National (excluding special plans)
2010

BRITISH HEALTH WAYS

COMPLEMENTARY HEALTH CARE INSURANCE

SOFICA's

INSURANCE BROKERS

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BRITISH HEALTH WAYS

TABLE OF BENEIFTS

Complementary reimbursements follow for all cover options of treatment pathway of an "Approved" policy according to Law No. 2004-810 of 13 August 2004 relative to Health Insurance as well as its decrees except where the words "Non-Approved Policy" is stated on the membership certificate.

		COVER OPTIONS			
		SUBSCRIPTION WITHOUT Health Questionnaire			
HOSPITALISATION (including maternity)		**1**	**2**	**3**	**4**
Surgical and medical hospitalisation, approved clinic or public hospital		100 %	100 %	200 %	200%
Surgical and medical hospitalisation, non- approved qualified clinic or public hospital private sector		100 %	100 %	200 %	200%
Specialised stays (limited to 60 days (1))		100 %	100 %	200 %	200%
Various procedures, Medical and Surgical Fees		100 %	100 %	200 %	200%
Hospital per diem allowance		Actual cost	Actual cost	Actual cost	Actual cost
Private room (limited to 60 days (1))	Approved establishment	None	Actual cost	Actual cost	Actual cost
	Non-approved establishment	None	35 €/day	45 €/day	55 €/day
Companion bed (limited to 60 days (1))		None	12 €/day	15 €/day	20 €/day
Maternity - Birth- Adoption		None	None	100 €	150 €
Transport by ambulance		100 %	100 %	100 %	100%
Home hospitalisation		100 %	125 %	150 %	175%
DENTAL					
Dental Procedures, Treatment and Surgery		100 %	100 %	150 %	200%
Dental prostheses		100 %	100 %	150 %	200%
Orthodontics		100 %	100 %	150 %	200%
EYE CARE					
Medical eye care: Lens and contacts-Frames Complement including refused contacts and operation for myopia		100 % None	125 % + 80 € (1)	150 % + 115 € (1)	200% + 145 € (1)
Additional bonus as of the 3rd year		None	80 € (2)	115 € (2)	145 € (2)
EXCLUDING HOSPITALISATION					
Consultations - Visits		100 %	100 %	125 %	150%
Chemist		100 %	100 %	100 %	100%
Vaccinations		Capped at 100 % (1)	Capped at 100 % (1)	Capped at 100 % (1)	Capped at 100 % (1)
Minor surgery -Medical technical procedures		100%	100%	200%	200%
Laboratory - Radiology		100%	100%	125%	150%
Medical assistant - Rehabilitation		100%	100%	125%	150%
Orthopaedics, Orthotics, Prosthetics other than dental		100%	125%	150%	175%
OTHER BENEFITS					
Medication not reimbursed by the mandatory health care scheme, prescribed by a doctor (contraception, anti-tobacco treatments, homoeopathy...)		None	50% of actual cost capped at 25 € (1)	50% of actual cost capped at 30 € (1)	50% of actual cost capped at 40 € (1)
Spa therapy (accepted by the mandatory health care scheme)		100 %	100 % + 50 € (1)	100 % + 100 € (1)	100 % + 150 € (1)
Unexpected care abroad (see-Article 9)		100%	100%	100%	100%
Assistance cover		Included	Included	Included	Included
Exemption or reimbursement of the premium		Guarantee	Guarantee	Guarantee	Guarantee

All percentages are expressed on the basis of the basis of reimbursement made by the mandatory scheme, including reimbursement of said and any non-reimbursed amounts according to the Law No. 2004-810 of 13 August 2004 relative health insurance as well as its decrees (lump-sum contribution, medical deductible, increase in co-payment and supplemental fees in the eventf non-compliance with the patient treatment pathway). If the policy is not state approved it should read "including reimbursement thereof, lump-sum contribution and medical deductibles".

(1) per calendar year and insured. (2) per calendar year and insured, subject to there having been no "EYE CARE " reimbursement during 2 consecutive calendar years.

The total of complementary reimbursements, the mandatory scheme and the services not covered by the present policy such as defined hereinbelow, may not exceed the actual proven fees to be paid.

The benefits listed in the table above are understood relative to the clauses and terms and conditions of the policy in every cases.

