Policy Guide

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LMG Insurance
A Liberty Mutual Company

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INSURANCE MADE EASY

In reliance upon the statements made in the proposal for insurance which is considered a part of this insurance policy, and in consideration of the premium paid by the Insured, and subject to the general conditions, insuring agreements, exclusions and attached endorsements of this insurance policy, the Company agrees to the covered persons as follows:

Please Note: This is an English Translation Only. The Original Thai Terms & Conditions are the Only Legally Binding version

I DEFINITIONS

Words or expressions to which specific meanings have been attached in any part of this Policy or of the Schedule shall bear such specific meanings wherever they shall appear.

1. ***ACCIDENT :*** An event which happens suddenly from external means giving rise to a result which is not intended or anticipated by the covered person.
2. ***AIDS :*** Acquired Immune Deficiency Syndrome caused by the Human Immuno-deficiency Virus (HIV) infection including opportunistic pathogenic infection, Malignant Neoplasm or infection or any illness that reveals an HIV (Human Immunodeficiency Virus) positive blood test. Opportunistic pathogenic infection is also including but not limited to Pneumocystis Carinii Pneumonia, Organism or Chronic Enteritis, Disseminated Viral/ Fungi Infection, Malignant Neoplasm including but not limited to Kaposi's Sarcoma, Central Nervous System Lymphoma and/or any severe diseases known that are caused by AIDS or sudden death, illness or disability. AIDS includes HIV, Encephalopathy (Dementia) and viral epidemics.
3. ***ACTIVE CANCER TREATMENT :*** A range of active treatments intended to control or cure the cancer . This also includes the initial consultation with the Oncologist and any associated diagnostic scans and tests.
4. ***ASEAN :*** Brunei; Cambodia; Indonesia; Laos; Malaysia; Myanmar; Philippines; Singapore; Thailand; Vietnam
5. ***ASSISTED CONCEPTION :*** The use of medical technology to increase the number of eggs during ovulation or to bring a human sperm and an egg, or eggs, close together, thereby increasing the chance of conception. This includes but is not limited to Intra-uterine insemination (IUI), In vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI) or the use of any form of treatment to induce or increase ovulation.
6. ***BEHAVIORAL OR DEVELOPMENT DISORDER :*** A disability classified in categories F50 to F98 of the International Classification of Diseases 10th Revision (2010 version).
7. ***CLINIC :*** An establishment or hospital department where outpatients are given medical treatment or advice.
8. ***COMPANY (WE, US, OUR) :*** LMG Insurance Public Company Limited
9. ***COMPLICATIONS OF PREGNANCY :*** Acute nephritis, nephrosis, cardiac decompensation, missed abortion, ectopic pregnancy, puerperal infection, eclampsia, toxemia, or hydatidiform mole. It also includes a condition whose diagnosis is distinct from pregnancy but is adversely affected or caused by pregnancy, and which requires confinement or surgery prior to the full term of pregnancy to avoid the threat of permanent damage to the life or health of the mother.
10. ***CONFINEMENT :*** Admission to a Hospital as an In-patient as a result of Bodily Injury or Illness for a continuous period of 18 hours or more.
11. ***CONGENITAL CONDITION :*** Any condition classified as a congenital anomaly in the International Classification of Diseases 10th Revision (2010 version).
12. ***COVERED PERSON :*** The Insured and/or the Insured's dependant(s) who are named in the policy schedule.
13. ***CUSTODIAL OR MAINTENANCE CARE :***

a. For personal needs, comfort or convenience for which specialized medical training or skills are not necessary; or
b. To maintain, rather than improve, a physical or mental function, or to provide a protected environment, including physician-prescribed bed rest.

