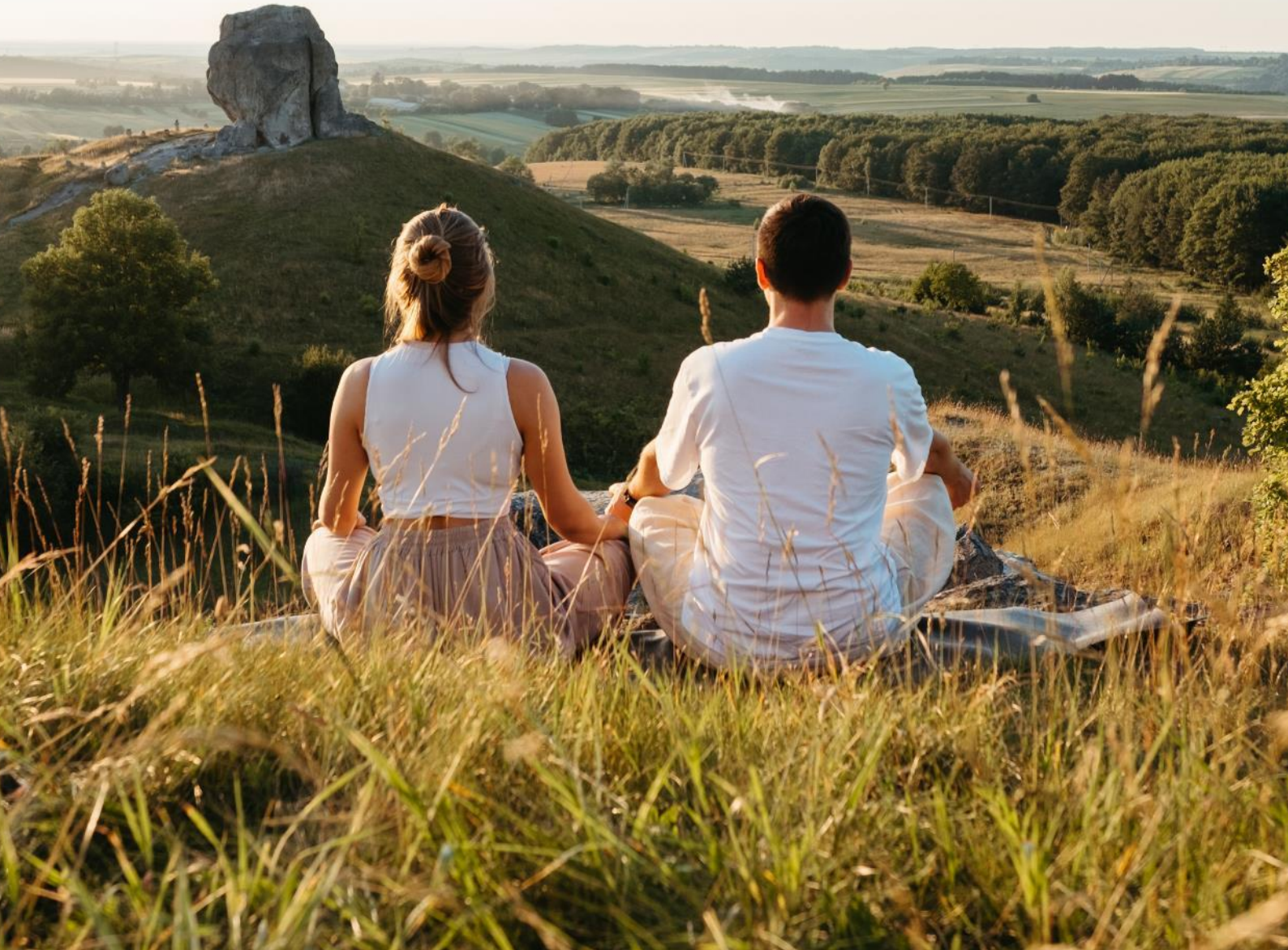
Summary of benefits

ACS Expat

1st Euro

Version 1 - 20240610



Summary of benefits - 1st Euro

ACS Expat – Expatriation Insurance

As a Member of the Globe Partner Association, you have chosen to take out cover underwritten by the Association with MGEN Portugal, Rua Duque de Palmela, 11 A 1250-097, Lisbon, Portugal, in respect of the underwriting authority delegated to VYV International Benefits (VYV-IB)) simplified joint stock company with a capital of € 1 000 000, and whose registered office is located 3 Square Max-Hymans - 75748 Paris Cedex 15, France. MGEN Portugal is regulated by the Autoridade de Supervisão de Seguros e Fundos de Pensões and authorised to operate in France through the Freedom to Provide Services, under policy no. MGENIB1100588SAN.

The policy administration is delegated to ACS, 153 rue de l'Université, 75007 Paris, France, (simplified joint stock company with a capital of €150 000, registration no. 317 218 188 RCS Paris, insurance broker licence ORIAS no. 07 000 350). ACS has sub-delegated the claim administration to Euro-Center Holding SE (Krizikova 36a, 186 00 Prague 8, Czech Republic, registration number CZ24853861).

The terms and conditions of benefits to which you are entitled are set out in this notice.

In the event of any discrepancy between the French and other language versions of this notice, the French version shall prevail.

Contents

317 218 188 RCS Paris –S.A.S (Simplified joint-stock company) with a share capital of € 150 000.- N° ORIAS 07 000 350 (www.orias.fr).
In case of complaint, please write to ACS Complaint Service at our address
ACS is controlled by the ACPR,4 place de Budapest CS 92549, 75436 Paris Cedex 09 France

General information

Eligibility - Enrolment

The Members of the Globe Partner Association who are under 65 and expatriates in the zone selected when cover is taken out, anywhere in the world, including their country of nationality (if selected), are eligible for cover.

To apply, these persons must complete an individual enrolment form, which includes a health questionnaire to be filled in for each beneficiary, and provide all required supporting documents, including copies of valid passports for each beneficiary. The health questionnaire must be approved by the Insurer's Medical Advisor. A medical examination, at the Insurer's expense, may be requested. The Insurer reserves the right to make acceptance conditional on the provision of any additional information it deems necessary.

Eligible persons and, if applicable, their beneficiaries, become beneficiaries once they enrol for the policy. This admission is formalised by the dispatch of an insurance certificate.

Members must back up their statements at all times by sending supporting documents appropriate to their situation.

Details concerning newborn babies: Newborns can be covered from birth without a health questionnaire (except with multiple births or the adoption of a child placed in a care centre or foster family), provided ACS is informed within 30 days of the child's date of birth and the birth certificate issued by the hospital is sent. If ACS is informed of the addition of a newborn more than 30 days after the birth, the Member must complete a health questionnaire for this child and wait for the Insurer's approval.

Members and beneficiaries of cover

Individuals may enrol in the policy if they are:

- an expatriate within the meaning of the policy;
- under 65 years of age on the date of enrolment;
- a Member of the Globe Partner Association and have paid the latter's enrolment fee.

Provided they are under 65 on the day of their enrolment, children of the Member and/or their Spouse (or civil or live-in partner), as defined in the policy, residing in the same zone of cover as the Member and who are dependent on the Member for tax purposes, are also eligible as Rightful Beneficiaries.
The following are eligible for the health insurance plan described in the policy:

- either the Member alone,
- or the Member and his/her Rightful Beneficiaries.

The following are eligible as Rightful Beneficiaries:

- the Spouse, i.e. the Member's husband or wife who is not divorced or legally separated,
- or the Member's Partner, bound by a Civil Union with the purpose of living their life together (article 515-1 of the French Civil Code) or an equivalent civil contract under foreign law,
- or in the absence of a Spouse or Civil Partner, the declared live-in partner.

A "declared live-in partner" is defined as a person living with the Member who meets both of the following conditions:

- they are both free of any matrimonial ties,
- their cohabitation has been declared by the Member at the time of enrolment, with the provision of a certificate or proof of joint residence and an affidavit of cohabitation. The affidavit must be valid and legally recognized by a competent authority in the country of cohabitation. The termination of cohabitation must be declared in writing by the Member.

Each Member may have only one beneficiary in the capacity of Spouse, Civil Partner or Live-in Partner.

- The Member's Children and/or those of his/her Spouse (or Civil or Live-in Partner): up to the date of their 25th birthday.

The adult premium applies from a child's 18th birthday.

To be considered as beneficiaries, the Rightful Beneficiaries must be indicated on the individual enrolment form and appear on the insurance certificate issued by ACS.

ACS must be notified of any change in the Member's situation within 30 days of the event.

Benefits are payable in respect of procedures, treatment and hospital stays during the period in which the beneficiary belongs to the category defined above.

Territorial scope of cover

The geographical zone of cover chosen by the Member must necessarily include the Member's country of expatriation. Cover is available 24 hours a day in the event of illness or accident in both private and professional life and:

- **in all the countries of the geographical zone chosen from the following geographical zones:**

ZONE 1: Worldwide except Hong Kong, Singapore, China, United Kingdom, Brazil, Mexico, Bahamas, Canada, Japan, Israel, Saudi Arabia, Bahrain, Brunei, Kuwait, Oman, Qatar, South Africa, Australia, New Zealand, and Countries Not Eligible for Cover.

ZONE 2: Worldwide except Hong Kong, Singapore, China, United Kingdom, Brazil, Mexico, Bahamas, Canada and Countries Not Eligible for Cover.

ZONE 3: Worldwide except Countries Not Eligible for Cover.

Countries Not Eligible for Cover: The following countries are not eligible for cover: Afghanistan, Iran, Morocco, Russia, North Korea, South Sudan, Switzerland, Syria, United Arab Emirates, United States of America.

As an exception, nationals of the United States of America may be covered for a maximum of six months per insurance year if they return to their country of nationality, provided they requested this when enrolling.

