ACS HEALTH IN ASIA

Globe Partner Association
Expatriate 1st USD Health Scheme
Summary of benefits

As a member of the Globe Partner Association, you have selected the "Health" cover (namely ACS Health in Asia Plan) that the Association has taken out with AWP Health & Life S.A. (joint stock company with a share capital of Euro 65,190,446 subject to the French insurance code, located Eurosquare 2, 7 rue Dora Maar, 93400 Saint Ouen, France – registration number 401 154 679 RCS Bobigny), under contract no.011767/006.
How the cover is applied and the details of the benefits to which you are entitled are set out in this leaflet.
The currency of ACS Health in Asia Plan is US Dollar (USD or $).

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1/ General

Qualification – affiliation

Those who qualify are *Expatriates* who are members of the Globe Partner Association, regardless their nationality, who are aged under 60. Age is calculated by difference of years: year of affiliation minus year of birth.
Children of the eligible person, who live therewith in the same home and who are under 25 years of age, as well as the *Spouse* or *Cohabitee* may also benefit from this insurance.
Upon their affiliation, these persons must fill out and sign the Membership form, which includes a medical questionnaire approved by the Insurer's Medical Advisor. A complementary medical examination may be requested by the Insurer.
The Insurer reserves the right to make its acceptance subject to the production of any supplementary information that it deems necessary. As a result of the medical examination, the Insurer reserves the right to deny cover, reduce the extent and/or amount thereof, or to increase the premium.
In that event, the eligible person's agreement is required prior to the start date of the medical cover.
Eligible persons and, if applicable, their beneficiaries, become Insured Member (hereinafter called "Member") once admitted to this insurance.

Formulas

The Plan offers four formulas namely: Bronze Basic, Bronze, Silver and Gold; the Member opts for one of them.
The formula selected by the Member is indicated on his certificate of insurance. These formulas apply as follows:

Choice of formulas

The choice of formula (Bronze Basic, Bronze, Silver or Gold) is made by the Insured at the time of joining the Plan. It cannot be modified until membership is renewed on each January 1. The Insured can also subscribe to an annual *Deductible* of USD 100, USD 500 or USD 1,000, or to a *Co-Insurance* of 10 or 20%.
It is agreed that:

- deductibles and co-insurance options are available only on Silver and Gold plans,
- the combination of *Co-Insurance* and *Deductible* is not possible.

Change of formulas

The Member may change the formula until membership is renewed; change takes effect on next January 1.
A change to a formula that provides a lower level of medical cover than that which the Member had previously selected is irrevocable. In the event the Member opts for a higher level of medical cover, he has to complete a new medical questionnaire. Once accepted into the higher level of medical cover, the *Waiting Periods* set forth below apply to the Member.

It is understood and agreed that, in case of family membership (Member but also his *Spouse* or *Cohabitee* and minor children), the choice of formula must be the same for each beneficiary.

Start date of cover

After being accepted by the Insurer (including approval of medical questionnaire), the Member receives a certificate of insurance.
Under no circumstances may the cover start before the Member has paid the first installment. Subject to the payment of this first installment, cover of medical expenses takes effect for each Member on the date of acceptance that appears on the Individual Membership Application for all expenses, except the following which take effect after the *Waiting Periods* set out below:

- ***Dental Prostheses*: 6 months**
- **Optical: 6 months**
- **Childbirth and maternity: 10 months**

The computation of these *Waiting Periods* begins on the start date of affiliation stipulated on the certificate of insurance.

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However, if the Member can provide documentation of equivalent cover that was in effect at least one month prior to the date he became a Member of this insurance, by producing a certificate of termination indicating the level of benefits and the termination date, the *Waiting Periods* are abrogated, including the expenses of child labor and complications during pregnancy and delivery.

Renunciation

The Insured may renounce to the insurance contract within a period of 14 complete calendar days from the moment he/she is informed that the contract is signed, by sending a registered letter with acknowledgment of receipt to ACS, 153 rue de l'Université 75007 Paris, France. ACS will then reimburse, in full, the amount paid, within 30 days of receipt of his letter. If the insured requests the implementation of the guarantees during the period of renunciation, the right of renunciation is no longer applicable.

Sanctions in case of false declaration

Any information supplied by the Insured or one of their beneficiaries that is incorrect, falsified, exaggerated or any fraudulent acts on their part shall be the direct responsibility of the Insured and shall give rise to:

- the nullity of your contract in case of intentional misrepresentation (L 113-8 of French insurance code), premiums paid are kept by the Insurer, who is entitled, as a compensation, to the payment of all premiums due; in such a case, the Insured will have to reimburse all the claims paid by the Insurer under the contract;
- if the intentional misrepresentation, discovered before any claim, is not established, premium increase or termination of the contract (L 113-9 of the French insurance code)
- if the intentional misrepresentation, discovered after the claim, is not established, decrease of claim according to the ratio between the paid premium and the premium that should have been paid if the initial declaration had been consistent with the reality (L 113-9 of the French insurance code).

Duration of cover

The Member subscribes both for himself and on behalf of his *Spouse* (or *Cohabitee*) and minor *Children* who are accepted as beneficiaries, from the start date of his medical cover to December 31 of the current calendar year.
Membership of the Plan is tacitly renewed on January 1 of each year for a period of 12 months, unless the Member gives notice of its termination by registered letter sent to the Insurer on or before October 31 of the previous year.
In addition, the membership can also be terminated, at the initiative of the Member, at any time without charge or penalty at the end of a period of 1 year from the first subscription. Termination takes effect 1 month after the insurer has received notification by registered letter, simple letter, e-mail or any other durable medium.
Upon his acceptance for this insurance, subject to the sanctions specified for false declarations, the Insured cannot be excluded for medical reasons or due to his/her age as long as s/he meets the requirements for insurability and as long as the Plan is effective.