14. ***DENTAL TREATMENT :*** Evaluation, diagnosis, prevention, and surgical or non-surgical treatment of diseases, disorders and conditions of the oral cavity, maxillofacial area and the adjacent and associated structures.
15. ***DEDUCTIBLE :*** The deductible is the amount of money the policy holder will pay in an insurance claim before an insurance provider pays any expenses.
16. ***DENTIST :*** A Dentist is a licensed physician whose practice is in the field of dentistry Specializing in the diagnosis, prevention and treatment of diseases and conditions relating to the oral cavity.
17. ***DEPENDANT :*** Dependants of the Insured who are named in the policy could be either of the below

i. Spouse/partner of the Insured
ii. legal unmarried children of the Insured or of the spouse up to the age of 19 for all or part of the period of insurance, or, if a full time student and primarily dependent on you for support and maintenance while a full-time student, under 23 years of age for all or part of the period of insurance.

18. ***DIAGNOSTIC SCANS AND TESTS :*** Medically necessary tests and procedures prescribed by an attending physician to investigate the cause and nature of symptoms of a disability. Limited to the following tests and scans unless otherwise stated on the benefits schedule: laboratory tests and pathology, CT scan, PET Scan, MRI, ultrasound, ECG, endoscopic exams, and x-ray.
19. ***DISABILITY :*** Symptoms, illness or injury, or any of its complications. In the case of injury, it means all injuries arising from the same event or series of contiguous continuous events.
20. ***EFFECTIVE DATE :*** The date on which the period of insurance in respect of any insured person commences under this policy.
21. ***EMERGENCY ASSISTANCE PROVIDER :*** APRIL Assistance
22. ***EXPENSES :*** Costs you incur during the period of insurance for a medically necessary service and for which fall within the categories of benefits shown on the benefits schedule.
23. ***EXTERNAL PROSTHESIS :*** An artificial body part prescribed by an attending physician as part of treatment relating to a disability covered by this policy.
24. ***FULL MEDICAL UNDERWRITING :*** Means that you must provide us with a detailed medical history on the Full Medical Underwriting Application Form to enable us to decide whether to accept/decline your application or whether we need to apply any specific exclusions or loadings to your policy.
25. ***HEREDITARY CONDITIONS :*** Is a genetic condition that occurs or could occur as a result of inheriting a gene from your parents that increases your risk of developing that particular condition. It does not include cancers where the hereditary condition is not causing other symptoms.
26. ***HOSPICE OR PALLIATIVE TREATMENT :*** A program of medical, psychological, social, and spiritual care provided to persons who has been diagnosed with a terminal illness. Treatment must be prescribed by a physician and provided by a hospital or institution licensed by the competent medical authorities of the country in which care is provided and which, in providing care, is practicing within the scope of its license. Hospice or palliative treatment costs may only be claimed under the hospice or palliative treatment section of the benefits schedule if available.
27. ***HOSPITAL :*** An institution providing medical and surgical treatment as well as nursing care for sick or injured patients.

28. ***HOSPITAL ROOM AND BOARD :*** Room type and board level including general nursing care, subject to the following accommodation levels as stated on the benefits schedule.

28.1 ***STANDARD PRIVATE ROOM :*** A class of room type that has one (1) patient bed per room with an en-suite bath or shower room. Standard private room does not include a suite.

28.2 ***SEMI-PRIVATE ROOM :*** A class of room type which has two (2) patient beds per room and a shared bath or shower room, whether both beds are occupied or not.

28.3 ***WARD :*** A class of room type that has three (3) or more patient beds per room, whether all beds are occupied or not.

29. ***INJURY :*** A Bodily injury which is caused directly and solely from an accident and is independent from other causes.

30. ***INSURED :*** The person(s) named on the policy documents.

31. ***INTENSIVE CARE UNIT :*** A unit dedicated to the constant, monitoring or care of critically ill patients. This unit also includes facilities for the resuscitation of patients. This definition also includes a coronary care unit which has facilities not less comprehensive than those described above.

32. ***INTERMEDIARY :*** The authorised agent, broker or financial advisor who arranged the cover and is acting on the behalf of the Client.

33. ***INTERMEDIATE CARE FACILITY OR NURSING HOME :*** A place dedicated to providing support services for individuals requiring medical, nursing, or custodial or maintenance care in a residential setting.

34. ***KIDNEY DIALYSIS :*** Hemodialysis and peritoneal dialysis. Kidney dialysis expenses may only be claimed under the kidney dialysis section of the benefits schedule if available.