I • GENERAL PROVISIONS

ARTICLE 1 – OBJECT OF THE POLICY

The present group insurance policy with optional membership is subscribed by the Association, hereinafter referred to as the Association, whose registered office is located at : 20, chemin des Sables - Boîte Postale N° 102 - 06167 JUAN-LES-PINS CEDEX, with AXA France Vie - Pubic Limited Company with capital of 487,725,073.50 euros - 310 499 959 R.C.S. (Trade and Corporate Register) PARIS or AXA Assurance Vie Mutuelle - Mutual life insurance company and defined contribution plans - Siren 353 457 245 - Companies governed by the Insurance Code, whose registered offices are located at : 26, rue Drouot - 75009 PARIS, hereinafter referred to as the Insurer. The policy between the Association and the Insurer automatically renews itself on the 1st January of each year, unless terminated by one of the parties by registered letter six months in advance. At said date the Insurer shall undertake to terminate the individual benefits granted to the Insured. Said policy is reserved for the members of the Association, hereinafter referred to as the Members. Said policy may also be modified by rider; the Member shall be informed by the Association before any and all modification brought to its benefits or obligations pursuant to article L 141-4 of the Insurance Code. The insured, individual upon whom the insurance is based, is also Member to the policy unless stipulated otherwise on the membership form.
Its object is to guarantee, for himself and insured family, the reimbursement of medical fees arising due to illness or accident, as a complement to the benefits paid by their mandatory health insurance scheme and within the limit of the expenses to actually be paid. Members declarations serve as the basis to their membership which not able to be uncontested once it becomes effective, except by effect of Laws and Decrees of the Insurance Code. Membership is comprised of the membership request, membership certificate and the present information form ; said latter lists the **BRITISH HEALTH WAYS** benefits and covers the general terms and conditions of the abovementioned optional group insurance policy. The Association provides the management activities required for policy acceptance and functioning as well as subscriptions. It may delegate all or part of said tasks to an organisation of its choosing.
The policy is rafted and executed in the French language.

ARTICLE 2 – TERMS OF ADMISSION

Admitted in the framework of mandatory family membership and subject to acceptance by the Association for the cover chosen, are Members having :
• filled out and signed for each member of the family a membership request specifying the cover chosen,
• paid the membership entry fees and premiums whose amounts are stipulated in Article 5 herein,
• subscribe the same cover for the entire family or cover corresponding to the mandatory health scheme of each member (one membership request must be used for each scheme requested).

ARTICLE 3 – START OF BENEFITS

The benefits take effect for each Member as from the date indicated on his membership certificate, and subject to payment of premiums ; said date may not be prior to the date of reception of the membership request by the Association.

CHANGE OF OPTIONS :

The cover varies depending on the options offered, the details are provided on the table of benefits making up an integral part hereof. Any and all reduction of cover is possible at the beginning of each calendar quarter, after one year of policy membership. Any and all increase in cover is subject to acceptance by the Association and is not possible until the beginning of each civil quarter, after one year of policy membership, and in said case no reduction of benefits may be accepted before another 12 months.

ARTICLE 4 – MISCELLANEOUS CLAUSES

REMOTE TRANSMISSION WITH CPAM RAM AND GAMEX (Primary health insurance funds) :

The detailed statement of reimbursement of the insured benefiting from said mandatory health plan schemes may be directly transmitted in the form of computer images to the Association by the health insurance funds, thus avoiding the detailed statements being sent to the Association by the Member. The Member may terminate such transmissions at any time upon written request to the Association.

THIRD PARTY HEALTH INSURANCE PAYMENT :

With no additional premium, upon simple presentation of certificate of Third Party Health Insurance Payment subject to the expenses being covered by direct payment, that the health professional also accept direct payment with the mandatory health insurance scheme and that the benefit provides for co-payment at least.
• Terms and conditions to comply with for both services : use of said services is dependent upon transmission of a copy of the Vitale certificate of each family member.

BNC (Non-commercial earnings) & BIC (Earnings from industry and commerce) :

Premiums paid on the basis of cover mentioned herein by non-salaried non-farming workers, benefit from the fiscal provisions of Law No. 94-0126 of 11/02/94 and its application order No. 94-775 of 5/09/94 (Law Madelin), subject to :
- the contract is "state approved"(see definition in Article 7),
- the earnings are declared as BNC or BIC,
- the limits of fiscal deductibility be complied with (Article 154a of the General Tax Code.).

ARTICLE 5 – PREMIUMS

1 - Terms of payment of premiums :
Premiums are payables in advance per full calendar year to the registered office of the Association with the possibility of payment broken down into monthly, quarterly or half-yearly payments (associative fees are included in the monthly tarif per insured in the amount of 0.30 € for persons under 21 years of age and 1.22 € for persons 21 years of age and older). The premium is free as of the 3rd child under 21 years of age, enrolled in the same policy as the parents. In the event of late and partial payment of premiums, the contributions shall be imputed on the oldest unpaid payment. Income taxes and other taxes are to be paid by the Member. In the event of membership during the term, premiums are calculated based on the number of months