In any event, the cover terminates:

For each Member, on the following date and in the following event:

- on the 31st December of the year of his/her 74th birthday,
- on the last day of the period of his/her affiliation as specified on his certificate of insurance,
- in the event that s/he fails to pay the appropriate premiums,
- in case of death of the main beneficiary,
- at the end of the calendar quarter following the date on which s/he is no longer a Member of the ACS Health in Asia Plan number 011767/006 concluded between the Globe Partner Association and AWP Health & Life S.A.

For all Members, in the following event:

- on the termination date of contract no.011767/006 concluded between the Globe Partner and AWP Health & Life S.A.

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Termination or suspension of medical cover simultaneously entails termination of the right of Members to receive benefits for all *Treatments* and care as of the date of termination, even if they commenced or were prescribed prior to the aforesaid date.

2/ Definitions

Terms and expressions used in this agreement in italics and starting with a capital letter have the following meanings:

Accident: any unintentional bodily injury caused to the Insured, arising from abrupt, sudden and unexpected action with an external cause, **to the exclusion of an acute or chronic *Illness***.

Children: either children by birth or by adoption, up to the end of the calendar month during which the child's twenty fifth birthday occurs, or his marriage whichever occurs first, and if declared, any other child or children including a step child or children who have with the eligible member child-parent relationship and who are dependent upon the eligible Member for not less than 50% of his support on a permanent basis up to the end of the calendar month during which the child's twenty fifth birthday occurs, or his marriage whichever occurs first.

Cohabitation (Common Law/Life partner)
Cohabitation means the person cohabiting with the Covered Person in a legally recognised marital/conjugal relationship and who together fulfil both of the following conditions:
both individuals are free from matrimonial ties; and
Cohabitation has been declared by the Covered Person to the Policyholder, who shall communicate such information to the Insurer, at the time of enrolment and the Covered Person provides a legal certificate attesting to this status.
If the cohabitation is declared subsequent to the enrolment date of the Covered Person, the person shall only be taken into account as a cohabiting partner after a 6 (six)-month period. This period is not required if a child born of this union is dependent on the Covered Person. The end of the state of cohabitation must be declared in writing by the Covered Person to the Policyholder who shall communicate this information to the Insurer.
Only one person of the above persons shall be considered as beneficiary.

Coinsurance: the percentage of the eligible expenses to be paid by the Member himself, not reimbursed by the plan.

Country of origin: the country appearing on the passport of the insurance beneficiary and/or the country declared as the country of origin on the Membership form.

Deductible: refers to the amount of expenses to be covered by the Insured, which must be deducted from the sum that is to be reimbursed.
Dental prosthesis: prosthetic *Treatments*, including crowns, inlays, onlays and implants, and all the necessary *Treatments*, including the refund of the laboratory and component expenses.

Emergency: term used in the event of an *Accident*, natural catastrophe, the beginning of sudden worsening of a serious *Illness* requiring immediate measures and medical *Treatment* for the Insured or one of the Insured's dependents. Only medical *Treatment* given by a doctor, generalist or specialist or *Hospitalization* occurring within twenty-four (24) hours of the direct cause of the emergency shall be considered conditions necessary for reimbursement.

European Economic Area (EEA): countries that belong to the EEA are Austria, Belgium, Bulgaria, Czech Republic, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and Croatia.

Expatriate: a person who resides outside his / her *Country of Origin.*

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Formal Hospital Admission:

(i) For stays of at least 24 hours, Formal Hospital Admission is the formal acceptance by a *Hospital* or other inpatient health care facility of a patient who is to be provided with a room, board as well as continuous nursing service in the *Hospital* in which the patient resides at least overnight.

(ii) For stays of less than 24 hours in case of *Surgical Procedures*, Formal Hospital Admission is the formal document indicating that the patient is provided with nursing services and a bed, despite the fact that s/he does not stay overnight.

(iii) For stays of less than 24 hours in case of non-*Surgical Procedures*, Formal Hospital Admission is the formal document indicating that the patient has entered the *Hospital* for less than 24 hours for chemotherapy, radiotherapy, dialyses, fibrescopy, colonoscopy or endoscopy, *treatment* for less than 24 hours. The patient enters for *treatment* and leaves after *treatment*.

Home care: refers to medical care given by a state-licensed nurse at the Insured's home, in accordance with the prescription of a qualified doctor, immediately after, or in replacement of, *Hospitalization* or outpatient care.

Hospital: refers to any establishment licensed as a medical or surgery hospital in the country where it is located. The establishment must offer its patients ongoing monitoring by a physician. Convalescent and nursing homes, thermal baths and cures at spas, are not deemed to be hospitals.

Hospitalization refers to:

(i) a stay for at least 24 hours for medical *Treatments* or *Surgical Procedures* in a public or private *Hospital* due to an *Accident* or *Illness*, provided that the insured receives a *Formal Hospital Admission*. In such a case are covered:
- *Surgical Procedures* and corresponding accommodation costs,
- medical and paramedical expenses provided in the context of Hospitalization, and
- the transportation of the patient between the patient's home or the site of the *Accident* and the closest *Hospital* located in the same country.

(ii) a stay of less than 24 hours, provided that the insured receives a *Formal Hospital Admission*, in case of:
- *Surgical Procedures,*
- Fibrescopy, colonoscopy, endoscopy, or
- chemotherapy, radiotherapy or dialyses *Treatments*.

Stays of less than 24 hours for emergency rooms visits which do not result in *Surgical Procedures* are deemed to be outpatient treatments and are not reimbursed as Hospitalization expenses.