35. ***MAJOR DENTAL TREATMENT :*** Surgical removal of impacted, buried, or unerupted teeth/roots or odontoma; treatment of disorders of the temporomandibular joint (TMJ); orthodontics; dental implants; root canal therapy or apicoectomy; dentures (new/repair of old); crowns and bridges; treatment by a dentist of illnesses of the oral mucosa and directly related laboratory tests or pathology services; antibiotics or medicines for pain management for which a prescription is required for purchase and which have been prescribed by a dentist; periodontics, deep oral prophylaxis or root planning.

36. ***MEDICAL APPLIANCES :*** The following items and their accessories only when prescribed by a physician for an eligible disability : cranial helmets, nebulisers, oxygen pumps, masks, hearing aids, corrective splints, insulin pumps, infusion pumps, glucose monitors, lancets, orthotics/orthopedic braces, supports, tracheo-esophageal voice prosthesis, arch supports, diabetes consumables and ostomy supplies.

37. ***MEDICAL CHECK UP :*** Consultations and tests that are undertaken without any clinical signs or symptoms being present.

38. ***MEDICALLY NECESSARY :*** Possessing an identifiable relationship to either a covered disability or symptom(s) of a disability which if existing would be covered under the policy.

a. A therapeutic service required to prevent permanent damage to life or health where you have an illness or injury; or
b. A diagnostic service to determine whether therapeutic services are necessary, where you have active symptoms, the cause of which are unknown, but which are suggestive of an illness or injury.

39. ***MEDICAL NECESSITY :*** Any medical services respecting the following terms :

a. Medical services undertaken to make a medical diagnosis and advise the medical treatment required to treat the patients' medical condition
b. A Medical condition recognized by a medical modern standard practice
c. Not treatment/tests undertaken for the convenience of the patient, his/her family or medical staff only
d. Medical treatment that follows standard medical services required for his/her illness.

40. ***MEDICINES AND DRUGS :*** Medicines and drugs for which a physician's prescription is required for purchase, and which have been dispensed by a physician's office or by a licensed pharmacist

41. ***MENTAL AND NERVOUS CONDITION :*** Any condition classified as a mental and behavioral disorder in the International Classification of Diseases 10th Revision (2010 version).

42. ***MINOR DENTAL TREATMENT :*** Dental checkup; fillings; inlays and onlays; routine tooth cleaning, scaling, and prophylaxis (including when done by an oral hygienist); simple extractions; and application of sealants.

43. ***MOBILITY AIDS :*** Air boots, crutches, canes, walkers, manual wheelchairs and non-motorised knee scooters.

44. ***MORATORIUM :*** Under moratorium policies, any pre-existing or related medical condition which occurred or was treated within a 24 month period prior to your effective date or has one of the following characteristics will be excluded from cover :

- Was foreseeable
- Clearly presented symptoms - and had signs or symptoms and were aware of the condition
- You have received treatment for or sought medical advice for the condition or a related condition (including medical checkups)
- To the best of your knowledge you were aware you had
- Requires monitoring according to generally accepted medical advice or opinion These conditions may be covered after you have had continuous cover with us for 24 months during which you have not had any symptoms, sought advice, needed or received any medication, treatment for the pre-existing condition or any related condition. If the pre-existing condition recurs, then once you have completed a 24 month period where none of these apply, the medical condition may then be considered for coverage.

45. ***NAMELIST :*** A section of the policy identifying the covered persons insured under this policy.

46. ***NEONATAL DISABILITY :*** A disability which existed during the neonatal period, and any disabilities directly or indirectly associated. Includes pre-term birth and any congenital conditions/symptoms which are diagnosed by medical professionals and the parents have been made aware of during the neonatal period.

47. ***NEONATAL PERIOD :*** The period between birth and either the 28th day of life or the 15th day following discharge from hospital (dates inclusive), whichever is later

48. ***NURSE :*** A qualified health-care professional licensed to practice in the medical nursing profession by law.

49. ***NURSING SERVICE FEE :*** Hospital expenses for nursing services providing by a registered nurse whilst the Covered Person(s) is admitted in the hospital.

