits set for State-approved insurance plans known as "Contrats Responsables" and the conditions under which excess fees charged by doctors who have not signed up to the Controlled Pricing System, DPTAM, may be covered. Under the "100% santé" reform and in application of Decree No. 2019-21 of 11th January 2019, expenses incurred for medical services from the "100% santé" basket of care will be fully covered up to the level of the retail price set under this system and less the reimbursement from the *Statutory scheme*. Cover of these expenses will be applied according to the schedule set out in the decree referred to above. The benefits and reimbursement levels under the LEVEL 2, LEVEL 3, LEVEL 4 and LEVEL 5 plans will be automatically adjusted in accordance with legislative and regulatory developments governing state-approved health insurance plans.

10.3. LIMITATIONS:

Any legal action arising from membership of this plan is inadmissible after a period of two (2) years from the event which gave rise to it under the provisions of articles L. 114-1 onwards of the French Insurance Code which state:

Article L. 114-1 "All legal actions arising from an insurance contract are barred two years from the event which gave rise to them. However, this time limit runs:

1) In the event of non-disclosure, omission or false or inaccurate declaration in respect of the risk incurred, only from the date on which the insurer became aware of it;
2) In the event of an insured loss, only from the day on which the relevant parties became aware of it, if they can prove they were unaware of it until then.

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

The limitation period is extended to ten years for life insurance policies where the beneficiary is a separate person from the policyholder and in personal accident insurance policies where the beneficiaries are the heirs of the deceased insured. In respect of life insurance policies, notwithstanding the provisions of paragraph 2, the action taken by the beneficiary must be brought within thirty years of the insured's death."

Article L. 114-2 "The limitation period is interrupted by one of the ordinary causes of interruption and by the appointment of experts following an insured loss. The interruption of the limitation period may also be initiated by the dispatch of a registered letter, or an electronic registered letter, with proof of delivery from the insurer to the insured regarding action for payment of the premium and by the insured to the insurer regarding payment of compensation."

Article L114-3 "Notwithstanding article 2254 of the French Civil Code, the parties to the insurance contract cannot, even by mutual agreement, modify the duration of the limitation period, nor add to the motives for its suspension or interruption."

The ordinary causes of interruption of the limitation period under the French Civil Code are:
- the acknowledgement by the debtor of the right of the person against whom they were seeking interruption of the limitation period (article 2240 of the French Civil Code);
- a legal claim (Articles 2241 to 2243 of the French Civil Code);
- provisional measures taken in application of the code of civil enforcement procedures or an act of enforcement (Article 2244 of the French Civil Code);
- a summons served on one of the joint debtors by means of legal action or an act of enforcement or the acknowledgement by the debtor of the right of the person against whom they were seeking interruption of the limitation period (Article 2245 of the French Civil Code);
- a summons served on the principal debtor or their acknowledgement in cases of limitation periods applicable to sureties (Article 2246 of the French Civil Code).

10.4. SUBROGATION :

It is stipulated that the insurer does not waive the rights and actions that they possess by virtue of Article L.121-12 of the French Insurance Code relating to the summary remedy it may seek for third party liability.
If *You* are involved in a road traffic *Accident* (involving a motorised vehicle), *You* must communicate to the insurance provider of the person having caused the *Accident*, when requested, the name of your third party healthcare provider. Failure to do so may invalidate your insurance cover.

10.5. COMPLAINTS - MEDIATION:

Quality of service is at the heart of our commitments, but if *You* do wish to make a complaint about the services provided by our company, *You* can do so through your usual contact.

If *You* are not satisfied with the response provided, *You* can contact our Customer Service department at:

APRIL International Care France - Service Courrier (Mail Service) -1 rue du Mont - CS 80010 - 81700 Blan - FRANCE
Email: complain.expat@april-international.com.

For your information, our insurance partner Axéria Prévoyance (90, avenue Félix Faure, 69439 Lyon Cedex 03, FRANCE) has entrusted *Us* with the handling of complaints.

We will do our utmost to respond to your complaint within a maximum period of 48 working hours and are committed to keeping *You* informed of the progress of your complaint within the same timescale if, for reasons beyond our control, it needs to be extended.