- **Outside the chosen geographical area** (apart from Iran, North Korea, Syria and Afghanistan): during a trip lasting less than seven (7) weeks, solely for expenses incurred as a result of an accident or illness of an emergency nature, as defined in the "Definitions" section, provided that the treatment was carried out by a medical doctor (general practitioner or specialist), or if hospitalisation was required as a direct result of the emergency and took place within twenty-four (24) hours.

Please note that travel documents proving the length of the stay outside the zone of cover may be required (plane or train ticket, boarding pass, etc.). In the absence of supporting documents, the Insurer will not be bound to pay the benefit.

- **In other cases, with the express agreement of the Insurer.**

Effective date of cover

Once cover has taken effect, benefits are available to each beneficiary on the date shown on the insurance certificate issued to the Member, subject to full payment of the first instalment.

Cover for the Member's Rightful Beneficiary/ies takes effect at the same time as the Member's cover, or at a later date, as soon as the interested parties meet the required conditions for eligibility and acceptance regarding the policy.

Period of cover

Once accepted for the insurance policy, and subject to the penalties stipulated by the French Insurance Code in the event of misrepresentation, the Member cannot be excluded provided all the conditions required to benefit from it are met. The Member's Enrolment is then renewed automatically on the enrolment anniversary date for a period of one year, unless terminated by the Member.

Cover terminates in any event:

- For each Member:
  - At the Member's initiative in the event of the annual or sub-annual termination of their individual insurance policy,
  - As soon as they cease to belong to the category of "Member" as defined in this notice,
  - In the event of non-payment of premiums,
  - On the date on which the Member ceases to be Member of the Globe Partner Association,
  - In the event of concealment or misrepresentation,
  - In the event of liquidation of the Insurer or the underwriting Association,
  - On the date of the Member's death.

The Member may terminate coverage:

- On the annual expiry date of his/her cover, by informing ACS at least two (2) months before this date. The dispatch date of the termination notice proves compliance with the deadline.
- Without charge or penalty, at any time during the year, after the expiry of a minimum period of twelve (12) effective months of coverage pursuant to the terms and conditions defined in articles L113-15-2 of the French Insurance Code. Termination of cover takes effect one (1) month after ACS has been notified.

The Member may notify his/her request for termination under the conditions provided for in Articles L.113-14 of the French Insurance Code, as follows, at the Member's discretion:

- by letter or any other durable medium,
- or by a declaration made at the head office or one of the Insurer's branches,
- or by an extrajudicial deed,
- or, if enrolment in the policy was carried out by a remote communication method, using the same method,
- or by any other means specified in the policy.

- For all Members, on the effective date of termination of group insurance policy no. MGENIB1100588SAN between the Globe Partner Association and MGEN Portugal.

Termination (or suspension) of cover means that the Member is no longer entitled to any benefits at the end of the period of cover taken out, subject to the application of any time limit for action.

Penalties for misrepresentation

Any intentional misrepresentation, omission, or inaccurate declaration of the risk or of new circumstances that either aggravate the risks or create new ones will entail the application of the following penalties, stipulated in the French Insurance Code:

- If it is intentional (Article L.113-8 of the French Insurance Code):
  - the nullity of your policy,
  - all paid premiums are forfeited to us, and we are entitled to the payment of all outstanding premiums by way of compensation,
  - you must reimburse us for claims paid out under your policy.
- If it is not intentional (Article L.113-9 of the French Insurance Code):
  - an increase in your premium or the termination of your policy if this occurs prior to any loss,
  - a reduction in your benefits in the ratio between the premium paid and the premium that would have been paid had the declaration been accurate, when this is established after a loss.

The insured loses all entitlement to benefits if he/she wilfully misrepresents the date, nature, causes, circumstances, consequences or amounts of the loss. Coverage will also be forfeit if the insured knowingly uses incorrect documents as proof.

Definitions

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

Accident: any bodily injury that is unintentional on the part of the Member, resulting from the sudden, fortuitous and unforeseeable action of an external cause, **excluding any acute or chronic illness**. The cause and symptoms must be medically and objectively definable, be subject to diagnosis and require treatment.

Ambulance transport: transport by ambulance within the same country, between the patient's residence or the site of the accident and the nearest hospital or medically licensed facility located in the same country and most appropriate to the situation required, in the event of an emergency or medical necessity. If the patient's condition so requires, their subsequent transfer from the receiving establishment to another closer establishment is also covered.

Assistance Provider: legal entity entrusted with the execution of Assistance services on behalf of the Insurer.

Authorised medical authority/doctor: persons holding a medical diploma legally recognised in the country where they usually carry out their professional activity.

Auxiliary medical staff: nurses, nursing auxiliaries and other state-qualified medical staff.

Beneficiary: an enrolled person to whom benefits paid by the Insurer in respect of the cover are due if the risk takes place.

Benefit thresholds: two types of benefit thresholds are indicated in the appended tables of benefits:

- The annual overall reimbursement threshold is the maximum amount the Insurer will pay for all benefits per insured person and per year of cover.
- Certain optional benefits (dental, maternity, optical, etc.) also have their own threshold, which is applied per insurance year.

Cancer treatment: treatment including chemotherapy, radiotherapy, oncology, immunotherapy, consultations, and medicines. Medicines prescribed to prevent cancer recurrence and associated specialist consultations are covered. Cancer treatment begins once the diagnosis has been made. The end of cancer treatment refers to a complete remission of cancer, which has not required treatment for three or more years with liquid tumours such as lymphoma or leukaemia, and for five or more years with solid tumours.

Childbirth costs: medical expenses incurred for a vaginal delivery or a caesarean section, if the latter is medically necessary.

Civil war: armed opposition by several parties belonging to the same country, as well as any armed rebellion, revolution, sedition, insurrection, coup d'état, application of martial law or border closure ordered by local authorities.

Complications of pregnancy and childbirth: these concern complications arising during the prenatal period of pregnancy, and in this context cover the following: ectopic pregnancy, gestational diabetes, pre-eclampsia, miscarriage, risks of miscarriage, stillborn child or embryonal mole. We also cover the following pathologies arising during delivery and requiring an obstetric procedure: post-partum haemorrhage and retained placenta.

Compulsory vaccinations: immunisations or injections required by the health authorities of the country in which the treatment is administered, or by those of the country

to which the Member is travelling. Medical appointment and vaccine purchase costs are covered.

Country of Expatriation: the country, outside the Country of Nationality, in which the Member is living during the period of expatriation.

Country of Nationality: this is deemed to be the country shown on the passport of the Member and any Rightful Beneficiaries.

Country of Usual Residence: the Member's country of residence prior to expatriation, or the Country of Nationality, different from the Country of Expatriation.

Deductible: part of the cost of the loss remaining payable by the Member.

Dental prosthetics: prosthetic care, including the fitting of crowns, inlays, inlay-cores, onlays, bonded reconstruction or repair, bridges, inlays and implants, as well as any necessary and ancillary treatments when dental cover is provided.

Emergency: term used in the event of an accident or the onset of a serious illness requiring immediate medical measures and treatment for the Member or one of his/her Rightful Beneficiaries. Only medical treatment given by a doctor, whether a general practitioner or specialist, or hospitalisation within twenty-four (24) hours of the direct cause of the emergency will be considered necessary conditions as regards reimbursement.

Emergency dental care: dental care following an emergency or accident, requiring treatment within 48 hours. Emergency dental care includes treatment for:

- Dental pulpitis (Persistent toothache)
- Tooth abscess and/or oedema
- A tooth that has broken or fallen out
- Dental haemorrhage
- Alveolitis (inflammation of the dental alveolus)
- Acute periodontal disease

Dental check-ups and conservative care such as scaling, cavity treatment or root canal treatment are not considered emergency care. It does not include dental implants, periodontics, or orthodontics.

Epidemic: contagious disease whose spread constitutes an epidemic according to the World Health Organisation (WHO) or the competent health authority of the country in which the Member lives.

Expatriate: person living at least six (6) months of the year outside his/her country of usual residence or nationality, alone or with his/her Rightful Beneficiaries.

Expenses for a relative accompanying a child under 16: cost of a hospital room for a relative during the admission of the Member's or Spouse's child to Hospital for treatment. If a hospital bed is not available, the Insurer will pay for the equivalent of a room up to the amounts indicated. Miscellaneous expenses such as meals, telephone calls or newspapers are not covered.

Extreme sports: Base jumping, Speed riding, Adventure racing, Bungee jumping, Zorbing, Jumping equipment tests.

Force majeure: an unforeseeable and irresistible event beyond the control of the party bound by the obligation.

Foreign war: declared or undeclared armed opposition by one State to another State, as well as any invasion or state of siege.

Funeral expenses: costs of the initial conservation and handling of the body, laying it in a coffin, specific transport arrangements, conservation care required by law, packing, the urn and coffin required for transport and compliant with local legislation, excluding burial (or cremation), embalming and ceremony costs.

Health check-up: medical examinations carried out in the absence of any apparent clinical symptoms. The purpose of these check-ups is to anticipate the detection of diseases.

Home care: medical care administered by a State-registered nurse in the Member's home in accordance with a doctor's prescription, immediately following hospitalisation or outpatient care, or to replace it. This care is subject to the prior agreement of the Medical Advisor.

Hospital/Regularly licensed facility: an institution legally licensed as a medical or surgical hospital in the country where it is located, and permanently overseen by a resident physician. Rest and nursing homes, spas and health and fitness centres are not considered as hospitals.

Hospitalization:

(i) Stays of more than 24 hours for medical treatment or Surgical Procedures in a public or private establishment following an Accident or illness. This covers:

- the Surgical Procedure and related accommodation costs,
- associated medical and paramedical expenses incurred during hospitalisation,
- transport of the patient between the patient's home or the site of the Accident and the nearest hospital in the same country.

(ii) Stays of less than 24 hours in the event of:

- outpatient surgery,
- fibroscopy, colonoscopy, endoscopy, or

- any cancer treatment, chemotherapy, radiotherapy or dialysis.