50. ***ORAL HYGIENIST :*** A licensed dental professional, registered with a dental association or regulatory body within their country of practice, they may be requested to render services such as cleaning and anesthesia, under the direct supervision of a dentist.

51. ***ORGAN TRANSPLANTATION :*** Transplantation of a cornea, kidney, heart, liver, lung or bone marrow from one human to another.

52. ***OUTPATIENT :*** a person who receives medical treatment in a clinic, hospital outpatient department, or emergency room or undergoes a procedure without the need (according to medical necessity) to be accommodated in a hospital bed.

53. ***PANEL NETWORK :*** Medical providers that form part of a network who are listed as panel network providers in the current Outpatient Direct Billing network list.

54. ***PERIOD OF INSURANCE :*** The period starting at 00:00 a.m. Thailand time on the first day shown on the policy cover page and ending at 11:59pm Thailand time on the last day shown on the policy cover page. If an insured person has been added to the policy mid-year, it means the period shown on the namelist in respect of that insured person. If this policy is renewed, the effective date shown on the renewal endorsement will be first day of the new period of insurance.

55. ***PHYSIOTHERAPY :*** Treatment of a disability by physical methods such as manipulation and mobilisation, Transcutaneous Electrical Neural Stimulation, heat treatment, and exercise rather than by drugs or surgery. Treatment must be performed by a qualified physiotherapist, other than someone related to you by blood, marriage or adoption, acting within the scope and training of the physiotherapy discipline and who, if required or permitted to be licensed or registered by the laws of the place where service took place, is licensed or registered in that place.

56. ***POLICY :*** Policy schedule, benefits schedule, insuring agreement, exclusions, conditions, specifications, endorsements, which are all regarded as being part of the contract.

57. ***POLICY YEAR :*** A period of one year from the first inception date and the subsequent annual anniversary thereafter.

58. ***POST HOSPITALISATION BENEFITS :*** Physician consultation fees, diagnostic scans and tests, medicines and drugs, physiotherapy, rental of mobility aids ordered/prescribed by a physician following confinement and used as a direct consequence of the disability which led to confinement.

59. ***PRE-AUTHORISATION :*** Means the determination by us that a service is medically necessary and appropriate, including consideration of the need for the proposed level of care and the availability of alternatives.

60. ***PRE EXISTING CONDITION :*** Any disability:

a. Which existed before the period of insurance and which presented signs or symptoms of which you were aware or should reasonably have been aware of; or

b. For which you have sought or received treatment, medication, advice or diagnosis in the two (2) years before the period of insurance; or

c. Which you knew to exist before the period of insurance and whether you sought or received treatment, medication, advice, or diagnosis for it.

61. ***PRE HOSPITALISATION BENEFITS :*** Physician consultation fees, diagnostic scans and tests, medicines and drugs used as a direct consequence of the disability which led to confinement.

62. ***PRE TERM BIRTH :*** Birth of a living child before 37 weeks of pregnancy are completed.

63. ***PROFESSIONAL FEES :*** Surgeon's fees, anaesthetist fees, dietician fees, general nursing fees, physiotherapist fees, speech therapist fees and attending physician fees.

64. ***RECONSTRUCTIVE SURGERY :*** Surgery performed to improve the function or appearance of abnormal structures of the body caused by a disability or injury.

65. ***REFERRAL :*** A dated, written letter or note from an attending physician prior to commencement of treatment identifying the disability to be treated and the reasons for treatment.

66. ***SICKNESS :*** illness or disease being experienced by the covered person(s).

67. ***SPECIALIZED PHYSICIAN / SPECIALIST :*** A doctor who is licensed by diploma from a national medical association or equivalent body who is highly skilled in a specific and restricted field.

68. ***STANDARD OF MEDICAL PRACTICE :*** The international medical criteria and processes used to provide appropriate medical treatment for the patient, consistent with the medical history, findings and investigations regarding any injury or illness, autopsy required

69. ***SUDDEN ILLNESS OR INJURY :*** Either
    - a disability occurring completely and exclusively during the first 30 travel days of any trip outside your area of cover; or
    - a disability existing prior to a trip outside your area of cover which had not required any advice (other than routine follow-up), treatment or any new/ changed medication in the 30 days prior to the time you commenced your journey

    In the case of an injury, the accident must occur during the trip in which treatment is obtained. Sudden illness or injury does not include any disability of which symptoms existed prior to the start of the trip and which would have caused a person to seek medical care, this does not include pregnancy or complications of pregnancy.