If the dispute persists and if no amicable solution can be found, *You* may, without prejudice to the other legal remedies available to you, contact the French Insurance Ombudsman - "La Médiation de l'Assurance" - TSA 50110 - 75441 Paris Cedex 09 - FRANCE.

Matters may be referred to the ombudsman within a period of one (1) year, in accordance with article L612-2 of the French Consumer Code.

If this plan was purchased remotely via the Internet, *You* can also apply to the relevant ombudsman by lodging a complaint on the European Commission's dispute resolution website at the following address: http://ec.europa.eu/consumers/odr/.

We would inform *You* that the data collected in order to handle your complaint will be processed electronically by our company for the purposes of complaint monitoring and will be passed on for this purpose only to the insurer, their reinsurers and the APRIL holding company as well as to our partner service providers for the implementation of your insurance cover. The information collected is essential for the registration, administration and activation of membership applications by APRIL International Care France, the insurer or their agents. *You* have the right to access and query your personal information and to have this information corrected or deleted (see paragraph 10.7).

10.6. DATA PROTECTION AND FREEDOM OF INFORMATION:

The personal data collected by APRIL International Care France is essential for the processing of the application for insurance .

It is governed by (EU) Data Protection Regulation No. 2016/679 of 27th April 2016.

This data is processed electronically for the purposes of studying, arranging and managing the insurance cover, the implementation of legal and/or regulatory obligations and the improvement of products and services.

APRIL International Care France has also implemented a procedure to combat insurance fraud. This may result in the application of civil, financial and/or criminal sanctions and inclusion on a list of persons presenting a risk of fraud.

To meet its legal obligations, April International Care France has also implemented a monitoring procedure the purpose of which is to combat money laundering and the financing of terrorism, and the application of financial penalties.

This data is intended for the insurer and APRIL International Care France in their capacity as processors of the data.

Depending on the purpose of the processing, it may also be passed on to their partners, subcontractors and the public authorities in accordance with the law.

Personal data is stored for the duration required for the purpose of its processing and in accordance with the statutory time limits.

It may be transferred outside the European Union. These transfers are subject to data protection and security rules. Information about the transferred data and the recipients will be provided by APRIL International Care France on request from the address shown below.

In accordance with (EU) Data Protection Regulation No. 2016/679 of 27th April 2016, data subjects have the right to access their personal information, have it corrected, restricted, deleted and, for legitimate reasons, opt out of this information being processed. They also have the right to portability of their data and the right to set guidelines with respect to what happens to their data after their death, except in cases where the regulations do not allow these rights to be exercised.

As the statutory health insurance scheme receives a certain amount of information, these persons may at any time and in writing opt out of copies of their Statutory Scheme statements being sent to APRIL International Care France.

To exercise one or more of these rights, data subjects should contact the APRIL International Care Data Protection Officer, enclosing a copy of an identity document, at the following address: APRIL International Care France, Service Courrier, 1 rue du Mont, CS 80010, 81700 Blan, FRANCE or by email to dpo.AICF@april.com.

In accordance with the provisions of Article L561-45 of the French Monetary and Financial Code, persons affected by monitoring of their data may exercise their right of access by applying to the French Data Protection Authority, Commission Nationale Informatique et Libertés - 3 Place de Fontenoy - TSA 80715 - 75334 PARIS CEDEX 07.

Complaints relating to the processing of personal data should be made to the French Data Protection Authority, Commission Nationale Informatique et Libertés, on its website www.cnil.fr or by post at the address shown above.

In application of the provisions of Articles L223-1 onwards of the French Consumer Code, you are informed that data subjects may register on the cold-calling opt-out list either by post, by writing to: OPPOSETEL - Service BLOCTEL - 6, rue Nicolas Siret - 10300 TROYES or by visiting the OPPOSETEL website at the following address: bloctel.gouv.fr. This service is free of charge.

Under no circumstances does inclusion on this list prohibit the insurer and APRIL International Care France from contacting them by telephone within the framework of existing contractual relations.

To cancel your policy, please use the tear-off slip 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

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 letter during a period of 14 days from the day of signature of the agreement without requiring to specify the reason for the cancellation or being subject to penalties.