Stays of less than 24 hours for procedures performed in hospital emergency departments that do not require a Surgical Procedure are considered outpatient care and are not included in the Hospitalisation benefit, unless specified in the Table of Benefits.

Treatment received in emergency departments during the 24 hours following an Accident or unexpected Illness, without the need for hospitalisation, is covered under the "Routine Medical Care, Prevention and Screening" option.

Hospitalisation at home: Care administered in the patient's own home, as an alternative to conventional hospitalisation. Hospitalisation at home must immediately follow a hospitalisation covered by the policy, and must have been prescribed by a physician. Under no circumstances does home hospitalisation consist of home help.

Illness/Disease: alteration of health certified by a medical authority, requiring medical care.

Insurance certificate: document issued by ACS confirming acceptance of the application for enrolment, specifying the benefits granted by the insurer and the date they take effect.

Insurer: MGEN Portugal, Rua Duque de Palmela, 11 A 1250-097, Lisbon, Portugal

Journey: the route taken to the destination indicated on the ticket or travel registration form, regardless of the number of flights taken, and whether an outward or return journey.

Lapse/forfeiture: loss of entitlement to cover for the Loss in question.

Loss: all the harmful consequences of an event, leading to the application of any cover taken out. All damage resulting from the same initial cause constitutes a single loss.

Managing agent: a legal entity entrusted with the performance of administration tasks (call for premiums, payment of benefits, etc.) on behalf of the Insurer.

Medically Assisted Reproduction: the cost of treatment for Medically Assisted Reproduction is covered in the context of both Hospitalisation and Outpatient Care, subject to the following conditions:

- it must involve primary sterility/infertility;
- expenses for each attempt are subject to a threshold indicated in the table of benefits
- sperm and egg donation costs are not covered;
- surrogacy costs are not covered;
- prior authorisation from the insurer's medical advisor is required in all cases.

“Primary infertility" refers to the inability of two partners in a long-term relationship to conceive within two years, even though they are sexually active and use no form of contraception. In the case of primary infertility, the woman has never become pregnant.

“Secondary infertility" refers to the inability of a couple who have already conceived to conceive again after trying for one (1) year.

No infertility treatment costs are reimbursed for either partner once the Member has passed the age of 43.

Medically necessary: applies to services and supplies defined as medically appropriate and necessary. They must:

- be required to define or treat a patient's condition, illness or injury.
- be appropriate to the patient's symptoms, diagnosis, or treatment.
- comply with generally accepted medical practices and professional medical standards in force at the time of treatment by the medical community.
- be required for reasons other than the comfort or convenience of the patient or the patient's physician.
- have a proven medical effect.
- be considered at the most appropriate type and level.
- be given with equipment in the quantity and quality appropriate to the level of care required by the patient's condition.
- be provided only during the period appropriate to the patient's condition.

The term "appropriate" takes patient safety and the cost of treatment into account. Concerning hospitalisation, "medically necessary" also means that treatment or a diagnosis cannot be carried out prudently and effectively on an outpatient basis.

A service will not be considered medically necessary if it is performed solely for the convenience of the service provider or the insured and/or is inadequate in view of the Member's symptoms and/or exceeds, in terms of extent, duration or intensity, the degree of care necessary to diagnose or treat a medical condition appropriately.

Member: the person with whom the risk rests. An individual expatriate under 65 at the time of enrolment, who has taken out the policy, paid the premium and resides in a country other than his/her country of origin, as well as any Rightful Beneficiaries under 65 on the effective date of their enrolment.

Natural disasters: abnormal intensity of a natural agent not caused by human intervention.

Non-dental prosthesis: any prescribed medical instrument, equipment, or appliance. These include orthopaedic, medical, and hearing aids.

Organ transplant: surgery to transplant the following organs or tissues: heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, spinal cord, parathyroid, muscle/bone or corneal transplants. Expenses incurred to acquire an organ are not reimbursable.

Orthodontics: use of devices to correct malocclusion and ensure the proper functioning and alignment of teeth.

Outpatient surgery: surgery performed in a doctor's surgery, hospital, medical day-care centre or outpatient clinic, for which the patient does not need medical supervision afterwards.

Pandemic: contagious disease whose spread constitutes a pandemic according to the World Health Organisation (WHO) or the competent health authority of the country in which the Member lives.

Postnatal care: routine post-partum medical care for the mother for up to six weeks after giving birth.

Pre-natal care: standard follow-up examinations and screenings required to monitor pregnancy.

Prescription eyeglasses and contact lenses: coverage of contact lenses or eyeglasses to correct eyesight.

Prescription medicines: medicines whose sale and use are legally subject to a doctor's prescription. Products that can be purchased without a doctor's prescription are not included in this definition.

Psychiatry: treatment of nervous or mental disorders by a qualified clinical psychiatrist. These disorders must be associated with real and present suffering or substantial inconvenience in the Member's major daily activities, such as studies or work. The pathology must be clinically severe and present the characteristics listed in an international classification, such as Mental Disorder Diagnosis (DSM-IV or ICD-10).

Rehabilitation: treatment designed to restore normal form and/or functioning after an accident or serious illness. The rehabilitation process must begin within thirty (30) days of Hospitalisation for an Accident or Illness.

Rightful Beneficiary/ies: the Spouse or Civil or Live-in Partner (including same-sex partners) and/or any unmarried dependent children (including those of the Spouse or Partner, and any adopted or fostered children) who are financially dependent on the Member.

Risk sports: Ballooning, Alpinism, Apnea diving, Martial arts (except judo) and combat sports, Bobsleighing, Canyoning, Ice yachting, Nordic combined, Hang-gliding, Climbing (except on artificial support with safety system), Horse-riding (except dressage and walking), Ice hockey, Jet skiing, Speed skiing, Kitesurfing, Snowmobiling, Whitewater swimming, Parasailing, Skydiving, Paragliding, Paraskiing, Scuba diving, Cave diving, Diving, Polo, Rafting, Rallies and expeditions, Freestyle skiing, Ski bob, Heli-skiing, Water skiing, Skiathlon, Snow cross, Snow kiting, Ski jumping, Caving, Automobile sports, Motorcycle sports, Trekking and hiking at altitudes above 3,500 metres, ULM, Rock climbing, Navigation at sea more than 20 nautical miles from the coast.

Routine medical care, prevention, and screening: expenses incurred as a result of illness or accident that do not fall within the scope of Hospitalisation.

Subrogation: legal situation whereby the rights of one person are transferred to another (in particular the Insurer's substitution for the Member in order to take legal action against the opposing party).

Surgical devices and equipment: devices and equipment required for surgical procedures. This includes prostheses or devices such as joint replacement material, screws, plates, valve replacement devices, endovascular stents, implantable defibrillators, and pacemakers.

Surgical Procedure: procedures performed under an anaesthetic (general or local) or the involvement of an organ to be treated after incision, are considered surgical procedures.

Transport company: any company duly authorised by the public authorities to transport passengers.

Time limit for action: period beyond which a claim is no longer admissible, i.e. within two (2) years of the event giving rise to it.

Treatment: medical procedure required to cure or relieve illnesses, infections, or injuries.

Underwriter: Globe Partner Association, which has underwritten policy no. MGENIB1100588SAN with MGEN Portugal for the benefit of its Members. This association is registered in the *Répertoire National des Associations* and its head office address is 153 rue de l'Université, 75007 Paris - France.

Unexpected illness: any sudden, unforeseeable, medically diagnosed deterioration in health.
Unforeseen event: event whose occurrence is unpredictable and beyond the Member's control.

Waiting period: period during which the Member is not entitled to certain benefits. The starting point of this period is the effective date of enrolment indicated in the insurance certificate issued by ACS.

Year of cover or insurance year: the first period of cover guaranteed by the Insurer begins on the date shown on the Insurance Certificate and lasts for one year. Enrolment is then renewed on each anniversary date.

Definitions specific to repatriation Assistance cover

Act of terrorism or sabotage, attack: any clandestine ideologically and/or politically motivated action carried out by an individual or group against persons or public or private entities in order to:

- Carry out a criminal act intended to harm the lives of others;
- Frighten the population and create an atmosphere of general insecurity;
- Disrupt the operation of public transport or disturb the functioning of companies or institutions that manufacture or process goods or provide services.

Assault: any bodily injury suffered involuntarily by the Member, resulting from a deliberate, sudden, and brutal action by another person or a group of people.

Close family members: children, father, mother, brothers, sisters, and grandchildren.

Consolidation: stabilisation of the state of health of a person who is the victim of an Accident or suffering from an Illness.

Family member: father, mother, sister, brother, child, grandparents or legal guardian domiciled in the Country of Nationality.

Medical team: structure adapted to each particular case and defined by the Assistance Provider's coordinating physician.

Health care benefits

Type of cover

Cover consists of reimbursing medical expenses incurred by the Member and any of his/her Rightful Beneficiaries, as from the very first € spent, and:

- Within the limits of the choice made by the Member to customise his/her cover.
- Up to the threshold limits listed in the Table of Benefits,
- Up to the difference between the expenses incurred and the corresponding benefits received from any organisation to which the beneficiary is affiliated (Social Security regime, government programme, other private medical insurance, etc.),
- Within the limits of reasonable and customary costs.

The treatment must be recognised by the local medical authorities, and provided by practitioners practising within the scope of their accreditation (in compliance with legislative, regulatory or other provisions concerning the practice of the profession in the country concerned), and must be recognised by the World Health Organisation.

Deductible

When they take out the policy, the Members can choose between several deductible levels. This deductible applies per year of cover and per insured person with all the modules chosen by the Members when they take out the policy, apart from "Assistance Plus" cover.

For information, several deductible levels are available: None, €500, €1,000, €5,000, €10,000

If the Member has opted for an annual deductible, any expenses incurred up to the amount of the deductible selected will be borne by the Member. The Member must systematically submit invoices for all healthcare expenses incurred so that the amount of the deductible already applied can be calculated. In calculating the amount of the deductible applied, the thresholds indicated in the table of benefits for the type of procedure used will be taken into account, depending on the plan chosen by the Member. If the type of procedure is excluded from the policy's coverage, the corresponding expenses will not be taken into account when calculating the deductible.