Illness: it means a deterioration of health confirmed by a physician. A physician means a person who is licensed to practise medicine in the country where the treatment is received and is not an Insured Person's relative.

Mandatory vaccines: refers to immunizations or injections required by the Health Authorities of the country in which the *Treatment* is administered or by those of the country that the Insured is visiting. Costs related to consultation and to purchase of the vaccine are covered.

Maternity cover: medical expenses (including double room) incurred for vaginal childbirth. Any complication, and private room, will be paid for by the "hospitalization" cover.
Qualifying times apply to all maternity-related expenses.

Medical auxiliaries: refers to nurses, nursing aides, and other personnel providing medical assistance who are licensed by the State.

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Organ transplant: refers to a surgical procedure for transplanting living organs or tissues – i.e. heart, heart/valve, heart/lung, liver, pancreas, pancreas/kidney, kidney, spinal cord, parathyroid; and transplants of muscle, bone or corneas. Costs incurred for obtaining an organ are not reimbursed.

Physical therapy: this *Treatment* is designed to restore a patient to a normal physical condition and/or function after a serious *Accident* or *Illness*. The physical therapy process must commence within 30 days after *Hospitalization* for an *Accident* or *Illness*.

Prescribed medical prostheses: refers to any prescribed medical instruments, equipment or appliances that facilitate or support the function or the capacity of a member or organ such as auxiliaries of phonation (electronic larynx), crutches, wheelchairs, orthopedic appliances, artificial members, hernia appliances, elastic support stockings, to the exclusion of orthopedic soles and shoes.

Prescribed medication: refers to products, including insulin and hypodermic syringes, prescribed by a physician for treating an *Illness* or compensating for a deficiency with a substance that is vital for the organism. The medication prescribed must have a medical effect that is proven and recognized by the pharmaceutical regulation and supervising authorities in the country in which it is prescribed.

Spouse/Civil Union Partner: The spouse not legally separated from the Covered Person, or his/her registered civil union partner (PACS or local equivalent), or cohabiting partner, as registered with the appropriate regulatory authority.

Subrogation: legal situation whereby the rights of one person are transferred to another person (in particular: the Insurer taking the place of the Contract holder for the purposes of proceedings against the opponent).

Surgical procedures: acts carried out under general or local anaesthetic or the reaching of an organ to be treated after an incision are deemed to be surgical procedures.

Transportation by ambulance: refers to transportation by ambulance within the same country, from the patient's residence or the place of the *Accident* to the nearest *Hospital* or licensed medical facility that is located in the same country and is best suited to the situation in the event of medical *Emergency* or necessity. Subsequent transfer of the patient from the hosting facility to a facility of closer proximity is also covered if the patient's condition so requires.

Treatment: refers to a medical procedure that is necessary for healing or relieving an *Illness*, infection or injury.

Waiting period: refers to the period during which the Member is not entitled to certain benefits.

3/ Health cover and benefits

Purpose of cover

Cover consists of reimbursing expenses that the Member has incurred for medical *Treatment* and care specified by the category of cover he has opted for.

Requests for reimbursements are accepted only if the Insurer deems the amount of invoices and receipts provided to be reasonable, in line with customary expenses and corresponding to medically justified interventions. The billed amounts must be in conformity with applicable standards; they must generally correspond to international medical procedures, and must be appropriate in the country where care is given. If that is not the case, the Insurer reserves the right to reduce the amount of payable benefits.

The "REASONABLE and CUSTOMARY" expenses defined by the Insurer is the expense charged by the provider, or the expense that prevails in the same country for a similar service offered by providers of an identical professional level, whichever is lower.

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Category of cover

The category of cover is the table of benefits opted for by the Member upon his affiliation and defined on the Certificate of Insurance. Only the benefits corresponding to the subscribed guarantees are covered. The list of these guarantees is indicated on the table attached to the present information booklet and varies according to the chosen formula.
The Member may subsequently change the category; change takes effect on next January 1.

A change to a category that provides a lower level of medical cover than that which the Member had previously selected is irrevocable.

It is understood and agreed that, in case of family membership (Member but also its *Spouse* or *Cohabitee* and minor *Children*), the choice of category must be the same for each beneficiary.

Coverage zone

Medical expenses are repayable in the following countries.

Zone 1: Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Taiwan, Thailand, Vietnam, and for stays of less than 120 consecutive days in one of the countries that belong to the *European Economic Area (EEA).*

Zone 2: Same countries as Zone 1 plus **United Kingdom** for stays of less than 120 consecutive days.

In case of any stay of less than 7 weeks outside the above- mentioned zones, expenses due to an *Accident* or *Illness* of an urgent character, as defined in chapter 2 - Definition, are reimbursed. In all other cases, expenses may be reimbursed only if expressly authorized by the Insurer.

Amount of benefit

For all formulas, the amount of benefits is determined for each medical expense pursuant to the following terms and conditions. Depending on the formula opted for by the Member, reimbursements are paid up to the maximum amounts indicated hereinafter in the tables of benefits, within the limit of the expenses that are actually incurred and per calendar year.
Actual expenses designates medically justified, customary and reasonable expenses that are determined on the basis of the prices that are generally charged by the establishments and practitioners in the country or state involved.
Reimbursements are paid after deduction of the *Deductible* or of the *Co-Insurance* (Silver and Gold only), if chosen by the Insured.

To be refunded under this insurance, a medical act or care has to be recognized by the **World Health Organization**.

If the *Spouse* is a salaried employee, the benefits paid by the Insurer are the difference between the covered actual medical expenses and insurance benefits of similar insurance Plans of which the said *Spouse* may personally be entitled to.
Covered benefits depending on the selected formula are set out in the tables of benefits in Article 12 below.