remaining in the period until the next payment due date, including the month underway. Months started are due in full. The payment of benefits is contingent upon payment of all premiums.
If the premium or a part of said latter is not paid within 10 days of its due date, the Association may send a registered letter that is valid as formal notification to the last known address of the Member, suspend the cover 30 days after dispatch of said letter, cancel the policy 10 days after expiry of said 30 day period (Article L. 113-3 of the Insurance Code) without prejudice to its right to pursue court ordered execution thereof.
Suspension or cancellation of the cover for non-payment of premiums does not release the Member from the obligation to pay all of the premium foreseen in the policy for the entire benefit period underway.
In particular, in the case of non-payment of a part of the yearly premium, it shall be all of said latter that shall be due to the Association. Legal and collection fees shall be paid by the Member.

2 - Increase in premiums :
Premiums are increased on 1st January each year, each year as of the 21st year, the calculation of age being carried out by difference of number of years.

And also :
a) based on the medical consumer index published by the Caisse Nationale de l'Assurance Maladie des Travailleurs Salariés (National Health Insurance Fund for Salaried Workers) in order to take the increase in health expenses and spending into account.
b) following a fiscal, legislative or regulatory modification that may come to effect or modify the reimbursement of social insurances and mandatory health care schemes.
c) subsequent to an increase in the technical results noted in a benefit category or a group of members. Said increase may result, in particular, from a progression of reimbursements exceeding the above mentioned indexes over the same period.
Moreover, the premiums may also be readjusted at a date different from that of the primary due date of 1st January ; in said event, the Member may terminate membership by registered letter within 30 days following the date that he became aware of the modification. The termination thus takes effect at the end of the month following dispatch of the registered letter.

ARTICLE 6 – RENEWAL- CANCELLATION

Membership to the policy and the Association is effective for at least one year, it then immediately renews itself at the date of the primary due date, set on 1st January, each subsequent year.
Cancellation thereof must be carried out by registered letter with acknowledgement of receipt, two months in advance, at the end of the first insurance year and at each primary due date thereafter in the same manner and deadlines. It may take place on another date under the condition foreseen by the Insurance Code. Cancellation by the Member may only be accepted to the extent that said latter is current with all premium payments.
In the event of default of one single payment, the provisions provided for in the Insurance Code shall apply.

ARTICLE 7 – DEFINITIONS

ACCIDENT :
Any and all bodily injury not intentional on the part of the insured, caused by a sudden and unforeseeable action from an exterior force.

FAMILY :
The head of the family, the spouse of said latter (or the person bound by a Civil Law Solidarity Pact (PACS) or common law spouse) and the dependent children up to the age of 20.

HOSPITALISATION :
Stay of at least 24 hours prescribed by a doctor in a clinic or public or private hospital, in view of receiving medical or surgical care that may not be legally be carried out by treatment outside of the concerned establishment.

ILLNESS :
Any and all changes to health established by a competent medical authority.

BASIS OF REIMBURSEMENT :
Tariff retained by the mandatory health care schemes in application of the CCAM or NGAP nomenclature taken as reference for calculation of reimbursement.

PROFESSIONAL NOMENCLATURE OF GENERAL ACTS (NGAP) :
List established by the mandatory health care scheme.

COMMON CLASSIFICATION OF MEDICAL CONSULTATIONS (CCAM) :
Classification Standard of the technical medical procedures (replacing the NPAG for certain procedures).

HOSPITAL PER DIEM ALLOWANCE :
Hospital per diem allowance provided for by the Law of 19 January 1983 and left to be paid by the insured by the mandatory health care scheme.

CO-PAYMENT :
Difference, on one hand, between the bases of reimbursement of the mandatory health care scheme and, on the other hand, the reimbursement made by said latter, lump-sum contribution, the medical deductible and the increase in contribution for the state approved policies.

LUMP SUM CONTRIBUTION :
Withholding carried out by the mandatory health care scheme on the consultations, procedures carried out by a doctor, radiology procedures, and biology procedures (such a defined by Article 20 of the Law of 13 August 2004).

MEDICAL PROCEDURES AND CONSULTATIONS OUTSIDE OF THE PATIENT TREATMENT PATHWAY
• Medical procedures or consultations carried out for an insured over the age of 16 not having declared a general practitioner to its health insurance fund.
• Medical procedures or consultations executed and not-recommended by the general practitioner declared by the insured over the age of 16 to its health insurance fund. Increase in co-payment and supplemental fees relative to non-compliance with the treatment pathway are partially reimbursed according to the table of benefits and cover subscribed.