Waiting period

The reimbursement of certain expenses comes into effect for each beneficiary from the effective date of their enrolment and after the expiry of the following deadlines:

- **Dental care and psychiatric hospitalisation: 3 months.**
- **Dental prostheses - prescription lenses and frames - laser treatment of visual corrections (including related surgical treatments): 6 months.**
- **Orthodontics: 9 months.**

- **Maternity: 12 months.**
- **Medically assisted reproduction: 18 months.**

However, expenses incurred following an Accident are reimbursable immediately. Similarly, waiting periods do not apply to Members who had equivalent cover with another insurer before taking out the ACS Expat policy (within a maximum of 2 months).

If, during the term of the policy, the Member requests a higher level of cover than the level originally chosen, the waiting periods apply to the increases in cover.

Modification of cover

The Member may change his/her choice of cover. In this case, the change of cover can only become effective at the enrolment renewal date.

If the Member opts for a higher level of cover, the agreement of the Medical Advisor will be required and waiting periods will apply. Returning to a lower level of cover than the level previously chosen will give rise to a two-year period during which the Member may not opt for higher levels of cover.

If the Member opts to extend his/her geographical zone of cover without changing his/her country of expatriation, he/she must complete a new health questionnaire and waiting periods will be applied.

Any change of cover, once accepted by the Insurer, will give rise to the issue of a new insurance certificate.

With group enrolments (the Member and his/her Rightful Beneficiaries), the choice of cover must be identical for each enrolled person, with the exception of the optional Maternity module, which can only be chosen by "adult" female beneficiaries, excluding children.

A change of deductible can only be made once during the life of the policy, at the date when enrolment is renewed. If the deductible is reduced or removed, a new medical questionnaire may be required.

Reimbursements limited to actual cost

In accordance with Article 9 of Act no. 89-1009 of 31 December 1989 and decree no. 90-769 of 30 August 1990, reimbursements or compensation for expenses incurred as a result of illness or accident may not exceed the amount of expenses remaining payable by Members after reimbursements of all kinds to which they are entitled.

Benefits of the same kind contracted with several insurers produce their effects within the limit of each benefit, regardless of the date on which a policy was taken out. Within this limit, the Member may obtain additional compensation by sending details of the reimbursement(s) made by the other insurer(s). For the application of the above provisions, the limit on the amount of expenses remaining payable by the Member is determined by the Insurer for each procedure or item of expense.

In the event of undue payment of benefits, the Beneficiary of the policy must repay any overpaid benefits to the Insurer as soon as possible. The Insurer may set off any amounts due in this respect against other benefits it owes to the Member.

Reasonable and customary cost

“Reasonable and customary" cost is the lower of the following amounts: the cost charged by the service provider, and the usual cost in the same region for a similar service offered by providers of the same professional level. The “reasonable and customary" cost of a service varies according to the type of treatment, the quality of the service and equipment, and the location and country where treatment is received. The Insurer reserves the right to limit the reimbursement of healthcare and related costs and the Hospitalisation period to those generally practised in the region where the patient is treated.

Abnormal and unreasonable expenses incurred may lead to reimbursement being refused or limited.

If one of the Member's Rightful Beneficiaries is covered by a French Social Security or equivalent scheme, the benefits applicable to that person will be deducted from the benefits received from that body.

In the event of hospitalisation, reasonable and customary expenses are covered for:

- Medical hospitalisation in public or private establishments.
- Hospitalisation and surgical procedures. Procedures performed under general anaesthetic or trauma surgery and surgical procedures performed under local anaesthetic are considered as surgical procedures.
- Medical expenses incurred in connection with hospitalisation.
- Local emergency ambulance transport for the patient.

In the event of hospitalisation, local emergency transport by ambulance is covered within the same country between the patient's home or the site of the accident

and the nearest hospital in the same country. It is also covered if the patient's condition requires a subsequent transfer from the receiving facility to the nearest facility.

Risks and benefits excluded from cover for medical expenses

This contract does not cover expenses not recognized by the World Health Organisation according to the international classification of health interventions (ICHI).

Expenses incurred are not covered by the insurer if they result from the following:

1. **Illness or accident caused voluntarily by the insured person, or resulting from voluntary mutilation,**
2. **The consequences of war, civil war, insurrections, riots, terrorist attacks or civil commotion, unless the insured person has not taken an active part in the event or was called upon to carry out maintenance or surveillance work to ensure the safety of people and property,**
3. **Any intentional act giving rise to coverage under the policy, and any consequences of criminal proceedings against the Member,**
4. **A loss resulting directly or indirectly from the disintegration of the atomic nucleus,**
5. **The Member's failure to comply with official prohibitions or to observe official safety rules concerning the practice of a sporting activity,**
6. **The consequences of professional and semi-professional sports competitions,**
7. **The consequences of an accident while practising an extreme sport or a risk sport as defined in the "Definitions" section,**
8. **Any circumcisions for non-medical reasons.**

The following services are not covered by the policy, except where indicated in the policy's table of benefits as being covered:

9. **Any interventions and/or reimbursements concerning medical check-ups and preventive screenings except as stipulated in the Table of Benefits,**
10. **Any expenses incurred for treatment or procedures prescribed prior to the effective date of the policy or during the waiting period, where applicable,**
11. **Any medical and surgical expenses not prescribed by a qualified medical authority,**
12. **Procedures subject to "Prior consent" for which consent has not been requested or has been refused,**
13. **Treatments outside the geographical zone covered,**
14. **Any form of experimental or uncontrolled treatment that does not follow commonly accepted, customary or traditional medical practices, except with the specific consent of the Insurer,**
15. **Additional or comfort expenses in the event of hospitalisation (telephone, television, etc.),**
16. **The cost of a caesarean delivery, unless medically necessary,**
17. **Expenses incurred in acquiring an organ,**
18. **Any operation or treatment concerning gender reassignment,**
19. **Aesthetic, rejuvenating and weight-loss treatments,**
20. **Tests and studies concerning sexual dysfunction (including medication and treatment for erectile dysfunction), sterilisation and contraception,**
21. **Growth hormones,**
22. **Medical care, procedures and treatment that do not comply with local legislation,**
23. **Any elective/voluntary surgery or treatment and/or plastic/cosmetic surgery,**
24. **Spa treatments,**
25. **Medical expenses concerning a stay at a thalassotherapy or fitness centre, rejuvenation treatments, treatments for losing or gaining weight,**
26. **The treatment of alcoholism, drug addiction or any other addiction or disease related to such an addiction,**
27. **Hospitals and care facilities for dependent elderly people, long-stay hospitalisation, stays in geriatric units, medical-educational institutes and similar establishments,**
28. **Medical expenses for a stay in a rest or convalescent home, except if the stay follows a hospitalisation of more than 30 days or a major surgical procedure,**
29. **Transport costs other than by land ambulance to the nearest appropriate medical facility,**
30. **Psychotherapy, psychoanalysis and outpatient treatment (consultations, medication, diagnostic tests and analyses) for:**
    a. **Mental and behavioural disorders linked with the use of drugs, alcohol, and other psychoactive substances;**
    b. **Sleep disorders (insomnia, hypersomnia, sleepwalking), sleep-wake cycle disorders,**
31. **Consultations, treatments, and complications related to hair loss, unless this is caused by a serious illness,**
32. **Expenses incurred to correct any congenital abnormality or malformation, except for children born after the effective date of coverage,**
33. **Over-the-counter medicines (apart from the "Self-medication costs" lump-sum benefit indicated in "Routine medical care, prevention and screening" if this optional benefit has been selected),**

cosmetic treatment and non-medicated products for routine use or hygiene, such as medical alcohol, absorbent cotton, sun creams and/or moisturisers, dental hygiene products, dressings, shampoos, vitamins and minerals, food supplements, dietary products, baby food, thermometers, blood pressure monitors, etc..

Medical control and arbitration

Doctors and representatives accredited by the Insurer must have access to the Member's medical file in order to ascertain his/her condition. The Member must provide all supporting documents and submit to any expert appraisal or examination requested by the Insurer.

In the event of an accident, the Member must provide the Insurer with an official report detailing the circumstances of the accident.

The Insurer's decisions, based on the conclusions of the Medical Advisor, are notified to the Member by registered mail. The Member may contest the validity of these decisions within ten days of their dispatch, by means of a detailed medical certificate sent to the Insurer by registered mail.

In the event of disagreement over the Member's state of health, an amicable assessment may be carried out together by the doctor chosen by the Member and the doctor appointed by the Insurer.

If the two doctors are unable to reach the same conclusion, they must choose another doctor to arbitrate. Failing their agreement on the choice of this doctor, the appointment will be made by court order.
Each party will bear the costs and fees of their own doctor and, in equal shares, those of the arbitrating doctor.

How to claim

For any Hospitalisation:

You must contact **(24/7)**
Euro-Center to obtain assistance:
+ 66 (0) 2569 0225
acs@euro-center.com

For outpatient medical cares:

You must contact Euro-Center so that they can arrange for your medical expenses to be covered in the most efficient way possible, within the limits and conditions of the policy. In certain cases, Euro-Center can issue a letter of guarantee for your outpatient medical expenses.

Euro-Center will also be able to provide you with information on hospitals and clinics within their network. Please bring your passport and the insurance card (e-card) received at enrolment when you visit the hospital or clinic. Please note that prior agreement is required for certain specific treatments, as indicated in this notice.