Details of inpatient benefits

For *Hospitalization* of at least 24 hours, or less than 24 hours only for surgery, medical expenses covered by the selected table of benefits are as follows:

1. accommodation expenses
2. intensive and coronary care
3. procedures of surgery, anaesthesia and resuscitation
4. costs of post-surgery recovery room
5. blood transfusions, plasma, and delivery of oxygen
6. *Organ Transplants*
7. medical fees: consultations, visits (including mandatory pre-surgery consultations and prescribed post-surgery *Treatments* due to *Hospitalization*)

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8. acts of *Medical Auxiliaries*
9. acts of medical biology
10. X-ray, scanners, ionizing radiations
11. *Prescribed medication*
12. physical rehabilitation care, re-education centres immediately following a *Hospitalization*
13. psychiatric *Treatments*, and *Treatments* of the nervous system
14. Cancer *Treatment* including chemotherapy performed in a *Hospital* during a stay of less than 24 hours
15. Outpatient care before and following *Hospitalization* (up to 30 days before and 90 days following *Hospitalization*)
16. Home nursing
17. daily all-inclusive fee (France only)
18. private standard room
19. extra bed

Personal expenditures such as telephone and television costs are not reimbursed.

Transportation by Ambulance
Costs of *Transportation by Ambulance* within a single country, related to *Hospitalization*, are covered.

Details of outpatient benefits (if covered by chosen formula)

For outpatient *Treatment*, medical expenses covered by the selected table of benefits are as follows:

1. *Prescribed Medication*
2. consultations, visits
3. surgery, apart from Hospitalization for more than 24 hours
4. treatments by prescribed Medical Auxiliaries (to the exclusion of Medical Auxiliaries who are members of the Insured's family and who live at his home)
5. home medical Care limited to 120 visits per insurance year
6. prescribed procedures of Physical Therapy, osteopathy, chiropractic, (prior consent)
7. prescribed procedures of homeopathy, acupuncture (prior consent)
8. procedures of medical biology, x-ray
9. MRI, PET (prior consent)
10. treatments using ionizing radiations
11. blood transfusions, plasma, and delivery of oxygen
12. physical rehabilitation care
13. medical prostheses of body members and eyes
14. *Mandatory Vaccinations*
15. orthopaedic devices, crutches
16. rental of medical equipment
17. hearing prostheses (prior consent)
18. check-up (1every 3 years)

Psychiatric treatments and treatments of the nervous system are not reimbursed in outpatient care.

Network of Bronze Basic formula

The Bronze Basic Formula offers access to a preferred provider network (List below). By choosing the Bronze Basic formula, the Member agrees to be covered only in an exclusive network of hospitals: 22 hospitals in Thailand, including 12 in Bangkok (see list below).
The benefits are for inpatient treatment only. If, as a result of an emergency, the Member is hospitalized in a non-network hospital in Thailand, he/she will be transferred to a network hospital as soon as his/her condition will allow it.
In case the Member chooses to be hospitalized in a non-network hospital in Thailand, the insurer will reimburse 50% of the amount specified for the benefits mentioned in the Table of Benefits of the Bronze Basic Formula, as long as the insurer considers that the amount of the claim is aligned with the usual level of prices observed within the medical network in the area of cover and is deemed as customary and reasonable by the insurer.

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The formula is only available if the country of expatriation of the Member is Thailand.

Country	City	Provider Name	Address
THAILAND	**Phuket**	Phuket City Care	18, 20 Anupatphuketkan Rd, Taladyai
	Phuket	Dibuk Hospital	89/8-9, Jaofatawantok Road 83000
	Phuket	Phuket International Hospital	44 Chalermprakiat Ror 9 Road, Phuket Town, Moo 5, 83000
	Koh Samui	Samui International Hospital	90/2 Moo 2, Bophut 84320
	Koh Samui	Bangkok Hospital Samui	57 Moo 3 Thaweerat Road, Bophut, 84320
	Pattaya	Pattaya Memorial Hospital	328/1 Moo 9, Central Pattaya Road 20150
	Udon Thani	Aek Udon International Hospital	555/5 Posri Road 41000
	Hua Hin	San Paulo Hua Hin Hospital	222 Petchakasem Road 77110
	Petchabun	Mahachaipetcharat Hospital	99/9 Moo 6, Baan Mor 76000
	Chiang Mai	Sriphat Medical Center	110/392 Sriphat Bld. Inthawarorot Rd., Sriphum 50200
	Bangkok	Saint Louis Hospital	27 Sathorn Road, 10120
	Bangkok	Bangkok Adventist Hospital	430 Pitsanulok Road, Dusit 10300
	Bangkok	Sukumvit Hospital	Sukumvit Hospital 1411 Sukhumvit Rd, (Near BTS Ekkamai station), Prakhanon Nue, Wattana 10110
	Bangkok	Paolo Memorial Phaholyothin Hospital	670/1 Phaholyothin Road, Samsennai, Phayathai 10400
	Bangkok	Phyathai Nawamin Hospital	44/505 Nawamin Road Bungkhum, 10230
	Bangkok	Praram 9 Hospital	99 Soi Sang-jam, Rama 9 Rd, Huai Khwang 10310
	Bangkok	Ramkhamhaeng Hospital	436 Ramkhamhaeng Rd, Huamak Bangkapi, 10240
	Bangkok	Sikarin Hospital	976 La Salle Road, Bangna 10260
	Bangkok	Bangpakok 9 International Hospital	Bangpakok 9 International Hospital 8/245 Moo. 4, Rama 2 Road, Bang-Mod, Jomthong 10150
	Bangkok	Thonburi 1 Hospital	34/1 Soi Saengsuksa (Soi 44), Issaraphap Road, Bangkok Noi 10700
	Bangkok	Thonburi 2 Hospital	43/4 Moo 18 Baroomarajchachonanee Road, Tawiwattan 10170
	Bangkok	Theptarin Hospital	3850 Rama IV Rd, Prakanong, Klongtoey 10110

This list is indicative and may be updated from time to time by Euro-Center (Thailand)

Details of Maternity Cover (if covered by chosen formula)

Medical expenses covered by this insurance are those incurred within a period of eight days commencing on the date of birth:

- accommodation expenses,
- medical fees.