STATE APPROVED POLICY :
Membership complies with the requirements mentioned in Articles 20 and 57 of Law No. 2004-810 of 13 August 2004, and its decrees.
Consequently,
- it provides for the minimum obligations of reimbursement of benefits concerning general practitioner consultations and prescriptions from said latter,
- it does not reimburse the reduction in reimbursement of the mandatory health care scheme, the lump sum contribution, the medical deductible and authorised supplemental fees for non-compliance with the patient treatment pathway,
- it covers two prevention benefits found on the list established by Order of 8 June 2006.

NON-STATE APPROVED POLICY :
Membership does not comply with all or part of the requirements mentioned in Articles 20 and 57 of Law No. 2004-810 of 13 August 2004, and its decrees.

II • COVER

ARTICLE 8 – BENEFITS- REIMBURSEMENTS - EXCLUSIONS - LIMITATIONS OF COVER

Reimbursement of fees for care are always carried out as a complement to reimbursement made by the mandatory health care scheme and within the limit of expenses actually engaged. The table of benefits making up an integral part hereof, lists the amount of reimbursement according to the cover subscribed; certain reimbursements are governed by the following provisions :

HOSPITALISATION BENEFIT :
The Member shall keep the free choice of medical establishment and may benefit from direct payment by the Association within the limits of 100 % of the basis of reimbursement (deduction made for reimbursement carried out by the mandatory health care scheme), of the Per Diem Hospital Allowance and a private room under the terms foreseen in the policy. Payment may only be made for medical or surgical stays in public hospitals or approved clinics.

SPECIALISED SERVICES :
Specialised rest stays, rehabilitation, convalescence, geriatrics, neuropsychiatry, psychiatry, dietary and similar treatments, regardless of the establishment as well as stays in health or social welfare type children's homes: the cover is always limited to 100 % of the basis of reimbursement (including the reimbursement of the mandatory health care scheme) with a maximum of 60 days per calendar year and per insured.

HOSPITAL PER DIEM ALLOWANCE :
Reimbursed within the limit of the cover foreseen in the table of benefits upon submission of the paid bill for any and all medical or surgical hospitalisation, or directly to the establishment if cover granted in advance (also see section "hospitalisation cover").
For rest home stays, rehabilitation stays, convalescence and other similar establishments as well as for neuropsychiatry treatments, psychiatry, geriatric and dietary treatments, reimbursement is limited to 60 days per calendar year and per insured.

PRIVATE ROOM (if provided for in the cover subscribed, including in maternity) :
In approved or certified establishments, reimbursement upon submission of a paid bill or direct payment to the establishment if cover granted in advance (also see section "hospitalisation cover") and within the foreseen and indicated in the table of benefits. For rest home stays, rehabilitation stays, convalescence and other similar establishments as well as for neuropsychiatry treatments, psychiatry, geriatric and dietary treatments, reimbursement is limited to 60 days per calendar year and per insured. Reimbursement is excluded in the case of Spa therapy and for stays in health and social welfare children's homes.

COMPANION BED (if provided for in the cover subscribed) :
In the event of medical or surgical hospitalisation of an insured under the age of 12, a companion bed for one of the parents is covered in the limits of the actual cost and limits stipulated in the table of benefits, with a maximum of 60 days per calendar year and per insured, upon submission of a paid, detailed bill.

MATERNITY - BIRTH- ADOPTION (if provided for in the cover subscribed) :
Payment of the lump-sum compensation foreseen in the table of benefits is subject to registration of the child in the month that follows its birth (or adoption) and upon submission of the birth (or adoption) certificate or a copy of the family record book.

HOME HOSPITALISATION :
Reimbursement is complementary to the mandatory health care scheme for treatments that are necessary for the beneficiary in the framework of medical treatment or surveillance, within the limits foreseen in the table of benefits.

EYE CARE :
Payment of the complement and supplementary bonus foreseen in the table of benefits also covers prescription contact lens not covered by the mandatory health care scheme as well as laser myopia operation upon medical prescription and paid bill. The supplementary bonus is granted to each insured, as of the 3rd calendar tear of membership, in the case where no eye care benefit has been allocated during two consecutive calendar years (date of treatment), renewable under the same conditions. No benefit may be subsequently granted in the case where it modifies the complementary amount that was already granted.

VACCINATIONS :
Vaccinations are paid by the Association regardless of whether or not they are accepted by the mandatory health care scheme, under the terms and in the limits provided for in the table of benefits upon submission of the paid bill and the medical prescription.

MEDICATION NOT REIMBURSED BY THE MANDATORY HEALTH CARE SCHEME (if provided for in the cover subscribed):
For medically prescribed medication and not covered by the mandatory health care scheme, including the birth control pill, anti-tobacco treatments (patches) and homoeopathy, reimbursement up to the amounts and within the limits stipulated on the table of benefits, upon submission of the medical prescription and the paid, detailed bill.

