AMI ASSOCIATION

ACS HEALTH IN ASIA
1st USD Health Scheme
Summary of benefits

As a member of the AMI Association (hereinafter referred to as AMI), you have selected the "Health" cover (namely ACS Health in Asia Plan) that the Association has taken out with Hauteville Insurance Company Limited (hereinafter referred to as HIC), a member of Allianz Group, 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.
This Summary is for information only. In case of conflict between the contract no.011767/006 and this Summary, the contract's terms shall prevail.
The currency of ACS Health in Asia Plan is US Dollar (USD or $).

Contents

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1/ General

Qualification – affiliation

Those who qualify are *Expatriates* who are members of the AMI Association, regardless their nationality, who are between 18 and 59 years of age. 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 three formulas namely: 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, 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 (the deductible of $1,000 option is only available for the Silver & Gold plans), or to a *Co-Insurance* of 10 or 20% (Co-Insurance option is only available for the Silver & Gold plans). It is agreed that 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.

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

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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.

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.
Upon his acceptance for this insurance, subject to the sanctions specified by English law 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 AMI and HIC.

For all Members, in the following event:

- on the termination date of contract no.011767/006 concluded between AMI and HIC.

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 by 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.

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.

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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, United Kingdom.

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

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.

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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.

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.

Prescribed 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.

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.

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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.

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)* **except the United Kingdom**.

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 11 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:

- accommodation expenses
- intensive and coronary care
- procedures of surgery, anesthesia and resuscitation
- costs of post-surgery recovery room

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- blood transfusions, plasma, and delivery of oxygen
- *Organ Transplants*
- medical fees: consultations, visits (including mandatory pre-surgery consultations and prescribed post-surgery *Treatments* due to *Hospitalization*)
- acts of *Medical Auxiliaries*
- acts of medical biology
- X-ray, scanners, ionizing radiations
- *Prescribed medication*
- physical rehabilitation care, re-education centres immediately following a *Hospitalization*
- psychiatric *Treatments*, and *Treatments* of the nervous system
- Cancer *Treatment* including chemotherapy performed in a *Hospital* during a stay of less than 24 hours
- Outpatient care before and following *Hospitalization* (up to 30 days before and 90 days following *Hospitalization*)
- Home nursing
- daily all-inclusive fee (France only)
- private standard room
- 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:
- *Prescribed Medication*
- consultations, visits
- surgery, apart from Hospitalization for more than 24 hours
- 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)
- home medical Care limited to 120 visits per insurance year
- prescribed procedures of Physical Therapy, osteopathy, chiropractic, (prior consent)
- prescribed procedures of homeopathy, acupuncture (prior consent)
- procedures of medical biology, x-ray
- MRI, PET (prior consent)
- treatments using ionizing radiations
- blood transfusions, plasma, and delivery of oxygen
- physical rehabilitation care
- medical prostheses of body members and eyes
- prescribed vaccinations
- orthopedic devices, crutches
- rental of medical equipment
- hearing prostheses (prior consent)
- check-up (1every 3 years)

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

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.

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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

Reimbursements or indemnifications for expenses incurred due to an *Illness*, pregnancy or *Accident* shall not exceed the threshold of the amount of expenses that remain to be payable by the Insured after all reimbursements to which s/he is entitled are made.
Benefits of the same type contracted with other insurance companies are effective within the limit of each benefits whatever its date of affiliation. Within this limit, the beneficiary of the Plan may obtain supplementary indemnification by sending the details of the reimbursement(s) made by the other companies.
For application of the foregoing provisions, the limitation to the amount of expenses that remains to be payable by the Member is determined by the Insurer for each *Treatment* or item of expenditures.