A newborn infant is automatically covered from the date of birth subject to a notification made within 3 months following the birth and to the payment of the premium.

With respect to natural childbirth, only expenses specified in the foregoing paragraph are covered.

Details of routine dental care (if covered by chosen formula)

For dental care, medical expenses covered by the selected table of benefits are as follows

- dental care (surgery, consultation and x-rays)
- adhering *Dental Prostheses*: crowns, Richmond crowns, inlays, onlays
- adjacent *Dental Prostheses*: removable appliances
- dental implants

Details of optical care (if covered by chosen formula)

- Prescribed spectacles lenses, frames and contact lenses

Limitation to actual cost

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In accordance with Article 9 of Act n° 89-1009 of December 31 1989 and Decree n° 90-769 of August 30 1990, reimbursements or payments covering expenses caused by an *Illness*, maternity or an *Accident* shall not exceed the amount of the expenses for which the Insured remains liable after the reimbursements of all kinds to which the Insured is entitled.

Similar cover taken out with several insurance organizations shall have an effect on the limit of each item of cover irrespective of when the cover was taken out.
In this limit, the beneficiary of the Agreement may obtain additional payment by sending details of the reimbursements made by the other organization(s).
For application of the aforementioned arrangements, the limitation of expenses for which the Insured is still liable is determined by the Insurer for each of the treatments or expense items.

Exclusions

Forfeiture of the right to a benefit
The Covered Person is deprived of all rights to the benefits of a claim in the event the Covered Person voluntarily makes a false declaration about that claim including the date, nature, causes, circumstances and/or consequences and/or amount of the loss.
The forfeiture of this right also applies in the event the Covered Person knowingly uses inaccurate documents as supporting documents for that claim.

Excluded risks
The Insurer does not cover Medical expenses incurred as a result of the following events:

- **Consequence of a voluntary or intentional sickness or *Accident* committed by the Insured, voluntary mutilations or suicide attempt.**
- **Consequences of war, civil or not, insurrection, riot, bombing or popular movement, unless the Insured has not taken active part in it.**
- **Direct or indirect consequences of any action relating to what is commonly designated as Nuclear risk.**

The Insurer reserves the right to modify the cover in specific countries, subject to a fifteen day prior notice.

Excluded benefits
It is understood and agreed that medical expenses not recognized by the World Health Organization are not covered in this agreement, except for prescribed contact lenses.
Furthermore, the following expenses are not covered, unless otherwise specified in the Certificate of insurance and if they would have otherwise been recognized as medical care by the World Health Organization.

It should be noted that this agreement does not cover:

1. **treatments outside the geographic zone of expatriation as indicated in the application form, except for cases specified in the section on the zone of coverage,**
2. **any form of experimental or unsupervised treatment that does not follow commonly accepted, customary or conventional medical practice, unless specific consent has been given by the Insurer,**
3. **incidental expenses or comfort expenses in the case of *Hospitalization* (telephone, television, etc.),**
4. **consequences of, or treatments for, drug addiction or alcoholism,**
5. **expenditure incurred on the acquisition of an organ (but not the organ itself),**
6. **any operation or *Treatment* relating to a sex change,**
7. **aesthetic treatments, age-reducing treatments, slimming treatments,**
8. **checks, examinations, treatments and complications associated with sterility, sterilization, sexual dysfunction, contraception including the insertion or removal of contraceptive devices,**

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the voluntary termination of pregnancy except in the case of a pregnancy termination that is medically necessary and complies with local legislation,

9. **any elective/voluntary surgery and/or plastic/cosmetic surgery,**
10. **spa treatments,**
11. **transport and accommodation costs associated with spa treatments,**
12. **orthodontics,**
13. **medical expenses associated with a stay at a thalassotherapy center or fitness centre, rest home or recovery home even if this stay is medically prescribed, (except for re-education centers immediately following a *Hospitalization*),**
14. **outpatient consultations with regards to psychotherapy, psychoanalysis and psychiatry, as well as related medication,**
15. **consultations, treatments and complications associated with the loss of or implantation of hair unless the treatment is related to a hair loss caused by a serious *Illness*,**
16. **treatments to modify the refraction of an eye or the eyes (laser eye correction), including refractive keratotomy (KR) and photorefractive keratotomy (KPR),**
17. **unprescribed medication, and commonly used non-medical products such as medical alcohol, absorbent cotton, sun creams, dental hygiene products, dressings, shampoos etc.**

4/ Premiums

Determination of premiums

The premium to be paid for this medical insurance is calculated for each Member according to his age and the category of cover selected. Its amount is specified on the Member's certificate of insurance.
The age that is taken into account is the one that is reached on December 31 of the year that membership of the Plan commences. Upon renewal of the membership, it will be revised according to the changes made in age brackets as defined in the premium scale.

Revision:
Premiums are automatically indexed on January 1 of each year, according to the annual consumption of medical care and medical inflation. Premiums are also revisable by the Insurer each January 1, depending on the Plan's technical results.

Payment of premiums

Premiums are payable yearly, half-yearly, quarterly or monthly in advance only in USD.
As a function of the payment by installment he has selected, the Member commits himself to pay what he owes within 30 days following due date. If he fails to do so, the Member will no longer be covered 30 days following the sending of a notice to pay sent by registered letter which has gone unheeded, and the insurance will be terminated upon expiration of another period of 10 days without any other notice being given by the Insurer.
Any request for benefits that is made during the period that payment is delinquent shall be refused.