EXEMPTION FROM PREMIUM :
Exemption from or reimbursement of the family premiums for the calendar year takes place upon request of the Member (1) in the event of long term hospitalisation of himself or his registered spouse, equal to or greater than 9 consecutive nights (the date of entry into hospital is taken into account for the calendar year).
Said hospitalisation must be the direct consequence of an accident and begin within 90 days of the said event.
(1) The Association shall send the Member a "medical certificate of initial findings" which must be completed by the general practitioner and returned to the management centre to the attention of the medical examiner, accompanied by the certificate of circumstances from the medical centre and the accident declaration.

ACCIDENTS :
In the event of an accident, complementary reimbursements are carried out within the limits foreseen in the table of benefits as well as herein. Should said latter be caused by a third party, then the declaration must be made out to the Association. Our participation, such as foreseen in the table of benefits, is in said event made in complement to the other organisations and within the limit of the actual cost.

SUBROGATION :
The Insurer who has paid compensation on the basis of health fees substitutes for the Member or his beneficiaries in their rights and legal claims against any and all liable parties in conformity with Article L 121-12 of the Insurance Code and up to the amount of said compensation.

MISCELLANEOUS EXCLUSIONS :
Excluded from reimbursement are :
• Procedures not recognised by mandatory health care schemes, procedures not provided for on the table of benefits, aesthetic surgery and treatments, stays in so-called medium and long term care facilities as well as those for dependant senior citizens, weight loss treatment, sleep therapy, detoxification, stays in a medico-pedagogical institute and similar establishments, procedures carried out prior to membership and after cancellation of membership.
• In conformity with the Insurance Code, the effects of civil and foreign war, riots and civil up-rise, as well as the direct or indirect effects arising from radioactivity or the transmutation of the nucleus of an atom.
• the lump-sum contribution,
• medical deductibles.
However, the obligations foreseen in the scope of an approved contract are complied with for all memberships in effect.
The non-reimbursable amounts mentioned in Articles 20 and 57 of the Law of 13 August 2004 and its decrees are, moreover, excluded if the contract is "Approved", in the event of non-compliance with the patient treatment path and/or refusal by the insured to authorise access to his personal medical records (dossier médical personnel (DMP)) by the health professional, namely :
• co-payment increase,
• supplemental fees.

ARTICLE 9 – TERRITORIALITY

The benefits are payable in France and in other countries when the French mandatory health care scheme covers medical expenses. Payment of benefits is carried out in FRANCE and in the legal currency in effect in FRANCE.
Documents providing proof must be translated where necessary and the amounts converted into the legal currency in effect in FRANCE. The terms are stipulated in the table of benefits under "unforeseen care abroad".

ARTICLE 10 – STATUTE OF LIMITATION

Any and all actions arising herefrom have a statute of limitations of two year as from the event that brought it on, under the terms foreseen by the Insurance Code.

ARTICLE 11 – CLAIMS

Any possible claims that you may have must be sent to the management centre: ASAF / AFPS - Service Réclamations - BP 102 - 06167 JUAN-LES-PINS Cedex. If they are not satisfied, the litigation claim shall be sent to the Client Quality Relations Department (Service Qualité Relation Clientèle) of the Insurer. Should dispute continue, said Department shall then propose use of a Mediator free of charge and shall indicate the procedures to follow.
The Mediator is an independent individual who shall undertake to submit a justified opinion within three months following the date on which he was seized. The opinion of said latter does not commit the concerned parties who remain free to appeal to the competent courts.

ARTICLE 1 – **OBJET**

The present information bulletin lists the general terms and conditions of the assistance agreement bearing number 5000096*00 subscribed by the Association AFPS (Action Familiale de Prévoyance Sociale) and number 5000096*00 subscribed by the Association ASAF (Association Santé et Action Familiale) for their members with AXA ASSISTANCE France, Public Limited Company with capital of 26,840,000 euros - 31 1 338 339 R.C.S. (Trade and Corporate Register) Nanterre - company governed by the Insurance Code, whose registered office is located at : Le Carat, 6 rue André Gide - 92320 Châtillon. Its purpose is to cover assistance service for its members and the members of their insured family provided on the membership form.

ARTICLE 2 – **DEFINITIONS**

2.01 - SUBSCRIBER : ASAF/AFPS - 20 chemin des sables BP 102 - 06167 JUAN-LES-PINS CEDEX

2.02 - BENEFICIAIRIES : The association member, head of the family, health or provident fund policy subscriber and his legal or de facto spouse or any person bound to the beneficiary by a PACS (Civic Law Solidarity Pact). Their unmarried children less that 25 years of age living at the domicile of the subscriber and declared as a dependent on the tax forms. Their ascendants living in the domicile of the subscriber. Said beneficiaries are covered once they are listed on the **BRITISH HEALTH WAYS** membership certificate of the policy issued by the Association.