Exclusions

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:

- **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,**
- **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,**
- **incidental expenses or comfort expenses in the case of *Hospitalization* (telephone, television, etc.),**
- **consequences of, or treatments for, drug addiction or alcoholism,**
- **expenditure incurred on the acquisition of an organ (but not the organ itself),**
- **any operation or *Treatment* relating to a sex change,**
- **aesthetic treatments, age-reducing treatments, slimming treatments,**
- **checks, examinations, treatments and complications associated with sterility, sterilization, sexual dysfunction, contraception including the insertion or removal of contraceptive devices, the**

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

- **any elective/voluntary surgery and/or plastic/cosmetic surgery,**
- **spa treatments,**
- **transport and accommodation costs associated with spa treatments,**
- **orthodontics,**
- **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*),**
- **outpatient consultations with regards to psychotherapy, psychoanalysis and psychiatry, as well as related medication,**
- **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*,**
- **treatments to modify the refraction of an eye or the eyes (laser eye correction), including refractive keratotomy (KR) and photorefractive keratotomy (KPR),**
- **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.
The Insurer reserves the right to require the Insured to provide all of the information that is necessary for processing his personal data and is related to applications for reimbursement. To that end, the Insurer may have access to the Insured's medical files with all of the legal obligations of confidentiality with respect thereto.
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.

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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.

Prior consent

Reimbursements of:

- hospitalization expenses (in Hospital or at home)
- physical rehabilitation that immediately follows a Hospitalization
- MRI, PET
- physiotherapy (if over 10 sessions)
- physical Therapy
- chiropractic
- osteopathy
- homeopathy
- acupuncture
- prescribed speech therapy and orthoptics
- prescribed medical prostheses
- 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 10 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 2 696 3675 or +66 2 696 3626 (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
Evergreen Place, 10th Floor
318 Phayathai Road, Ratchathevi
10400 Bangkok
THAILAND

Telephone: +66 2 696 3675 or +66 2 696 3626 (24/7)
Fax. +66 2 696 3628
e-mail: acs@euro-center.com

Cashless coverage for outpatient claims:
Should you need cashless service 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.

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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, section 11.

6/ Prescription

Any action or any claim for insurance benefit settlement deriving from this Plan is prescribed one calendar year calculated from the date on which the event has occurred.

7/ Administration

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

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Administration of claims is assumed by:

Euro-Center
Euro-Center (Thailand) Co., Ltd
Evergreen Place, 10th Floor
318 Phayathai Road, Ratchathevi
10400 Bangkok, THAILAND
Tel. +66 2 696 3675 or +66 2 696 3626 (24/7)
Fax. +66 2 696 3628
e-mail : acs@euro-center.com (24/7)

8/ Legal action

The Insurer may be subrogated to the right of the person entitled to benefits in order to exercise any recourse proceedings against any liable third party. The Insurer waives its right of recourse proceedings against the Member and his beneficiaries.

ACS : 153, rue de l'Université 75007 Paris, France - E-mail : contact@acs-ami.com - Tél : 00 33 (0)1 40 47 91 00 - Fax : 00 33 (0)1 40 47 61 90
S.A.S. A.C.S. au capital de 150 000 € - Société de courtage d'assurances - 317 218 188 RCS Paris - N° ORIAS 07 000 350 – Site web ORIAS : www.orias.fr

9/ Applicable law

This agreement is governed by, construed and interpreted in accordance with the English law.
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.

10/ Mediation

If the Policyholder or the Insured want specific information, their regular contact will thoroughly analyze their requests and complaints.
If, at the end of this analysis, the Insured considers the responses he is given to be insufficient, he may address his complaint to:

ACS, Complaint Department
153, rue de l'Université
75007 Paris
France

Receipt of the complaint will be acknowledged within 10 days of its date of reception, unless the answer itself is given to you within this time-frame. In any case, in accordance with applicable legislation, an answer will be given to you within 2 months following the receipt of the complaint.

Finally, if there is still a disagreement with the Insurer regarding cover, the Insured may call upon the services of a mediator, whose name and address will be provided by the Insurer upon his simple request, without any prejudice to any other legal action.

The parties declare that they are subject to English Law and abandon any legal action in any country other than the United Kingdom.

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

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S.A.S. A.C.S. au capital de 150 000 € - Société de courtage d'assurances - 317 218 188 RCS Paris - N° ORIAS 07 000 350 – Site web ORIAS : www.orias.fr

11/ Tables of benefits

	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 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			

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