5/ Formalities necessary when claiming medical expenses

Declaration

The declaration form is provided by the Insurer, and must be returned thereto with the documents requested by the Insurer.

Within the context of reviewing the claim, that the Insurer's advising medical expert may request any other supporting documentation necessary to process the claim. Insofar as the documentation listed herein to be submitted is incomplete, gives rise to doubt, or the Insurer is unable to investigate thoroughly its obligation to pay the claim, the Insurer's advising medical expert is entitled to request data from the following organisations and persons subject to the Article on date protection:

ACS – INSURANCE BROKERAGE COMPANY
153 RUE DE L'UNIVERSITÉ 75007 PARIS - FRANCE
TEL. +33 (0)1 40 47 91 00
contact@acs-ami.com www.acs-ami.com

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 92459, 75436 Paris Cedex 09 France

- Doctors,
- Hospitals,
- Other medical institutions,
- Care homes,
- Caregivers,
- Other personal insurance providers,
- Statutory health insurance bodies,
- Occupational insurance organisations and
- Official bodies

In the event the members of the category of covered persons, including dependents, where applicable, as defined herein, explicitly reject concrete data collection in the context of claims processing or revoke consent the benefit may not become due if the Insurer is unable to determine whether and to what extent the Insurer is liable for payment of the claim.
The Insurer shall not otherwise be held liable by the Policyholder for the impossibility of performing the services under the present contract.

Any information provided by the Insured, or one of the persons under his care, that turns out to be erroneous, falsified or overstated, or any fraudulent or intentional misconduct on their part will result in the Insured's direct liability and reimbursement of sums that were unduly paid by the Insurer on the basis of such incorrect data.

Documentation to be provided

In case of *Hospitalization*, documentation of *Hospitalization* costs (invoices, fees).
In case of *Illness*, detailed bills.
In case of childbirth at home, extract of the child's birth certificate.

The Insurer may request any other documentation that it deems necessary.
Copies, photocopies or duplicates of invoices are not accepted.

E-claiming:

However, for claims not exceeding USD 500, scanned supporting documents are accepted.
They may be sent to: **acs@euro-center.com**
Please note that the Insurer may request the corresponding original documents during 18 months following reimbursement for reasons of control and prevention of fraud.
In case of impossibility for the Insured to provide original documents, at the request of the Insurer the Insured takes the commitment to repay, as soon as possible, the amounts received on the basis of the scanned documents. Therefore, the Insurer is entitled to compensate any amount due in this respect with other reimbursements of claims due by the Insurer to the Insured.

Prior consent

Reimbursements of:
1. hospitalization expenses (in Hospital or at home)
2. physical rehabilitation that immediately follows a Hospitalization
3. MRI, PET
4. physiotherapy (if over 10 sessions)
5. physical Therapy
6. chiropractic
7. osteopathy
8. homeopathy
9. acupuncture
10. prescribed speech therapy and orthoptics
11. prescribed medical prostheses

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12. maternity cover

is subject to the Insurer's prior approval, except in the event of *Emergency* (as defined in this Plan). Each admission to a *Hospital* must be notified to the Insurer at least 7 days prior to the effective admission, and within 48 hours for *Hospitalizations* following an *Emergency* (as defined in this Plan).

The Insurer reserves the right not to reimburse expenses that have not been notified beforehand, as required by the Plan. If, thereafter, *Treatment* becomes medically necessary, the Insurer will reimburse only 80% of the amount specified for the benefits in case of *Hospitalization* and 50% for other benefits.

In the event of *Hospitalization*, the Insured may obtain a guarantee of payment, in order to prevent making advance payments, by calling Euro-Center at + 66 (0) 2569 0225 (24/7), or e-mailing us at: acs@euro-center.com (24/7)

For other expenses, the documents must be sent to:

Euro-Center (Thailand) Co., Ltd
188 Spring Tower Building, Unit 6-10, Floor 22,
Phayathai Road, Thung Phayathai, Ratchathewi
10400 Bangkok
THAILAND

Telephone: + 66 (0) 2569 0225 (24/7)
Fax: + 66 (0) 2696 3628
e-mail: acs@euro-center.com

Cashless coverage for outpatient claims:
For your outpatient treatment, please contact us in advance so that we can arrange this service in the smoothest way, subject to your policy conditions and benefits coverage.

Additionally, we will also be able to give you information on a preferred hospital or clinic where we have a direct billing setup. Direct billing can typically be provided for minor acute outpatient treatments which would normally have been paid by the policy holder themselves.

Please bring your passport and insurance card with you when visiting the hospital or clinic.

Please note that prior consent is required for certain treatments as specified in the table of benefits.

6/ Limitation

TIME LIMIT OF ACTIONS STEMMING FROM THE INSURANCE CONTRACT

The provisions relating to the time limit within which action stemming from the insurance contract may be taken are set out by Articles L 114-1 to L 114-3 of the French Insurance Code (Code des assurances), as reproduced below:

Article L 114-1 of the French Insurance Code:
Any actions stemming from an insurance contract are time barred two years after the event from which the actions stem.
However, this time limit only starts running:
1 In the event of reticence/concealment, omission, misrepresentation or inaccurate declaration of the risk incurred, from the date when the Insurer learned of the said risk;
2 In the event of an insurance loss, from the date when the interested parties learned of it, if they prove they were unaware of it prior to that date.

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When the action by the Insured Person against the Insurer is caused by recourse by a third party, the time limit for action only starts running from the date when the third party takes legal action against the Insured Person or has received compensation from the Insured Person.