Conditions : If you wish to cancel your insurance policy, please fill in and sign this tear-off slip. You should then send it in a sealed envelope to the above address. It must be sent no later than 14 days on the day following signature of your application 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 policy:

Policy name: **MyHealth France Ref. MHF Cov**

Date of signature of Application form: d d / m m / y y y y

Member's surname:

Member's first name:

Member's address:

Postcode: City:

Country:

Telephone: + /

Name of insurance consultant:

Address of insurance consultant:

Postcode : City:

Country:

Telephone: + /

Date and member's signature:

d d / m m / y y y y

Reserved for APRIL International Care France: Client reference number C

ASSOCIATION DES ASSURÉS APRIL

ÉCOUTER • AGIR • SOUTENIR

114 bd Vivier Merle 69439 LYON Cedex 03

STATUTES

ASSOCIATION DES ASSURES APRIL

Updated 17th April 2018

CONTENTS

TITLE 1 – CREATION – PURPOSE – HEADQUARTERS – DURATION p.2

TITLE II – MEMBERS AND CONDITIONS OF MEMBERSHIP p.3

TITLE III – LIABILITY OF AND ENFORCEABILITY ON MEMBERS p.4

TITLE IV – RESOURCES – EXPENSES p.4

TITLE V – SOCIAL OUTREACH p.5

TITLE VI – ADMINISTRATION AND OPERATION p.5

Association des Assurés APRIL
Association governed by the French Act of 1st July 1901 and the Decree of 16th August 1901
Registered with the Prefecture of the Rhône department under n° W691060414

TITLE I – CREATION – PURPOSE – HEADQUARTERS – DURATION

Article 1. CREATION AND NAME

An Association named the “Association des Assurés APRIL”, or abbreviated to Association 3A, was founded by private deed in Lyon on 1st January 1984. It is governed by the French Act of 1st July 1901 and the Decree of 16th August 1901.

It is a non-profit association.

On 27th April 2018 the Extraordinary General Meeting of the Association des Assurés APRIL recorded the effective completion of the merger of the Association des Assurés d’APRIL INTERNATIONAL with the Association des Assurés APRIL and the automatic dissolution without liquidation of the Association des Assurés APRIL INTERNATIONAL.

Article 2. PURPOSE

The purpose of this Association is:

- to study, research, arrange and develop all types of insurance and assistance products and services, particularly in the field of death & disability, health and retirement, in order to optimise for its Members, the purchase of supplementary or additional voluntary benefits, or benefits from the 1st euro, as required in addition to the benefits provided by the mandatory schemes, in particular by the signing of group insurance contracts with optional or compulsory membership;

- to raise awareness amongst its Members of the essential aspects of prevention in order to enable them to take care of their health on the one hand and, on the other hand, to obtain preferential terms from insurance companies which take into account the responsible behaviour of its Members in matters of health;

- to carry out statistical studies and analyses on the day-to-day behaviour of its Members in the field of health and personal risk insurance;

- to implement actions in respect of prevention, support and assistance to the Insured through an Outreach Fund.

Article 3. HEAD OFFICE

The head office is located in the 3rd district of Lyon at 114 boulevard Marius Vivier Merle.

It may be transferred by decision of the Board which has the power to amend the statutes for this purpose.

Article 4. DURATION

The association is formed for an unlimited period. It ceases to exist, however, in the event of voluntary, statutory or judicial dissolution.

TITLE II – MEMBERS AND CONDITIONS OF MEMBERSHIP

Article 5. COMPOSITION

The Association is made up of Members broken down into:

- Members;

- Members with non-salaried status;

- Group Members (companies, organisations or other legal entities) who have signed up to one of the agreements entered into by the Association on behalf of their employees.

To be a Member of the Association, you must be covered by the insurance under one of the agreements entered into by the Association and have paid the membership fee.

Member status is acquired 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 the application for membership is not accepted, the membership fee will be refunded no later than thirty days after notification of refusal by the insurer.

The following are also Members, but without voting rights, by decision of the Board:

- Persons or legal entities that serve or have served the Association with distinction. They are known as honorary members or members of honour;

- Persons or legal entities that have made a donation or bequest to the Association. They are known as supporting members.