All requests and supporting documents must be sent to:
Euro-Center (Thailand) Co., Ltd
Spring Tower Building, Unit 5-10, Floor 22,
188 Phayathai Road, Thung Phayathai, Ratchathewi
10400 Bangkok
THAILAND
+ 66 (0) 2569 0225 (24/7)
acs@euro-center.com

E-claims

For claims of less or equal to **€1,000**, scans of supporting documents are accepted and should be sent to:
acs@euro-center.com

It is specified that the Insurer reserves the right to **demand the original invoices for 24 months after the date of reimbursement**, in the event of an audit, inspection or fraud prevention.
If the insured is unable to provide the original documents when requested by the Insurer, the beneficiary must pay back to the Insurer, as soon as possible, the benefits received on the basis of the digitised documents. The Insurer may set off any sums due in this respect against other benefits it owes the Member**.**

Prior agreement

For any hospitalisation (including for childbirth), prior agreement from the Insurer is required, except in the event of an emergency.

The medical procedures subject to prior agreement (unless there is a serious emergency) are listed below and appear in the attached table of benefits:

- Expenses arising from a scheduled hospitalisation;
- Magnetic resonance imaging (MRI);
- All serial procedures (such as physiotherapy, acupuncture, chiropractic, osteopathy);
- Prescribed speech therapy and orthoptics;
- Prescribed medical prostheses;
- Dental prostheses, including inlays, onlays and implants;
- Orthodontics;
- Surgical and laser treatment of visual corrections;
- Diagnosis of chromosomal abnormalities.

A request for a prior agreement must include a medical report and a detailed estimate for the treatment for

which Prior Agreement is requested. Failure to meet this obligation may result in cover being refused.

With hospitalisations, the insurer must be notified of each admission to hospital at least seven (7) days before the actual admission, and within 48 hours in case of hospitalisation following an emergency.

The insurer reserves the right not to reimburse expenses that have not been notified in advance as required by the policy. If, after this, treatment becomes medically necessary, the insurer will reimburse only 80% of the indicated amount for Hospitalisation benefits and 50% for other benefits.

In the context of analysing a claim, the Insurer's medical expert may request any information and supporting documents required to process the loss. If the documents provided prove to be incomplete or raise doubts, the Insurer's medical expert is entitled to request data from the following organisations and persons pursuant to the Article on Personal Data:

- Doctors,
- Hospitals,
- Other medical institutions,
- Nursing homes,
- Nursing staff,
- Other insurers,
- Basic health insurance organisations,
- Professional insurance organisations, and
- Official bodies.

If policyholders, including their Rightful Beneficiaries and/or beneficiaries, as defined in this summary, explicitly refuse the collection of their personal data for claims processing purposes or revoke their consent, the Insurer may not be held liable for the non-payment of benefits.

Medical Evacuation and Assistance Plus cover

It is imperative to have prior agreement from the Assistance Provider to benefit from "Medical Evacuation" and "Assistance Plus" cover.

The Member's organisation of one of the assistance situations indicated in this summary can only give rise to reimbursement if the Assistance Provider has been informed of this procedure, given its express agreement and communicated a case number.

In this case, expenses are reimbursed on the basis of receipts, up to the limit of those the Assistance Provider would have incurred had it organised the service itself.

The Member must declare the Loss in writing to the Insurer within 5 working days of the damage. After this period, the Insurer reserves the right to withdraw the cover. A list of supporting documents will be requested from the Member.

Evacuation and repatriation cover

(included in Health cover)

Health cover automatically includes a **Repatriation Evacuation** benefit, as described below.

Evacuation and repatriation

If you are ill or injured as a result of a covered event (including an Epidemic or Pandemic) and your state of health requires a transfer, and if local medical infrastructures do not have the capacity to provide appropriate care, we will organise and pay for your transfer:

- either to the nearest competent hospital,
- or to the nearest competent hospital in your country of residence,
- or we will organise and pay for your repatriation to your home in your country of usual residence.

Depending on the seriousness of the case, repatriation or transport will be carried out under medical supervision, if necessary, by the most appropriate of the following means:

- special medical aircraft
- scheduled passenger plane, train or, ambulance.

A ticket back to your place of expatriation will also be covered.

Only medical requirements are taken into consideration when deciding on the date of repatriation, the means of transport or the place of hospitalisation.

The decision to repatriate is made by the Assistance Provider's Medical Advisor, after consulting the local attending physician and, if necessary, the family doctor.

In all cases, the decision to provide assistance and the choice of appropriate means rests exclusively with the Assistance Provider's Medical Advisor, after contact with the local attending physician and, where applicable, the Member's family. Only the medical interests of the Member and compliance with current health regulations are taken into consideration when deciding on transport, the choice of means of transport and the possible place of hospitalisation.

In case of **assistance request, before taking any initiative or incurring any expense**, you must contact (24/7):

Euro-Center
+66 (0) 2569 0225
asc@euro-cernter.com

When transport or repatriation is organised, you must return the original tickets to us without fail, as they become the property of Euro-Center.

Under no circumstances does Euro-Center take the place of local emergency rescue organisations.

Any refusal of the solution proposed by our medical team will entail the cancellation of personal assistance cover.

Assistance Plus

(optional cover)

The additional "**Assistance Plus**" option (if chosen) includes the cover described below.
If taken out, this option must apply to all beneficiaries of the policy.

Coverage of pre- and/or post-hospitalisation hotel expenses for the Member

If following a medical evacuation, your state of health does not require immediate hospitalisation or no longer requires it, in agreement with our doctors, we will cover the cost of any hotel accommodation (room and breakfast only), on presentation of receipts and up to the amount shown in the table of benefits. These expenses are reimbursed up to €80 per night per person, for a maximum of 10 nights.

Presence of a relative if the Member is hospitalised

If the Member's state of health does not allow or require repatriation, and if Hospitalisation in a local establishment is longer than six (6) consecutive days, the Insurer will provide one Family Member with a round-trip economy air fare or train ticket to get to the hospital. This service is only available if there is no adult Family Member on site. The Assistance Provider will also organise and pay for hotel accommodation (room and breakfast only) for a maximum of 10 nights at up to €80 per night. No compensation will be paid for any other temporary accommodation.

Care of dependent children under 16

In the event of medical evacuation following a covered event and if the Dependent Children are unable to make their own arrangements or cannot be supervised by a family member, the Insurer will pay for:

- care of Dependent Children at the Member's home up to a maximum of 20 hours;
- cover is limited to €500 for the entire service.

Repatriation of insured family members following the death or repatriation of one of the beneficiaries

In the event of the death of one of the beneficiaries, the Insurer will cover transport costs for family members, spouse and child(ren), living with the Member. This cover includes a one-way economy-class flight or 1st class train ticket.

In the event of repatriation of one of the beneficiaries, the Insurer will cover the cost of transporting a family member, spouse or child(ren), living with the Member. This cover includes a round-trip economy-class air fare or 1st class rail travel.

To benefit from this cover, the other beneficiaries must also be covered by the policy.

Repatriation in the event of Terrorism or Sabotage, Attack or Assault, Political Unrest, or a Natural Disaster

If the Member is the victim of an Act of Terrorism or Sabotage, an Attack or an Assault, resulting in Bodily Injury or a state of shock, the Insurer will organise the Member's repatriation to their Country of Nationality (or Country of Origin if different). Repatriation and the most appropriate means of transport are decided and chosen by the Insurer. Members taken unawares by the occurrence of such events in their country of expatriation should leave the location of the hostilities as soon as possible.

If the Member, on the advice of the local authorities or those of his/her Country of Nationality, because of events making the political regime unstable or because of a natural disaster (such as an earthquake or flood), is obliged to leave their place of expatriation, they must provide the Insurer, upon his/her return to his/her Country of Nationality, with all supporting documents enabling him/her to be reimbursed for the cost of the trip back, up to the price of a one-way plane ticket (economy class) or train ticket (1st class). The Member must provide proof that, as a result of events making the political regime unstable or following the occurrence of a natural disaster, the French Ministry of Europe and Foreign Affairs has classified the area in which they are domiciled as a “strongly discouraged” red zone. This cover cannot be granted in countries not eligible for cover, as listed in the "Territorial scope of cover" section.

Early return in the event of the death or hospitalisation of a close family member

In the event of the death or Hospitalisation lasting more than five (5) days of a member of the Member's immediate family, the Insurer will provide a round-trip economy air fare or 1st class rail fare to the Country of Nationality. The benefit is limited to one round trip per Member per insurance year. The outward journey must be made within eight (8) days of the date of death or hospitalisation.

This benefit is payable when the date of death or hospitalisation falls after the date of departure to the country of expatriation. The Assistance Provider reserves the right to verify the facts of the insured event (hospitalisation report, death certificate, etc.) prior to any intervention by its services.

Transport of the body (in the event of death)

In the event of death, the Insurer organises and pays for the transport of the Member's body or ashes from the place of death to the place of burial in the Country of Nationality (or the Country of Origin if different).

Funeral expenses necessary for transport

In the event of death, the Insurer will cover the cost of post-mortem treatment, laying the body in a coffin and the necessary transport arrangements. Transport costs for the coffin organised by the Assistance Provider are covered up to a maximum of €2,000. Funeral expenses, ceremonies, local convoys and burial or cremation are the family's responsibility. The choice of companies involved in the repatriation process is the sole responsibility of the Assistance Provider.

Burial expenses in the country of expatriation

In the event of death, and if the Member's family wishes to bury the deceased in the country of expatriation, the Insurer will cover local burial costs up to €1,000.

Search and Rescue Costs

The purpose of this cover is to reimburse the cost of search and rescue operations on private or public property by specialised teams using any available resources, including a helicopter, in order to locate and evacuate the Member to the nearest suitable reception centre, up to a maximum of €5,000 per Member and €15,000 per period of cover.

In all cases, the Member must present the invoices and supporting documents from the official bodies that intervened. The Member (or any person acting on their behalf) must notify the Assistance Provider within 48 hours of action by the search and/or rescue teams.

Psychological support following an insured event

The Assistance Provider will provide the Member with psychological support. The clinical psychologist will provide Members with confidential medical and psychological support, enabling them to confide in someone after an event covered by the "Assistance Plus" policy.

The support offered is limited to a maximum of three (3) telephone sessions per insurance year. Depending on the situation and the beneficiary's requirements, an appointment can be arranged to meet with a state-qualified psychologist near his/her home. The choice of practitioner is up to the Member, who is responsible for all consultation costs.