2.03 -TERRITORIALITY : Benefits are paid in France, Andorra, Monaco, and the Overseas Departments and Territories.

2.04 - FRANCE : Mainland France and Corsica.

2.05 - DOMICILE : Place of main and usual residence of the beneficiary listed as domicile on the income tax declarations or any other official document.

2.06 - ILLNESS : Sudden and unforeseeable change in the health of the beneficiary established by a competent medical authority.

2.07 - ACCIDENT : Sudden change in the health of the beneficiary caused by a sudden, unforeseeable, violent exterior event that is independent of the victim's will.

2.08 - SERIOUS BODILY INJURY : Bodily accident or illness that is unforeseeable of such a kind that risks bringing about an important aggravation of the state of the beneficiary over a short period of time if care is not rapidly provided.

2.09 - HOSPITALISATION : Unexpected stay lasting more than 5 days in a public or private care establishment, prescribed medically for medical or surgical treatment as a consequence of serious bodily injury.

2.10 - HOME HOSPITALISATION : Obligation to remain at home following a serious bodily injury on medical order and for a period greater than 8 days.

2.11 - MEDICAL AUTHORITY : Any person holding a valid medical or surgical diploma in the country where the beneficiary is located.

2.12 - MEDICAL TEAM : Structure adapted to each particular case and defined by the triage doctor of AXA Assistance.

2.13 - CLOSE RELATION : Any physical person designated by the beneficiary or his beneficiaries and domiciled in the same country as the beneficiary.

2.14 - DOMESTIC ANIMALS : Domestic animals (dogs and cats only) living on a regular basis at the home of and is the responsibility of the beneficiary, and whose vaccinations, which are proven in the vaccinations booklet, are up to date in conformity with the regulations in effect.

2.15 - DEDUCTIBLE : Part of damage to be paid by the beneficiary.

2.16 - INVESTITIVE FACT : Illness, accident.

ARTICLE 3 – **DEFINITIONS OF ASSISTANCE BENEFITS**

3.01 - CHILD CARE : In the case of hospitalisation of the beneficiary for more than 5 days and if no one is able to provide child minding for the beneficiary children under the age of 15 starting on the first day of the incident, AXA Assistance shall arrange for and cover :

- either transportation of a close relation to the domicile of the beneficiary,
- or transport of the children to the domicile of a close relation,
- or minding of the children by qualified personnel at the domicile of the beneficiary, for 40 hours maximum in the 5 days following the date of the incident with a minimum of 2 consecutive hours.

Said individual, based on the age of the children, shall also accompany them to school. Under no circumstance may said cover exceed the duration of hospitalisation or home hospitalisation. AXA Assistance covers the round-trip transportation fees by airline in economy class or train, in 1st class and, depending on the case, the expense of accompanying children to the home of a close relation by qualified personnel.

AXA Assistance shall intervene upon request of the parents and may not be held liable for events that may arise during the trip or during the care of the children entrusted thereby.
Said cover is limited to one operation per calendar year. Above one operation per year, AXA Assistance may communicate the contact information of qualified personnel to the beneficiary. The cost of the qualified personnel shall be paid by the beneficiary.

3.02 - SICK CHILD CARE : When the general practitioner deems that the state of a child beneficiary of less than 15 years requires medically ordered hospitalisation exceeding 8 consecutive days, and in the case where no one may provide child minding for the child, from the first day of the incident, AXA Assistance shall arrange for and cover :

- either round-trip transportation of a close relation by airline in economy class or by train, in 1st class,
- or minding of the child by qualified personnel at the domicile of the beneficiary, for 40 hours maximum in the 10 days following the date of the incident with a minimum of 2 consecutive hours.

AXA Assistance shall intervene upon request of the parents and may not be held liable for events that may arise during the trip or during the care of the children entrusted thereby.
Said cover is limited to one operation per calendar year.
Above one operation per year, AXA Assistance may communicate the contact information of qualified personnel to the beneficiary. The cost of the qualified personnel shall be paid by the beneficiary.

3.03 - PRIVATE TUTORING : AXA Assistance shall arrange for and cover one or several tutors in the event that the general practitioner esteems that the state of health of the beneficiary child requires home hospitalisation and that said obligation brings about school absence exceeding 15 consecutive days.
Said private tutoring is available for children schooled in FRANCE in a French school to take courses in a class from the 11th to the terminale year (final year before the Baccalaureate exam).
The tutor(s) shall provide tutoring in the main subjects : French, Mathematics, History, Geography, Physics, Biology, and Foreign Languages.
Only the fees of the tutor(s) are paid for all of the subjects up to a limit of 5 hours maximum per week for primary school tutoring and 10 hours maximum per week for secondary school tutoring.
Said courses are given on the 16th day of home hospitalisation of the child for a maximum period of 2 months, excluding bank holidays and school holidays.