Article 6. LOSS OF MEMBERSHIP STATUS

Membership is lost in the following cases:

- death, disappearance or absence for individuals;

- voluntary or legal liquidation or dissolution for legal entities;

- expulsion decided by the Board for breaches of these statutes or if conduct is found to conflict with the financial and moral interests of the Association;

- loss of insured status under one of the agreements entered into by the Association (termination, disenrollment or cancellation);

- resignation submitted to the Chairman at the Association's registered office by registered letter with proof of receipt. A copy of the letter issued by the administrator of the plan(s) confirming the termination of their insurance must be enclosed with this letter; these terminations must meet the conditions stipulated in the information notice(s) serving as the general conditions of the plan(s).

In all cases, any membership fees charged for the year in which the loss of membership status occurs will be retained by the Association.

TITLE III – LIABILITY OF AND ENFORCEABILITY ON MEMBERS

Article 7. LIABILITY OF MEMBERS

Members who have signed up to the agreements entered into by the Association are in no way personally liable for commitments made by the Association with liability being limited to the assets of the Association.

Article 8. ENFORCEABILITY ON MEMBERS

Any membership of the Association falls within the framework of the insurance agreements entered into by the Association and the insurers. The content of these agreements, in particular the conditions and consequences of termination of the agreements by the Association or the insurer, is given to Members when they join the Association and the plan in the form of an information notice serving as the general conditions.

TITLE IV – RESOURCES - EXPENSES

Article 9. ASSOCIATION RESOURCES

The Association's resources are made up of:

- the membership fees paid by Members;
- income from its property;
- sums received in return for services provided by the Association;
- grants or payments authorised by law;
- any other resources not prohibited by law.

Article 10. EXPENSES

The expenses of the Association consist of all sums necessary for its operation and representation. They are ordered by the Board or by any other person appointed by the Board for this purpose.

TITLE V – SOCIAL OUTREACH

Article 11. OUTREACH FUND

An Outreach Fund has been created for the purpose of financing support and assistance to Members.

The amount allocated annually to the Outreach Fund is decided by the Board which sets out the guidelines, missions and operating rules.

The various Outreach Actions carried out by the Association and their conditions of access and award are set out in the Association Rules and Regulations.

TITLE VI – ADMINISTRATION AND OPERATION

Article 12. BOARD OF DIRECTORS

1. Composition

The Association is managed by a Board of Directors consisting of a minimum of six (6) members and a maximum of fifteen (15) members appointed for six (6) years. The members of the Board of Directors are appointed by the General Assembly and are chosen from among the Members of the Association.

More than half of the Board members must be Members who do not hold, or have not held in the two years preceding their appointment, any interest or office in the insurance companies having signed the insurance agreements entered into by the Association and who do not receive or have not received, during the same period, any remuneration from these same insurers.

Any current Directors who take up office in, or receive any remuneration whatsoever from, one of the insurance companies having signed an insurance agreement with the Association agree to immediately notify the Chairman by registered letter with proof of receipt.

If this declaration were to reduce the number of Directors who do not, or did not during the two years preceding their appointment, hold any interest or office in the insurance organisations having signed the insurance agreements entered into by the Association and who do not or did not during the same period receive any remuneration from these insurance companies, to less than 51%, the Director in question will automatically forfeit

his or her role as Director and will be replaced in accordance with article 12 of the statutes. In the event of a vacancy arising due to a death, a resignation, a Board member reaching the upper age limit or any other cause, the Board will provisionally replace these members. They will be permanently replaced at the next General Assembly. The term of office of any member elected in this way will come to an end when the term of office of the member they replaced would normally have expired.

If they are not ratified, the deliberations and actions of the Board during the period since the provisional appointment will nonetheless remain valid.

A third of the Board is renewed every 2 years. Outgoing members are eligible for re-election. The order of outgoing members is determined by the length of their term of office.

Any person aged 18 or over on the day of the election who is a Member of the Association and has paid the membership fee is eligible for Board membership.

The age limit for the position of Director is 70. If this age is reached during the term of office, the term of office will automatically end on the Director’s anniversary date.