70. ***SURGERY :*** Cutting or destruction of tissue performed by a physician involving the use of surgical instruments, ultrasound, heat, cold, or radiation. It also includes reduction of broken bones or manipulation of a joint under anaesthesia, when performed by a physician.

71. ***SURGICAL IMPLANTS :*** A device or devices which are surgically implanted to form a permanent or long-term part of the body but does not include external prosthesis.

72. ***TERMINAL ILLNESS :*** An illness that is approaching its final stages, will lead to death and for which treatment can no longer be expected to cure.

73. ***TERRORISM :*** An act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

74. ***TRAVEL DAYS :*** Successive 24-hour periods between the time you first arrive at an international border of a country outside your country of residence, and the time you next arrive at an international border of a country within your area of cover

75. ***UNITED STATES OF AMERICA (USA) :*** The United States of America (including its territories and possessions).

76. ***YOU, YOUR :*** The policyholder and/or his or her dependents named on the namelist.

II POLICY GUIDE

1 Insurance Agreement

This insurance agreement issued by the Company relies on the declaration of the Covered Person in the insurance application, health certificate or additional declarations (if any) that the Covered Person has signed as a precondition of the insurance agreement. Therefore, the insurance policy was issued by the Company.

In the event that the Insured knowingly makes false statements or fails to disclose true statements without informing the Company in advance; and the Company is aware of such information, the Company has the right to increase the premium or void the policy according to clause 865 of civil and commercial code.

The Company shall not deny acceptance of responsibility except where there has been material misrepresentation in the aforementioned documents submitted by the applicant.

2 Free Look Period

Please examine the policy carefully to ensure you have the cover you want. If you have any questions about the policy, please contact us or the person who arranged this policy for you. Within 30 days after delivery of this policy to you, you may return it to us for a full refund of any premium paid, less benefits paid. The policy will be deemed void from the effective date.

3 Co-Insurance and Deductibles

All eligible expenses will be settled after the deductible and any co-insurance percentage have been applied. If three or more members of your family suffer injury in the same accident while covered under this policy, we will pay expenses after deducting only one deductible, which shall be the largest of the deductibles which would have otherwise applied.

4 Where Are You Covered?

4.1 This plan covers services rendered within the area of cover stated in the benefits schedule.

4.2 Services rendered outside the area of cover will be subject to the limits for Out of Area Cover shown on the benefits schedule, be covered only if they are directly caused by sudden illness or injury occurring during the first 30 travel days of any trip outside the area of cover. This section does not apply to any trip if the below applies:

4.3 commenced or continued against the orders or advice of any physician or other medical practitioner; or undertaken in whole or in part for the purpose of obtaining medical care.

4.4 In the event you are hospitalised outside the area of cover on the 30th travel day for a covered sudden illness or injury, provided notice of such hospitalisation has been given to us prior to that date, and subject otherwise to the terms and conditions of this policy governing termination of benefits, coverage under section 4.2 shall be extended until such time that you no longer require hospitalisation for the disability

5 Who is Covered?

You and your dependants whose names appear on the namelist.

6 Period of Cover

The minimum initial period of insurance is twelve months.

7 Breach of Insurance Contract

In case of the event that the Insured has breached the insurance contract or tried to or made a fraudulent claim. The Company reserves the right to immediately

7.1 Reject claims

7.2 Cancel the policy at renewal

7.3 Agree new terms and conditions

7.4 Cancel the Policy

8 Incontestability Clause

The Company waives the right to dispute the validity of the insurance contract after 2 years from the first inception date, except when the premium is not received. In case the Company knows of any information which may lead the insurance contract to be void but does not exercise the right to void within 1 month after that information is known, the Company can no longer exercise the right to void this insurance agreement.