Said cover is limited to one operation per calendar year. Above one operation per year, AXA Assistance may communicate the contact information of qualified personnel to the beneficiary. The cost of the qualified personnel shall be paid by the beneficiary.

3.04 - HOUSEHOLD HELP : AXA Assistance shall arrange for and cover the services of household help at the request of the beneficiary either during his period of home hospitalisation or hospitalisation exceeding 8 days, or as of his return home from hospital.
Said help shall be responsible among other things for the usual daily household tasks. AXA Assistance shall cover 30 hours maximum in the 15 days following the date of the incident with a minimum of 2 consecutive hours.

The beneficiary must submit his request within the 8 days following the incident.
Only the medical team of the assistance service is authorised to establish the duration of the presence of household help after medical assessment.
Said cover is limited to one operation per calendar year.
Above one operation per year, AXA Assistance may communicate the contact information of qualified personnel to the beneficiary. The cost of the qualified personnel shall be paid by the beneficiary.

3.05 - CARE AND TRANSFER OF DOMESTIC ANIMALS (dogs and cat only) :
In the event of hospitalisation exceeding 8 days and if the domestic animals are not have access to their usual care, AXA Assistance shall arrange for and cover within a 50 km radius of the beneficiary's domicile :

- either the transfer and care of the animals (maximum 2) to the animal boarding establishment located closest to the domicile. The boarding fees are covered up to 2291 per event and for all animals.
- or the transfer of animals (maximum 2) to the domicile of a close relation.

ARTICLE 4 – EXCLUSIONS

Excluded from and unable to give rise to intervention by AXA Assistance, or be subject to any compensation on any basis whatsoever :

- any and all interventions and/or reimbursements relative to medical evaluation, check-up, preventative screening, regular treatments and analyses and in a general manner any and all intervention or payment of a repetitive nature,
- pregnancy with less than one unforeseeable complication,
- voluntary abortion,
- suicide attempts and their consequences,
- rejuvenation treatments, weight loss therapy, treatments for aesthetic purposes,
- medical fees,
- treatments, stays in rest homes and physiotherapy.

4.01 - EXCLUSIONS FOR ALL COVERS : Excluded from and unable to give rise to intervention by AXA Assistance, or be subject to any compensation on any basis whatsoever :

- the consequences resulting from abusive use of alcohol (alcohol levels proven to be greater than the level established by the regulations in effect), usage or absorption of medications, drugs or narcotics that are not medically prescribed,
- damage provoked by an intentional or fraudulent act of the beneficiary,
- participation as a competitor in a competitive sport or rally,
- the consequences of voluntary non-observation of the regulations of the country visited or the practice of activities that are not authorised by the local authorities,
- the consequences of the practice of any sport on a professional basis, or airborne, defence, and combat sports on an amateur basis,
- the consequences of participation in competitions or endurance or speed challenges and in their preparatory trails, on any land, sea or airborne locomotive engine,
- the consequences of non-compliance with the recognised security rules bound to the practice of any sport or leisure activity,
- the consequences of a motor explosion and the effects of nuclear radiation,
- the consequences of civil or foreign war, riots, strikes, piracy, official bans, seizures or constraints by public authority,
- the consequences of climatic vents such as storms or hurricanes.

ARTICLE 5 – RESTRICTIVE TERMS OF USE

5.01 - LIMITATION OF LIABILITY : AXA Assistance may not be held liable for any professional or business damage whatsoever that may be suffered by a beneficiary subsequent to an incident requiring intervention of the assistance services.
AXA Assistance may nor substitute for the local or national government emergency rescue or search services, and does not cover the expense incurred by their intervention unless stipulated contractually otherwise.

5.02 - EXCEPTIONAL CIRCUMSTANCES : AXA Assistance may not be held liable for lateness or obstruction in execution of assistance benefits herein, in the event of strike, riot, social uprising, reprisal, restriction on free movement, sabotage, terrorism, civil or foreign war, heat release, radiation or blast effect arising from the fission or fusion of atoms, radioactivity, or any other case of fortuitous event or force majeure.

ARTICLE 6 – GENERAL TERMS OF USE

6.01 - VALIDITY OF COVER : Cover takes effect on the date of declaration of the subscriber and during the entire period of membership of the beneficiary inasmuch as the benefits hereof be acquired by the subscriber.