Locating and shipping medicines that cannot be found locally

If the Member requires medication that cannot be found locally, subject to a prescription from the Member's local attending physician matching the date of the request, the Insurer will pay for the shipment of medicines that cannot be found locally, and are essential for ongoing curative treatment, provided that no equivalent medication can be prescribed to the Member on site and that national or international health or customs regulations do not prevent such a shipment.

The Assistance Provider will send these products to the Member as soon as possible. The Assistance Provider cannot be held responsible for delays attributable to the transport companies used, nor for the possible unavailability of medicines.

This service is available for one-off requests. Under no circumstances can it be granted for long-term treatments requiring regular shipments, or for vaccinations. The cost of the medication is borne by the Member, unless it is covered under the Member's Health Care benefits. The Member undertakes to reimburse the amount, plus any customs clearance fees, within 30 days maximum of the shipment date.

Legal assistance abroad (except in the country of nationality)

Following an unintentional infringement of current laws and regulations in the Country of Expatriation, and for any act not classified as a crime, the Assistance Provider will intervene on written request if legal action is taken against the Member. This benefit does not apply to events linked with the professional activity of the Members. The Insurer will pay local legal fees up to a maximum of €3,000 per event.

Advance of bail abroad (except in the country of nationality)

In the event of travel abroad, and in the countries covered in the zone of cover chosen by the Member, the Insurer will advance the bail required by the authorities for the Member's release or to enable them to avoid imprisonment. This advance is limited to a maximum of €12,000 per event.
The Member is required to draw up an acknowledgement of debt to the Insurer in an amount equivalent to the bail required by the authorities.
The Member is required to repay this advance to the Insurer:

- Upon the return of the bail in the event of discharge or acquittal;
- Within 15 days of the enforceable court decision in the event of a conviction;
- In all cases, within 3 months of the payment date.

Risks and services excluded from Assistance coverage

Medical Evacuation and Assistance Plus cover does not include costs arising from the following events or circumstances (for which the Insurer will not be liable to pay any compensation of any kind):

1. **Minor ailments or injuries that can be treated on site;**
2. **Convalescence, illnesses undergoing treatment and not yet consolidated and/or requiring further scheduled care;**
3. **Pre-existing illnesses established prior to the cover start date, which carry a risk of aggravation or recurrence;**
4. **Pregnancy, childbirth and their aftermath for newborns;**
5. **Trips undertaken for diagnostic and/or treatment purposes;**
6. **The consequences of the failure, impossibility or consequences of vaccination or treatment required or imposed by travel;**
7. **Congenital diseases or malformations;**
8. **Consequences of participating in a bet, challenge, duel or crime;**
9. **The consequences of non-compliance with recognised safety rules concerning the practice of sporting activities;**
10. **Accommodation costs, except those covered by a prior agreement with the assistance service;**
11. **Fuel, tolls, boat crossings;**
12. **Expenses not supported by original documents;**
13. **Any other expenses not included in the cover granted.**

The following are not covered:

1. **Treatment courses, stays in rest homes and rehabilitation expenses;**
2. **Repetitive transport necessitated by the insured's state of health.**

The following are not included in Search and Rescue Cost cover:

1. **Search and rescue costs resulting from failure to observe the safety rules laid down by the site operators and/or the regulations governing the activity practiced by the insured;**
2. **Search and rescue costs incurred in connection with the practice of semi-professional or professional sports or participation in expeditions or competitions, unless expressly stipulated otherwise.**

The following are excluded from cover for Bail Advance Abroad and Foreign Legal Assistance Abroad:

1. **No legal assistance will be provided for disputes originating or arising prior to the cover start date.**
2. **Litigation connected with the insured's business activities is excluded from legal assistance coverage.**
3. **No legal assistance will be provided if there is a conflict of interest between the insured and the opposing party.**

Risks excluded from all cover

Expenses incurred will not be reimbursed by the Insurer if they result from any of the following:

1. **The consequences of wilful non-compliance with the regulations of the country visited or the practice of activities not authorised by local authorities;**
2. **Intentional acts on the part of the Member or the insured, and/or breaches of the laws of the country in which the insured is staying;**
3. **Civil or foreign war, riots, insurrections, strikes, acts of piracy and sabotage, voluntary participation in brawls, popular movements or acts of terrorism, wherever the events take place and regardless of the protagonists (except in cases of self-defence). Members taken unawares by the occurrence of such events must leave the place of hostilities as soon as possible. Their cover remains in effect for a maximum of fourteen (14) days from the date of the outbreak of hostilities until the insured's return to his/her country of nationality or usual residence prior to expatriation;**
4. **The Member's voluntary participation in acts of terrorism wherever the events take place;**
5. **Suicide or attempted suicide in the first year of coverage;**

6. **The use of drugs or narcotics;**
7. **The insured's blood alcohol level or inebriation (alcohol level higher than the level stipulated by the motor vehicle traffic legislation in force on the day of the loss in the country of occurrence);**
8. **Two-wheeled vehicle accidents if the insured was not wearing a helmet;**
9. **The direct or indirect effects of changes in the structure of the atomic nucleus, climatic events such as storms or hurricanes, earthquakes, floods, tidal waves and other cataclysms, except in the case of compensation for natural disasters;**
10. **Accidents or illnesses existing before the effective policy date, subject to relapse or non-consolidation; congenital illnesses or deformities. This exclusion does not apply to accidents and illnesses existing before the effective date which were declared when the policy was taken out and accepted by the Insurer;**
11. **The exercise of any professional activity on an oil platform;**
12. **Hunting;**
13. **Air navigation accidents unless the insured is a passenger on an aircraft for which the owner and pilot possess all the necessary authorisations and licences;**
14. **Participation in and training for all sporting competitions, as well as the practice of all sports within a club or federation;**
15. **Participation in sports diploma courses and study programmes;**
16. **The practice of semi-professional or professional sports.**

The Insurer will not be bound to provide any insurance (or reinsurance) coverage or settle any claim or provide any benefits under these provisions if this coverage, settlement or benefits would expose the Insurer to any sanctions, prohibitions or restrictions arising from United Nations resolutions on economic or trade sanctions, by virtue of the laws and regulations of the European Union, the United States of America or any other jurisdiction.

Basis of the Insurance Policy

This policy is governed by the French Insurance Code. The definition of cover, pricing and application rules factors in the legislative and regulatory provisions in force on the effective date of the insurance policy concerned by this summary.

Subrogation

The Insurer is subrogated, up to the indemnity paid by it, to the rights and actions of the Insured against third parties responsible for the loss.

If subrogation can no longer be exercised in favour of the Insurer due to the Insured's fault, the Insurer will then be discharged of its obligations towards the Insured to the extent that subrogation could have been exercised.

Time limit for action arising from the insurance policy

Articles L. 114-1 to L. 114-3 of the French Insurance Code set out the provisions governing the time limit for action arising from insurance policies, as follows:

Article L. 114-1 of the French Insurance Code:

Any action arising from an insurance policy is time-barred after 2 years from the event giving rise to it.
However, this period runs:
1° In the event of a concealment, omission or false or inaccurate statement concerning the risk involved, only from the date the Insurer became aware of it;
2° In the event of a loss, only from the date on which the interested parties became aware of it, if they can prove that they were unaware of it up to that point.
If the Insured's action against the Insurer is based on the action of a third party, the time limit for action runs only from the date on which the third party took legal action against the Insured or was compensated by the latter.
The time limit for action is extended to 10 years with life insurance policies if the beneficiary is a different person from the policyholder and with insurance policies covering accidents to people, if the beneficiaries are the Rightful Beneficiaries of the deceased Insured.
With life insurance policies, notwithstanding the provisions of 2°, the beneficiary's actions are time-barred at the latest 30 years from the date of the Insured's death.

Article L. 114-2 of the French Insurance Code:

The time limit for action is interrupted by one of the ordinary causes for interrupting the time-bar limit and by the appointment of experts following a loss. The time limit for action may, however, be interrupted by the dispatch of a registered letter with acknowledgement of receipt to the Insured by the Insurer regarding action for payment of the premium and to the Insurer by the Insured regarding the settlement of indemnification.

Article L. 114-3 of the French Insurance Code:

Notwithstanding article 2254 of the Civil Code, the parties to the insurance policy may not, even by common consent, modify the time limit for action, or add to the causes of its suspension or interruption.

The time limit for action is interrupted by one of the ordinary causes for interrupting the time-bar limit as

indicated in articles 2240 and thereafter of the Civil Code and by the appointment of experts following a loss.

The ordinary causes for interrupting the time limit for action provided for by the Civil Code are:

- Recognition by the obligee of the right of the person against whom the obligee could claim inaction within the time limit (article 2240 of the Civil Code),
- Legal proceedings (articles 2241 to 2243 of the Civil Code),
- Protective measures taken pursuant to the Code of Civil Enforcement Procedures or by an enforcement order (article 2244 of the Civil Code),
- One of the jointly and severally liable obligees being summoned or notified through legal proceedings or through an enforcement order or recognition by the obligee of the right of the person against whom the obligee could claim inaction (article 2245 of the Civil Code),
- Summons or notification made to the main obligee or the latter's recognition of the right interrupts the time limit for action against the guarantor (article 2246 of the Civil Code).

Anti-money laundering

The checks we are legally required to carry out to combat money laundering and the financing of terrorism, in particular with cross-border capital movements, may lead us to ask you for explanations or proof at any time. Pursuant to the French Data Protection Act of 6 January 1978, amended by the Act of 6 August 2004, and the French Monetary and Financial Code, you have the right to access your personal data by writing to the CNIL (French data protection authority).

Jurisdiction/Applicable law

Pre-contractual and contractual relations are governed by French law, chiefly the Insurance Code.
Any legal action concerning coverage will be subject to the exclusive jurisdiction of the French courts.
However, if you are domiciled in the Principality of Monaco, the Monaco courts will have jurisdiction in the event of a dispute between you and us.
The language used in pre-contractual and contractual relations is French.