9 Changes to the Policy

Any changes in the contract must be approved by the Company and noted in the insurance policy or endorsement before such changes shall be valid.

10 Premium Payment and Insurance Commencement

10.1 Insured and Company can agree for premium payment type as follows:

10.1.1 Annual premium

10.1.2 Premium payment every _____ month (Monthly, Quarterly or Semi-Annual premium)

10.2 For the payment of the first installment of premium, the Insured Person is obligated to pay the premium no later than the commencement date of the insurance policy and the policy will incept as of the commencement date as specified in the Schedule.

10.3 Subsequent premium payments due must be paid on the due date for each payment type. Premiums can be paid by direct debit credit card or any other method agreed by Insured and Company.

10.3.1 If the Insured does not pay the premium on the due date then the policy will expire as of this date. Only annual premium type can the Company apply for a grace period extension of 30 days.

10.3.2 If the Insured pays the premium within 30 days from due date, the Insured will be continually covered and there will be no new pre-existing condition or no new waiting period conditions applied to the policy. If there are eligible claims during the grace period, then the Company will consider these claims payable when the insured has paid the premium. If the eligible claim amount is greater than the premium then the Company will first deduct the premium amount before paying the eligible claim amount.

10.3.3 If the Insured does not pay the renewal premium within the 30 days the Company shall terminate the policy.

11 Misrepresentation of Age or Gender

If there is a misrepresentation of age or gender which caused the following:

11.1 the Company received the premium less than what it should have been, the Company shall pay the compensation equal to the coverage amount of which the previously paid premium can buy for the correct age or gender. If the correct age is not within the normal accepted risk for this insurance, the Company will not pay the benefit but will refund the paid premium.

11.2 if the premium received by the Company is more than the premium charged for the correct age and gender, the Company will refund the excess premium. However, this refund will not be calculated back to the expired policies.

12 Renewal of the Policy

12.1 This insurance policy shall be renewed until the policy year when the insured reaches the age of 90 years without having to provide additional evidence. The Company reserves the right

12.2 to adjust the premium in accordance with the age and risk profile of the covered person(s).

12.3 to adjust any terms and conditions or coverage as necessary.

12.4 The Company reserves the right not to renew the policy with reason(s) for doing so given in written notice to the insured at least 30 days prior to the policy expiry date as stated in the policy schedule.

13 Premium adjustment

In case of renewal, the Company reserves the right to adjust the premium in accordance with the age and risk profile of the covered person(s), and the premium adjusted must be within the approved rate by the Insurance Commissioner. The Company must also give prior written notice to the Insured.

14 Changes or Upgrade of Benefits during policy year or after policy expired in each year

Should there be any upgrades of the benefits for any covered person under this policy during the policy year or at the time of the policy renewal, the new higher benefits will be effective on the first day of the following months after the date that the Company has been informed of the change. The following conditions will also apply:

14.1 If the covered person is sick or injured prior to the change, then the old benefit limit still applies

14.2 Any diseases or injuries for which benefits have already been paid prior to the upgrade will continue to be paid under the old benefit entitlement. This also applies to any conditions which have not been excluded from the Policy but existed prior to the upgrade and for which the covered person has not yet received treatment.

The Insured must submit a request to the Company for a change or upgrade of the benefit, and it will be effective once the Company agrees to it.

15 Termination of Contract

15.1 The coverage for the Insured is terminated if any of the following incidents occur or whichever comes first:

15.1.1 With effect from the policy expiry date if the covered person has reached the age of 90 years on the policy renewal date

15.1.2 If the Insured has deceased, the Company will refund the premium to the beneficiary on a pro-rata basis

15.1.3 If the Insured has not paid the premium

15.1.4 When the Company has paid claims up to the maximum payable as stated in the policy schedule.

15.2 The coverage for each dependant will be terminated if any of the following incidents occurred, whichever comes first:

15.2.1 With effect from the policy expiry date if the dependant no longer qualifies as a dependant under the aforementioned definition

15.2.2 If the dependant has deceased, the Company will refund the premium to the beneficiary on a pro-rata basis

15.3 The Company has paid up to the maximum benefit shown in the policy schedule for the insuring agreement and or endorsements.