Article L 114-2 of the French Insurance Code:
The time limit for action may be interrupted by any of the ordinary causes for interruption thereof, and by appointment of appraisers after a loss. Interruption in the time limit for action may also result from a registered letter with acknowledgement of receipt being sent by the Insurer to the Insured Person to obtain payment of the premium, and by the Insured Person to the Insurer to obtain payment of compensation.

Article L 114-3 of the French Insurance Code:
Notwithstanding Article 2254 of the Code Civil (French Civil Code), the parties to the insurance contract may not, even by mutual agreement, either change the length of the time limit for action, or add causes for suspension or interruption thereof.

Additional information:
The ordinary causes for interruption of the time limit are set out in articles 2240 and following of the French Civil Code

7/ Administration

Administration of membership, premium collections and any request or inquiry regarding medical insurance are assumed by:

ACS
153, rue de l'Université
75007 Paris - FRANCE
Tel: +33 (0)1 40 47 91 00
Fax: +33 (0)1 40 47 61 90
e-mail : contact@acs-ami.com

Administration of claims is assumed by:

Euro-Center
Euro-Center (Thailand) Co., Ltd
188 Spring Tower Building, Unit 6-10, Floor 22,
Phayathai Road, Thung Phayathai, Ratchathewi
10400 Bangkok, THAILAND
Tel. + 66 (0) 2569 0225 (24/7)
Fax. + 66 (0) 2696 3628
e-mail: acs@euro-center.com (24/7)

8/ Legal action

SUBROGATION
In accordance with the French Insurance Code, the Insurer is subrogated to the rights and actions that the Insured may have against the *Third Party* responsible.

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9/ Option of cancellation in case of remote sales

The insured has an option of cancellation in case of remote sales (by phone, mail, or over the Internet), according to Articles L. 112-2-1 and R. 112-4 of the French Insurance Code (*Code des Assurances*).

The following constitute remote insurance operations as defined by Article L.112-2-1 of the French Insurance Code: providing insurance operations to a subscriber who is a natural person, and who is acting outside any commercial or business activity, in the context of a remote system of sale or of provision of services that is organised by the insurer or the insurance intermediary who, for the contract in question, exclusively uses remote communications techniques up to and including the signing of the contract.

Thus, the Insured has a right to cancel throughout a cooling-off period of 14 full calendar days starting as from the date s/he is informed that the contract is signed, by sending a registered letter with return-receipt (lettre recommandée avec avis de réception) to ACS, 153, rue de l'Université, 75007, Paris, FRANCE. The sum paid by the Insured will hen be reimbursed within 30 days following the receipt of the registered letter. If the Insured has asked for the contract to be performed before the expiry of the cooling-off period, the right of cancellation will not be applicable anymore.

The Insured who wishes to use this right according to the above conditions, may use and complete the following letter template.

Letter of Cancellation Template:

"I the undersigned, M……residing at ……hereby cancel my Contract No. ……. taken out with ……., pursuant to Article L 112-2-1 of the French Insurance Code (*Code des Assurances*). I hereby certify that, at the date of sending of this letter, I have no knowledge of any loss that might involve the cover of the contract being applied."

10/ Governing law and competent jurisdiction

This contract governed by French law and primarily by the French Insurance Code.
Le présent contrat est régi par la loi française et le Code des assurances.
Any legal action relating to this contract shall be brought before French courts which have exclusive jurisdiction.
The definition of cover, premiums, and their rules of application take into account the regulations of the World health organization that are applicable on the effective date of the insurance Plan.

11/ Data Protection

Personal data concerning the Parties to the present contract, the Members, the Insured, their Dependents and/or beneficiaries as applicable, and/or any identified or identifiable natural living person to whom personal data relates hereto, including the signatories to this contract or any other relating contractual documents, are used for the sole purpose of the implementation and management of the present contract. These persons are referred to as "Data Subjects".

Processing measures, whether or not by automated means, such as collection, processing, recording, organization, purpose limitation and data minimization, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transfer, dissemination or otherwise making available, alignment or combination, security, of personal data, are carried out in accordance with:

- the Amended French Data Protection Act no. 78-17 of 06.01.1978 on Information Technology, Data Files and Civil Liberties and all applicable laws and regulations relating to the protection and processing of Personal Data,

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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)
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- the General Data Protection Regulation (Regulation (EU) 2016/679) of the European Parliament and of the Council of 27 April 2016, hereinafter referred to as the "Regulation",
- to sector-specific laws and applicable guidance and codes of practice issued by supervisory authorities,
- the AERAS agreement, effective since 2006, amended on 1st February 2011 and 2nd February 2015 and the conduct code annexed thereto as well as the medical ethical code.

The Data Subjects have the rights to request access to, rectification, deletion of their personal data, restriction of processing concerning their data, objection to processing, and data portability as defined in Annex Data Privacy Notice hereto.

In addition, in accordance with the performance of the contract, personal data may be subject to an extra-European transfer. This transfer occurs in full compliance with the different aspects of protection of personal data and the security of information provided for by the Regulation.

The terms used herein shall have the meaning given in the Regulation.

In the event the Data Subject wishes to exercise his/her rights in relation to the present contract, a request may be sent to:

AWP Health & Life S.A.
Information Technology and Civil Liberties
Eurosquare 2
7 rue Dora Maar
93400 Saint Ouen
France
Email: informatique.libertes@allianzworldwidecare.com

The Insurer will assess the corresponding requests under the scope of the Regulation, and will respond by justifying meeting the request or denial thereof.

The Data Subjects have as well the right to lodge a complaint with the Data Protection Supervisory Authority as provided hereunder if they consider the processing of their data is not lawful or do not agree with the conclusions resulting from their requests for exercising their rights.