Withdrawal

If you are already insured for the same risk:

You should check that you are not already covered for any of the risks insured by the new policy. If this is the case, you have the right to cancel this policy within 14 calendar days of its signature, with no costs or penalties applicable, if all the following conditions are met:

- you have taken out this policy for non-business purposes;
- this policy is supplementary to the purchase of a service sold by a supplier;
- you can prove that you are already covered for one of the risks covered by this new policy;
- the policy you wish to cancel has not been fully executed;
- you have not reported any loss covered by this policy.

In this case, you may exercise your right to cancel the policy by sending a letter or any other durable medium to ACS, 153 rue de l'Université, 75007 Paris, FRANCE, together with documentary proof that you already have cover for one of the risks covered by the new policy. We are bound to reimburse the premium paid within 30 days of your cancellation.

"I,..... *(indicate surname(s), first name(s) and address)*, hereby notify you that I am cancelling my enrolment in policy No. XXXXX, which I took out on..... *(indicate date)* and request reimbursement of the premium I paid of ..... *(indicate amount and currency)*, after the portion of the premium corresponding to the period covered has been deducted.
For my part, I undertake to reimburse the amount of any benefits paid to me outside the period of cover."

Payment of premiums

Premiums are due by the Member and are payable in advance in Euros to ACS. In the event of termination, the premium is calculated *prorata temporis* for the period between the effective date of enrolment and the effective date of termination.

The payment frequency is chosen by the Member: monthly (SEPA and credit card only), quarterly, half-yearly and annual.

Payment can be made by bank transfer, credit card or SEPA direct debit.
With bank transfers, bank charges are borne exclusively by the payer.
Any exchange fees are also payable by the payer.

The choice of frequency and method of payment is made at enrolment. From then on, any changes can only be made at the policy's anniversary date.

In the event of non-payment or the partial payment of premiums, a formal notice will be sent to the Member by registered letter at least ten (10) days after the due date, informing them that on expiry of a period of thirty (30) days, cover will be suspended following the dispatch of the registered letter. Should the premiums not be paid

within ten (10) days of the expiry of the thirty (30) day period, cover will be terminated. The non-payment of premiums will entail termination of enrolment without further notice.

If the late payment of premiums results in the dispatch of a formal notice, the Member will be charged a penalty of €40.

In any event, neither the suspension nor the termination of your policy will discharge your debt, and any outstanding amounts may be subject to legal action.

Revision of premiums

Premium amounts may be revised at the anniversary date of your policy, depending on the technical results of the insurance policy and demographic trends.

If the Insurer introduces new pricing, ACS is required to inform Members at least two (2) months before the new premium amounts are applied. If in disagreement with the new premium amounts, the Member may request the cancellation of their enrolment within one (1) month of notification, according to the terms and conditions set out in article L. 113-14 of the French Insurance Code. Cancellation will take effect on the first day of the month following receipt of the cancellation request by the Underwriter.
The Insurer will collect the pro rata premium due up to the date of termination, calculated on the basis of the premium amounts previously in force, if this pro rata premium has not yet been paid by the Member.

If this is not the case, premiums will be calculated automatically on the basis of the new amounts notified.

Personal data protection

Pursuant to the French Data Protection Act of 6 January 1978, as amended, the Member's personal data may be transferred to the Insurer, its agents, service providers, subcontractors or reinsurers for the purposes of managing the insurance policy. Insureds are hereby informed that data processing concerning them and any beneficiaries is carried out in connection with the drawing up, management and execution of the insurance policy, as well as for its commercial management. It may also be used for control and prospecting purposes, to combat fraud, money laundering and the financing of terrorism, to find the beneficiaries of unpaid policies covering death, and to comply with legal and regulatory provisions, in application of the policy.

The data collected is essential to implement this processing and is intended for the relevant departments of the Insurer and its Managing Agent, as well as its subcontractors, service providers or partners, where applicable. The Insurer is responsible for ensuring that this data is accurate, complete and, where necessary, updated. The data collected will be kept for the entire period of the contractual relationship increased by any legal requirements, or in compliance with the time periods stipulated by the CNIL (French data protection authority).

Personal data may be transferred to service providers or subcontractors established in countries outside the European Union. These transfers may only be made to countries recognised by the European Commission as having an adequate level of personal data protection or to recipients offering appropriate guarantees.

Insureds and/or beneficiaries have the right to access, rectify or delete their data, to limit the processing of their data, to portability, to object to the processing of their data, and to lay down directives concerning what happens to their data when they die.

They may exercise these rights by contacting:

ACS,
For the attention of the Data Protection Officer
153 rue de l'Université
75007 Paris
France
dpo@acs-ami.com

When exercising their rights, they may be asked to provide an identity document. In the event of a persistent dispute, they have the right to contact the CNIL at www.cnil.fr or at 3 place de Fontenoy - TSA 80715 - 75334 Paris cedex 7, France.

Mediation

What is the procedure for examining complaints?

In the event of difficulties in the application of your contract, ACS is able to investigate all your requests and complaints. You can address your complaints to our dedicated complaints department, whose contact details are given below:

ACS, Complaints Department,
153, rue de l'Université, 75007 PARIS, France
recla@acs-ami.com

ACS undertakes, from the date of sending your written complaint, to acknowledge receipt of your complaint within 10 days and to provide you with a response within a maximum of 2 months.

In any event, after this two-month period, and regardless of response you receive or in the absence of a response,

you may appeal to the MGEN Mediator, whose contact details are as follows:

Le Médiateur de l'Assurance (LMA)
TSA 50110 –
75441 PARIS CEDEX 09, France
www.mediation-assurance.org

Insurer and Broker supervisory authority

The Insurer's supervisory body is **Autoridade de Supervisão de Seguros e Fundos de Pensões**, located at Av. da República 76, 1600-205 Lisbon, Portugal.

ACS is supervised by the **Autorité de Contrôle Prudentiel et de Résolution (ACPR)** located at 4 Place de Budapest, 75009, Paris, France.

Consumers' right to object to cold calling

If you do not wish to be contacted by phone for commercial purposes, you can register free of charge on an anti-cold-call list. However, telephone canvassing to propose new offers will still be authorised for all professionals with whom you have at least one current contract. These provisions apply to all consumers, i.e. any natural person acting for purposes unrelated to their commercial, industrial, artisanal, or professional activity.

Emergency numbers

To request any **assistance or hospitalisation**, please contact us **24/7** at:

Euro-Center
+ 66 (0) 2569 0225
acs@euro-center.com

If you have any further questions **about this policy**, please contact:

ACS
153 rue de l'Université, 75007 Paris - France
+ 33 (0)1 40 47 91 00
contact@acs-ami.com

Table of benefits

Hospitalisation & Evacuation/Repatriation module

Hospitalisation (prior agreement required)				
Cover	**BRONZE**	**SILVER**	**GOLD**	**PLATINUM**
Maximum limit per beneficiary per year of coverage	**€500,000**	**€1,000,000**	**€2,000,000**	**€3,000,000**
Medical, surgical hospitalisation and outpatient day surgery	100% of actual cost			
Expenses related to hospitalisation (medical and paramedical expenses incurred during hospitalisation)	100% of actual cost			
Private room	100% of actual cost, limited to €100/day	100% of actual cost, limited to €150/day	100% of actual cost, limited to €250/day	100% of actual cost
Organ transplant (excluding organ acquisition costs and transplant-related medicines)	100% of actual cost			
Cancer treatment (including outpatient care and treatment)	100% of actual cost			
Psychiatric hospitalisation (Waiting period: 3 months)	Not covered	100% of actual cost, limited to €3,000 per year of coverage	100% of actual cost, limited to €3,500 per year of coverage	100% of actual cost, limited to €4,000 per year of coverage
Companion's bed (hospitalisation of a child under16)	100% of actual cost, limited to €50/day	100% of actual cost, limited to €75/day	100% of actual cost, limited to €100/day	100% of actual cost, limited to €150/day
Outpatient care related to hospitalisation (within 90 days of hospital discharge)	100% of actual cost			
Hospitalisation at home immediately following hospitalisation covered by the policy (including hospital transport costs to home) (on prescription and with prior agreement)	100% of actual cost, limited to €2,000 per year of coverage	100% of actual cost, limited to €2,000 per year of coverage	100% of actual cost, limited to €3,000 per year of coverage	100% of actual cost, limited to €4,000 per year of coverage
Rehabilitation immediately after hospitalisation (within 90 days of hospitalisation or if the threshold is reached)	100% of actual cost, limited to €2,000, per year of coverage	100% of actual cost, limited to €2,000, per year of coverage	100% of actual cost, limited to €3,000, per year of coverage	100% of actual cost, limited to €4,000, per year of coverage
Local emergency ambulance transport	100% of actual cost			
Emergency reconstructive dental surgery following an accident	100% of actual cost			
Emergency treatment of less than 24 hours in a hospital (not related to a hospitalisation) **in the zone of cover, in the event of accident or unexpected illness**	€250 per year of coverage			
Emergency hospitalisation outside the zone of cover (travel less than seven weeks from departure from zone of cover)	100% of actual cost			
Medical evacuation	100% of actual cost			
Following a medical evacuation, return of the Member to the country of expatriation after consolidation	100% of actual cost			