Any new application must be brought to the attention of the Chairman of the Board by registered letter received at least thirty days before the date of the General Assembly, together with:

- a copy of an identity document;
- a sworn declaration that no criminal convictions are held or no measures referred to in paragraphs 1 to 5 of Article L322-2 of the French Insurance Code apply;
- a certificate indicating the existence or absence of any office held with or remuneration received from any of the insurance organisations having signed an insurance agreement with the Association.

No-one can be a member of the Board of the Association, either directly or indirectly or by proxy, or administer, direct or manage the Association in any capacity whatsoever, or have the authority to sign on behalf of the Association if he or she has held any of the convictions or been subject to any of the measures referred to in paragraphs 1 to 5 of Article L322-2 of the French Insurance Code.

Each year the Board elects an executive committee by secret ballot of its members by a majority vote. This executive committee consists of a Chairman, a Vice-Chairman, a Secretary, a Treasurer and any deputies. Outgoing members of the executive committee are eligible for re-election. The Board may be assisted by any person it deems useful, whether or not they are members of the Association.

2. Board meetings

The Board meets as often as the interests of the Association require when convened by the Chairman. The Board may be convened by any means at his or her convenience.

The deliberations of the Board are minuted and recorded in a register signed by the Chairman and at least one Director.

The Board will be valid only if more than half of the Directors are present.

Decisions of the Board are taken by a majority of the Directors present. In the event of a tie, the Chairman has the casting vote. Only items on the agenda may be put to a vote.

Any member of the Board who, without justification, fails to attend three consecutive meetings may be excluded by the Board, having first been given the opportunity to comment.

3. Remuneration

Directorships are not remunerated. However, expenses and disbursements incurred in the performance of their duties are reimbursed on the basis of documentary evidence. The financial report presented at the Ordinary General Assembly must state the amount of expenses and disbursements reimbursed to Directors.

4. Powers

The Board is vested generally with the widest powers to act on behalf of the Association. It sets the amount of the membership fee payable by members of the Association.

It can delegate authority to the Chairman or to a member of the executive committee.

5. Functions and powers of the Chairman – Functions of the Secretary and the Treasurer

The members of the executive committee are specially entrusted with the following responsibilities:

1. The **Chairman** directs the work of the Board and is responsible for the running of the Association. He or she is the Association's representative in legal proceedings and in all civil acts. He or she has full authority in this respect. He or she may delegate his or her authority to another Director. In his or her absence, the Vice-Chairman will deputise.

2. The **Secretary** is responsible for correspondence, in particular for sending out the various notices to attend meetings. He or she drafts the minutes of proceedings and transcribes them in the records and carries out all formalities required by law.

3. The **Treasurer** is responsible for managing the Association's assets and accounts. He or she collects revenue and makes payments under the supervision of the Chairman. He or she submits an annual administration report to the General Assembly in order that it may rule on the accounts.

The duties of the members of the Executive Committee may not be remunerated in any form whatsoever.

Article 13. GENERAL ASSEMBLIES

1. General Assemblies

1.1. Ordinary General Assembly

At least once a year, Members are invited to attend the Ordinary General Assembly in accordance with the procedure described above.

The General Assembly hears:

- the management report prepared by the Board covering the operation of insurance agreements entered into by the Association. This report is made available to Members who request it;
- the auditor's reports;
- the chairman's report;
- the financial report.

The General Assembly, having deliberated and ruled on the various reports, approves the accounts for the previous financial year (calendar year) and deliberates on all other points on the agenda.

It provides for the renewal of Board members under the conditions set out in Article 12 of these statutes.

1.2. Extraordinary General Assembly

Extraordinary General Assemblies are convened under the conditions set out above.

The Extraordinary General Assembly rules on matters within its exclusive jurisdiction: amendments to the statutes and mergers or dissolutions.

2. Notices to attend

2.1. Notices to attend the Ordinary and Extraordinary General Assemblies

Members of the Association, as defined in article 5 who are members on the day of the decision to issue notices to attend and who have paid their membership fee, meet at least once a year at the Ordinary General Assembly and as required at an Extraordinary General Assembly.

Meetings of Ordinary General Assemblies and Extraordinary General Assemblies consist of all Members of the Association who have paid their membership fee.

The invitation is personal and is valid if extended by the Board:

- either by letter or email sent at least sixty calendar days before the date of the General Assembly;

- or by an announcement in a publication sent out to all Members.