6.02 - CALLING OF BENEFITS : Only those benefits organised by or in agreement with AXA Assistance shall be covered. AXA Assistance shall intervene in the scope established by national and international laws and regulations. In the event of an incident requiring intervention by AXA Assistance, the request must be made directly :

✆ BY TELEPHONE AT 01 55 92 25 99
BY FAX AT 01 55 92 40 50
BY TELEGRAM TO : « AXA ASSISTANCE FRANCE »
Le Carat - 6 rue André Gide
92320 CHÂTILLON

The general terms and conditions of the ASSISTANCE agreement are made available to beneficiaries upon simple request.

6.03 - ACCIDENT DECLARATION PROCEDURE : Under penalty of forfeiture, except in the case of fortuitous event or force majeure, the beneficiary must inform AXA Assistance and make an accident declaration accompanied with all supporting documents.
Said item must be sent to: AXA Assistance, Service Gestion des Sinistres - 6 rue André Gide - 92320 Châtillon.
Any and all declarations not in conformity with the provisions set forth in the assistance benefits bring about forfeiture of all rights to reimbursement.
Reimbursement is carried out upon submission of original bills issued by the approved and locally recognised organisations. Reimbursement is made exclusively to the beneficiary, or his beneficiaries, after receipt by AXA Assistance of a completed file. AXA Assistance reserves the right to subject the beneficiary to a medical exam at its expense, submitted on a confidential basis and sent by registered letter with acknowledgement of receipt.

6.04 - PRIOR AGREEMENT : The organisation of one of the individual assistance benefits foreseen herein by the beneficiary or his entourage may not give rise to reimbursement without prior agreement from AXA Assistance.
Said prior agreement is proven by communication of a file number to the beneficiary or any other person acting in his name.

6.05 - FORFEITURE OF COVER : Non-compliance of the beneficiary with its obligations toward AXA Assistance during the term of the policy shall bring about forfeiture of its rights such as foreseen in the present agreement.

ARTICLE 7 – LEGAL FRAMEWORK

7.01 - LAW ON INFORMATION STORAGE AND FREEDOM : In the scope of quality control of the services rendered, the telephone conversations between the beneficiaries and the services of AXA Assistance may be recorded.
In conformity with articles 32 et seq. of the law no. 78-17 of 6 January 1978, modified relative to computer science, files and freedom, the beneficiary is informed that the personal data collected during his call is required for the implementation of assistance benefits defined herein.
An absence of response shall being about forfeiture of benefits foreseen by the agreement.
Said information is intended for internal use by AXA Assistance, as well as those persons who shall come to intervene and responsible for the submission, management and execution of the contract within the limits of their respective powers.
Consequently, the data may be transferred to the country in which the beneficiary is located at the moment of his request. The beneficiary has a right to access and correct the data that concerns him, by contacting the **Service Juridique d'AXA Assistance - 6 rue André Gide - 92321 Châtillon Cedex.**

7.02 - SUBROGATION : AXA Assistance is subrogated in its rights and actions of any physical person or legal entity, beneficiary of all or part of the insurance benefits and/or assistance provided herein, against any third party liable for the incident having triggered its intervention up to the amount of the fees by it for execution hereof.

7.03 - STATUTE OF LIMITATION : Any and all actions arising herefrom have a statute of limitations of two year as from the event that generated it.

7.04 - SETTLING OF DISPUTES : Any and all dispute concerning the present agreement and which is not able to be settled by amicable agreement between the parties shall be brought before the competent court.

Group contracts subscribed (by ASAF for no.5000096*00 and by AFPS for no. 5000097»00) with "AXA ASSISTANCE FRANCE" a public limited insurance company with capital of 26,840,000 Euros
Le Carat - 6 rue André Gide - 92321 CHÂTILLON CEDEX - Company governed by the Insurance Code

Association Santé et Action Familiale – Association established under Law 1901 No. 3703X73 - J.O. of 05/01/74 - C.N.I.L. No. 80738
Action Familiale de Prévoyance Sociale – Association established under Law 1901 No. 3212X70 - J.O. of 27/06/70 - C.N.I.L. No. 80738
20, chemin des Sables – BP 102 – 06167 JUAN-LES-PINS Cedex
Group Contracts subscribed with AXA France Vie - Public Limited Company with capital of 487,725,073.50 euros - 310 499 959 R.C.S. (Trade and Corporate Register)
PARIS or AXA Assurance Vie Mutuelle - Mutual life insurance company and defined contribution plans - Siren 353457245 457 245
Companies governed by the Insurance Code- Registered Offices: 26, rue Drouot - 75009 PARIS
Authority for the Auditing of Insurances and Mutual Insurance Companies (ACAM: Autorité de Contrôle des Assurances et des Mutuelles)
61, rue Taitbout - 75436 PARIS Cedex 09