Routine Medical Care, Prevention, and Screening Option

Cover	Level 1	Level 2	Level 3
General practitioners' and specialists' fees	100% of actual cost, limited to €65 per act and per consultation	100% of actual cost, limited to €150 per act and per consultation	100% of actual cost, limited to €300 per act and per consultation
Psychiatrists, psychologists and psychotherapists	Up to 5 visits/year, maximum €60 per visit	Up to 10 visits/year, maximum €200 per visit	Up to 20 visits/year, maximum €200 per visit
Tests, radiology, scans and MRI (prior agreement for MRI)	100% of actual cost limited to €2,000 per year of coverage	100% of actual cost limited to €4,000 per year of coverage	100% of actual cost limited to €8,000 per year of coverage
Prescription medicines and vaccines	100% of actual cost		
Prescribed medical aids	100% of actual cost		
Physiotherapy (prior agreement)	100% of actual cost, limited to €50 per session and €500 per year of coverage	100% of actual cost, limited to €60 per session and €900 per year of coverage	100% of actual cost, limited to €80 per session and €1,200 per year of coverage
Chiropractor (prior agreement)**, osteopath** (prior agreement), **homeopath, acupuncturist** (prior agreement)**, naturopath, chiropodist**	100% of actual cost, limited to €50 per session and €500 per year of coverage	100% of actual cost, limited to €60 per session and €900 per year of coverage	100% of actual cost, limited to €80 per session and €1,200 per year of coverage
Prescribed speech therapy and orthoptics (prior agreement)	100% of actual cost, limited to €50 per session and €500 per year of coverage	100% of actual cost, limited to €60 per session and €900 per year of coverage	100% of actual cost, limited to €80 per session and €1,200 per year of coverage
Prescribed medical prostheses (prior agreement)	100% of actual cost, limited to €1,200 per year of coverage	100% of actual cost, limited to €2,500 per year of coverage	100% of actual cost, limited to €4,000 per year of coverage
Health check-up (laboratory tests, blood tests, electrocardiogram, hearing test, chest x-ray, etc.)	Reimbursement limited to €300/every three years	Reimbursement limited to €500/every three years	Reimbursement limited to €1,000/every three years
Cancer screening tests (mammogram, PSA, colorectal, pap smears, etc.) - **every 5 years from age 20 to 35** - **every 3 years from age 35 to 45** - **every 2 years from age 45 to 55** - **every year beyond age 55**	Reimbursement limited to €300	Reimbursement limited to €500	Reimbursement limited to €1,000
Self-medication package: over-the-counter medication, aids to stop smoking, COVID-19 self-tests	Not covered	Up to €75 per year of coverage	Up to €150 per year of coverage
Dietician (consultation)	Not covered	Not covered	3 sessions per year of coverage, up to €150 per consultation

Dental and Optical Option

Cover	Level 1	Level 2
Dental		
Maximum limit per beneficiary per year of coverage	**€2,000**	**€4,000**
Dental care (waiting period: 3 months)	100% of actual cost limited to €1,000 per year of coverage	100% of actual cost limited to €2,000 per year of coverage
Orthodontics (children under 16) (prior agreement) (waiting period: 9 months)	100% of actual cost limited to €1,000 per year of coverage	100% of actual cost limited to €2,000 per year of coverage
Dental prostheses, including inlays, onlays, implants (prior agreement, waiting period: 6 months)	100% of actual cost, limited to €300 per tooth and €1,000 per year of coverage	100% of actual cost, limited to €500 per tooth and €2,000 per year of coverage
Optics		
Prescription lenses, frames and contact lenses (waiting period: 6 months/one pair of glasses every 2 years) **Cost of surgical and laser treatment for vision correction** (once during the life of the policy) (waiting period: 6 months) (prior agreement)	100% of actual cost limited to €400 per year of coverage	100% of actual cost limited to €800 per year of coverage

Maternity Option

12-month waiting period		
Cover	**Level 1**	**Level 2**
Maximum limit per beneficiary per year of coverage	**€12,000**	**€24,000**
Delivery expenses: Hospitalisation, private room, accommodation, medical and surgical fees.	Up to €6,000 per pregnancy	Up to €12,000 per pregnancy
Home delivery (midwife or other specialist fees)		
Consultations, pharmacy, pre- and post-natal examinations and care		
Childbirth preparation sessions (carried out by a doctor or midwife)		
Diagnosis of chromosomal abnormalities (prior agreement)		
Newborn screening		
Complications directly related to childbirth (including Caesarean section if medically justified by the practitioner)	The above threshold doubled	The above threshold doubled
Medically assisted reproduction (MAR) (waiting period: 18 months)	Not covered	€1,000 per attempt, with a maximum of 3 attempts during the life of the policy

Assistance Plus Option

Cover	Limit
Following a medical evacuation - Coverage of pre- and/or post-hospitalisation hotel costs for the Member	€80/night/person (10 nights maximum)
Following a medical evacuation, transport costs for a companion Member	Round-trip ticket
Following a medical evacuation - Care of dependent children under 16	Reimbursed up to 20 hours per year, max. €500
Repatriation of insured family members following the death or repatriation of one of the beneficiaries	One-way ticket
Repatriation in the event of Terrorism or Sabotage, Attack or Assault, Political Unrest or a Natural Disaster	One-way ticket
Early return in the event of the death or the hospitalisation of more than six days of a close family member excluding grandparents (parents, siblings, children and grandchildren)	Round-trip ticket, limited to one trip per enrolled person per year of coverage
Presence of a family member in the event of hospitalisation for more than six days	Round-trip ticket + €80 per night (max. 10 nights)
Transport of the body if one of the beneficiaries dies	Actual cost
Funeral expenses required for transport (cost of coffin)	Limited to €2,000
Burial expenses in the country of expatriation	up to €1,000
Search and Rescue Costs	up to €5,000 per person and a maximum of €15,000 per period of coverage
Psychological support following an insured event	3 telephone sessions per enrolled person and per year of coverage
Locating and shipping medicines not available locally	100% actual cost
Legal Assistance	Up to €3,000 per year of coverage
Advance of bail	Up to €12,000 per year of coverage

If the Member is covered by any basic health insurance plan, our reimbursements are additional to these.

Appendix: ACS Privacy Statement

Protecting data and the privacy of insured members is a top priority. This privacy notice explains how and what type of personal data will be collected, why it is collected and to whom it is shared or disclosed. Please read this notice carefully.

Processing of personal data

The information collected by ACS, insurance broker, simplified joint-stock company registered under number 317 218 188 RCS Paris, and located at 153, rue de l'Université – 75007 Paris, France, either directly from you or via your insurance intermediary, is subject to data processing for the sole purpose of:

- preparing, concluding, managing and executing your quote or contract (study of needs, underwriting, calculation and collect of premium, preparation of endorsements, claims management, treatment of complaints if any…),
- enforcing regulations related to anti-money laundering and terrorist financing prevention, fight against fraud,
- elaborating statistical and actuarial studies,
- redistributing risks via reinsurance or coinsurance.

The processing of such data is carried out in compliance with the requirements applying to the collection, processing, recording, organization, purpose limitation and data minimization, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transfer, dissemination, security of personal data.

The recipients of such data are, within the limits of their relevant assignments and according to applicable purposes, the insurers, reinsurers, insurance intermediaries (your direct broker, if applicable), and eventually their subcontractors, which intervene in the context of the execution or the management of your contract, third party administrators, the mediator if a case is submitted to him/her, authorities legally authorised to manage your complaints, Tracfin for the fight against terrorism and anti-money laundering. Your data may also be transmitted to any person benefiting from the contract (subscriber, insured, member, and beneficiary of the contract).

You expressly accept the collection and processing of data concerning your health. This information is necessary for the execution and the management of your contract and your benefits, which is the sole purpose of the processing, and made in accordance with the regulations of medical confidentiality. This information is exclusively intended for the medical advisors of ACS, its departments in charge of managing your benefits, its third-party administrators and assistance providers if applicable, as well as for the insurers and reinsurers of your contract.

Transfer of personal data :

In addition, we inform you that your personal data, or that of other parties concerned by or benefiting from the contract, may be transferred outside the European Union if necessary for the performance of your contract.

The sole purpose of such transfers is to allow the performance of insurance and assistance claims, and only the data necessary for the achievement of this purpose are transferred.

The recipients or categories of recipients authorised to receive the data are the accredited staff of the medical administrators and assistance companies as well as of the insurers, where appropriate.

These transfers are made according to the regulations relating to the protection of personal data applicable in the European Union.

Your rights:

In accordance with the French data protection law n° 78-17 of January 6 1978 as amended in 2004 and 2018 and to EU regulation 2016/679 of April 27th 2016, you have the right to Access, Rectify, Erase, and to the Portability of, any data concerning yourself, as well as the rights to the Restriction of and to Object to the processing of your personal data, which you can pursue by writing to our Data Protection Officer: dpo@acs-ami.com or by postal mail to « ACS, To the attention of the DPO, 153, rue de l'Université, 75007 Paris, France » (together with a copy of an official ID).

You may send a complaint:

- On the CNIL website by filling out the online form.
- By postal mail writing to CNIL - 3 Place de Fontenoy - TSA 80715 - 75334 PARIS CEDEX 07 FRANCE

Regarding your health data, these rights may also be exercised by writing to the ACS Medical Consultant (ACS, To the attention of the Medical Consultant, 153, rue de l'Université, 75007 Paris, France) together with of a copy of an official ID.

Data retention Duration :

Personal data will be retained in accordance with applicable laws and regulations, and specifically as follows :

Documents	Data Retention Duration
Proposal, quotations	3 years
Individual Enrolment Forms	- 5 years from the date of the termination of contract (if no claim) - 5 years from the date of the termination of the insurance coverage
Contributions and premiums	5 years
Healthcare claims (illness/ accident medical expenses)	3 years from the date the claim is closed
Claims files in the event of Death, Total and Irreversible Loss of Autonomy, Incapacity, Disability	- if the benefit has been paid: 10 years from the last date of payment - if the benefit has not been paid in totality or partially to the beneficiary(ies) in the event of death of the Insured: 30 years from the date of the recognition of the death of the Insured by the company - if the benefit could not be paid in total or partial due to the disappearance of absence of the Insured: 30 years from the date of recognition by the company of the determination of the disappearance or absence of the Insured
Permanent Partial Disability Due to Illness (PPDI)- Permanent Partial Disability Due to Accident Disability (PPDA)	- if the benefit has been paid: 10 years from the last date of payment - if not paid: 30 years