In the event the Data Subject has any queries about how the personal and/or sensitive data is used in relation to the present contract, the Data Subject may contact the Insurer as follows:
AWP Health & Life S.A.
Data Protection Officer
Eurosquare 2
7 rue Dora Maar
93400 Saint Ouen
France
Email: AWC.DataPrivacyOfficer@allianz.com

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12/ 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
Email : 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 Insurance Mediator, whose contact details are as follows:

LMA – TSA 50110 –
75441 PARIS CEDEX 09 France,
E-mail : www.mediation-assurance.org ; or

- contact the insurer directly at the following address:

AWP Health & Life S.A. - Relations Clients(Customer Relations)
Eurosquare 2, 7 rue Dora Maar,
93400 Saint Ouen, France
Email : client.care@allianzworldwidecare.com

This is without prejudice to other legal remedies.

AUTHORITY IN CHARGE OF OVERSEEING INSURANCE COMPANIES

L'Autorité de Contrôle Prudentiel et de Résolution (ACPR) ***(the Prudential Oversight and Resolution Authority)*** 4 place de Budapest CS 92459 75436 Paris Cedex 09, France.

CONSUMERS' RIGHT TO OBJECT TO TELEPHONE MARKETING

If you do not wish to be contacted for the purposes of telephone marketing, you can have yourself added to a telephone marketing opt-out list, free of charge.
These provisions apply to any consumer, i.e. any natural person acting for purposes unrelated to their commercial, industrial, craft or self-employed activities.

In case of difference between the French and English versions of this summary of benefits, the French version shall prevail.

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13/ Tables of benefits

	BRONZE BASIC* / BRONZE	SILVER	GOLD
ANNUAL LIMIT	**US $ 500 000 or US $ 1 000 000****	**US $ 500 000 or US $ 1 000 000**	**US $ 500 000 or US $ 1 000 000**
HOSPITALIZATION (with prior consent)	**Full refund**	**Full refund**	**Full refund**
Medical *Hospitalization*			
Surgical *Hospitalization*			
Hospitalization ancillary expenses			
Mandatory preoperative consultations (surgeon and anesthetist)			
Day surgery			
Cancer treatment including chemotherapy			
Intensive care			
Organ transplant			
Emergency dental plastic surgery following an accident			
Local *Emergency* transport by ambulance			
Nursing care			
Physician's fees			
Pathology, X-rays and diagnostics			
Medical prostheses			
Private standard room			
Accompanying bed for *Hospitalization* of a child under 16 years	100% of actual expenses limited to $ 25 per day	100% of actual expenses limited to $ 50 per day	100% of actual expenses limited to $ 50 per day
Outpatient care before and following *Hospitalization* (up to 30 days before and 90 days following hospitalization)	100% of actual expenses limited to $ 1 500 per year	100% of actual expenses within the limits of routine medical expenses	100% of actual expenses within the limits of routine medical expenses
Physical therapy immediately following *Hospitalization*	100% of actual expenses limited to $ 1 000 per year	100% of actual expenses limited to $ 2 000 per year	100% of actual expenses limited to $ 2 000 per year
Psychiatry treatment	100% of actual expenses limited to $ 1 500 per year	100% of actual expenses limited to $ 3 000 per year	100% of actual expenses limited to $ 3 000 per year
Home nursing	100% of actual expenses limited to $ 1 000 per year	100% of actual expenses limited to $ 2 000 per year	100% of actual expenses limited to $ 2 000 per year
Out of zone of coverage (trip of up to 7 weeks): hospitalization resulting from an *Emergency*	Full refund	Full refund	Full refund
ROUTINE MEDICAL TREATMENT	**Not Covered**	**$ 6 000**	**$ 6 000**
Maximum limit per beneficiary for 12 months of membership			
Generalist and specialist fees		**Full refund**	**Full refund**
Analyses, radiology, scans			
MRI, PET (with prior consent)			
Prescribed Medication and Mandatory Vaccines			
Prescribed *Medical auxiliaries*			
Physiotherapy, chiropractor, osteopath, homeopath and acupuncturist (with prior consent)		100% of actual expenses limited to $ 50 per session and $ 1 000 per year	100% of actual expenses limited to $ 50 per session and $ 1 000 per year
Prescribed speech therapy and orthoptics (with prior consent)		100% of actual expenses limited to $ 50 per session and $ 1 000 per year	100% of actual expenses limited to $ 50 per session and $ 1 000 per year
Prescribed Medical Prostheses (with prior consent)		100% of actual expenses limited to $ 2 000 per year	100% of actual expenses limited to $ 2 000 per year
Check-up (1 every 3 years)		100% of actual expenses limited to $ 300 per visit	100% of actual expenses limited to $ 300 per visit
MATERNITY COVER (with prior consent)	**Not Covered**	**Not Covered**	100% of actual expenses limited to $ 4 000 per year
Childbirth expenses			
ROUTINE DENTAL COVER	**Not Covered**	**Not Covered**	**$ 1 000**
Maximum limit per beneficiary for 12 months of membership			
Dental care			90% of actual expenses
Dental prostheses, including inlays, onlays, implants (with prior consent)			90% of actual expenses limited to $ 150 per tooth (maximum 4 teeth)
OPTICAL COVER	**Not Covered**	**Not Covered**	90% up to $150 per year
Prescribed spectacle lenses, frames and contact lenses			

** Bronze Basic plan offers a preferential rate with the same level of coverage as Bronze plan. By choosing Bronze Basic plan, the insured accepts to be covered at 100% only in a dedicated hospital network. Bronze Basic plan is exclusively available for expatriates in Thailand.*
*** 1 000 000 USD annual limit is not available for Bronze Basic plan.*

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Annex : Privacy notice ACS

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 authorized 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 authorized 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 Enrollment 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

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