General Assemblies are convened by the Chairman of the Association or, for Extraordinary General Assemblies, at the request of at least 10% of Members. In this case, notices to attend the Extraordinary General Assembly must be sent out within eight days of filing the request and the Extraordinary General Assembly must be held within thirty days of these notices being sent out.

Notices to attend must specify the date, time, place and agenda planned and drawn up by the Board.

Draft resolutions signed by at least one hundred Members are also included on the agenda, if they are sent by registered letter to the Chairman of the Board at least forty-five days before the date set for the General Assembly.

Only resolutions passed by the General Assembly on items on the agenda will be considered valid.

Notices to attend must also state that, in the absence of a quorum, they serve as notices to attend a second General Assembly.

3. Voting rights

3.1. Voting rights at Ordinary and Extraordinary General Assemblies

Each Member of the Association has voting rights and one vote at Ordinary and Extraordinary General Assemblies.

Legal entity members of the Association are represented by their legal representative.

Each individual Member has the right to name another Member or his or her spouse as their proxy. A single Member cannot hold more than 5% of voting rights. The proxy vote applies to only one General Assembly, or two if a quorum is not reached at the first meeting, or if two Assemblies – one Ordinary and one Extraordinary – are held on the same day.

Blank proxy forms returned to the Association are allocated to the Chairman or to his or her delegate on the Board and enable a vote to be held on the adoption of draft resolutions presented or approved by the Board.

3.1.1. Ordinary General Assembly

Decisions of the Ordinary General Assembly are adopted by a majority vote.

All decisions are taken by a show of hands.

However, if at least a quarter of Members in attendance make the request, votes can be cast by secret ballot.

For the election of Board members, a secret ballot is compulsory.

3.1.1. Extraordinary General Assembly

Decisions of the Extraordinary General Assembly must be taken by a two-thirds majority of Members in attendance or represented.

Votes are held by a show of hands unless at least a quarter of Members in attendance request voting by secret ballot.

4. Meetings of the Assemblies

Assemblies are chaired by the Chairman of the Association who may delegate his or her duties to the Vice-Chairman or to another Director.

Proceedings are recorded in the minutes, entered in a special register and signed by the Chairman and the Secretary. The minutes are available at the Association headquarters.

An attendance sheet is completed and certified by the Chairman and the Secretary.

All Members, including those who are absent, are bound by the decisions of the General Assembly within the limits of the powers conferred by these statutes.

4.1. Meetings of the Ordinary and Extraordinary General Assemblies

Ordinary and Extraordinary General Assemblies cannot validly deliberate unless at least one thousand Members are present or represented. If, at the first meeting, the General Assembly does not reach a quorum, a second meeting of the General Assembly is convened. The meeting can then deliberate validly regardless of the number of Members present or represented.

If a quorum is not reached, the second General Assembly may be held following the first with the same agenda.

By decision of the Chairman, the Ordinary and Extraordinary General Assemblies may be held remotely using electronic voting.

Article 14. ASSOCIATION RULES AND REGULATIONS

Association rules and regulations may be drawn up by the Board of Directors to supplement the statutory provisions.

Article 15. DISSOLUTION – MERGER – TRANSFER OF ASSETS

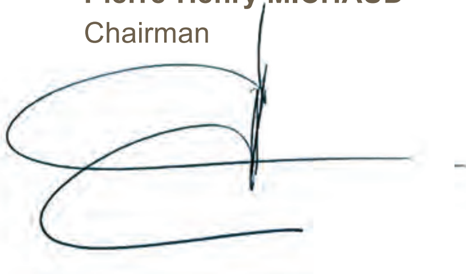
The dissolution of the Association or its merger or union with another organisation can only be approved if proposed by the Board at an Extraordinary General Assembly, in accordance with the conditions set out above.

In accordance with Article L140-6 of the French Insurance Code, in the event of the liquidation or dissolution of the Association, memberships of group insurance agreements which are active on the date of the dissolution or liquidation will continue as of right.

Article 16. LANGUAGE

These statutes are in French. If they are translated into other languages, only the French version is binding.

Pierre-Henry MICHAUD
Chairman



Jean-Louis FAVROT
Secretary

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