15.4 At the time of the expiry date ending at 16:30 hours, Thailand time.

16 Re-instatement

If this insurance policy is terminated because the Insured did not pay the renewal premium by the due date, the Insured may request the policy to be re-instated but only with the agreement by the Company within 90 days from the payment due date. In this case -situation there will be no break for "pre-existing conditions" and "Waiting Period"

Cover for injury will be effective from the date the Company agrees to re-instate the policy while the coverage for sickness will be effective after 10 days from the effective date of the policy re-instatement

17 Medical History Examination Rights

The Company has the right to medically examine the covered person who is claiming benefit under this policy and has the right to conduct an autopsy, within the limits of the law, in case of death, expenses incurred shall be covered by the company.

If the covered person does not allow the Company to investigate his claim or give permission to access his medical records or diagnosis, the Company reserves the right to decline such claims.

18 Proof of Claim and Cooperation

18.1 As a condition precedent to liability, all claims for reimbursement must include the following (the "required claim documents"):

18.1.1 Receipts and supporting documents showing the breakdown of expenses and the diagnosis of the condition treated;

18.1.2 Proof of payment showing the costs have been paid by you

18.1.3 A claim form with all relevant sections completed.

18.2 All required claim documents must be received by us within 90 days from the date service was rendered. Where it is not reasonably possible to present the required claim documents to us within this period, they must be received by us within 365 days from the date you incurred the expenses.

18.3 You must be fully cooperative with us and our appointed agents in connection with any claim. Your cooperation may include, but is not limited to, providing original documents upon request, or providing any consent we reasonably need to obtain information relevant to your claim from any source, including a physician or other medical provider, hospital, or an insurance company.

18.4 If we ask for cooperation, documents, information, or consent to obtain documents or information, it shall be a condition precedent to liability that you provide the requested cooperation, document, information, or consent in a timely manner.

19 Process to obtain Pre-authorisation

19.1 The following services on the benefits schedule require pre-authorisation:

- Hospital benefits
- Surgery performed while a day-patient in a clinic or in a physician's office

19.2 Co-payment for pre-authorisation applies when:

- 0% co-payment applies when services have been pre-authorised by us
- 20% co-payment applies for services not pre-authorised by us

The co-payment for services that are not pre-authorised will not apply where you can show the service was medically necessary due to an emergency and you contacted us within 24 hours following the admission.

19.3 To obtain pre-authorisation, you must submit your request at least 5 working days in advance before admission or treatment.

19.4 Upon receiving your request we will review the medical necessity and appropriateness of the requested service and within five working days will notify you of our decision to:

- Grant pre-approval
- Deny pre-approval
- Request further information

19.5 Pre-approval may be partly given and partly denied. If within the five days pre-authorisation is not given or denied, or additional information requested, then such service will not be subject to the co-payment applicable to services for which pre-authorisation was not maintained.

19.6 If we request further information you are required to provide any additional information we may require. Sections 18.3 and 18.4 of this policy apply.

19.7 Pre-authorisation is not a guarantee of benefits or eligibility and all services are subject to benefit limitations and other policy terms. Pre-authorisation may be revised or withdrawn if we determine later that the service is not covered or is not medically necessary. If pre-authorisation is given for a particular service, that pre-authorisation applies only to that service and further pre-authorisation must be obtained for other services even if related to the same disability.

19.8 If an extension of the length of stay is necessary, you must contact us before the pre-approved length of stay finishes. If you fail to do so any services rendered after the end of the planned admission period will be subject to the co-payment for services for which pre-authorisation was not obtained.

19.9 If pre-authorisation is denied you may appeal the decision, and we will make a further determination or request additional information within five days of receiving your appeal. Only one appeal is permitted per service.

20 Claims against third parties or other insurance

20.1 As a condition precedent to liability, if another medical or accident insurance covers you for expenses relating to a disability also covered by this policy, we will only be liable for the excess of the amount recoverable from such other source or insurance.

20.2 As a condition precedent to liability, if another person or entity may have liability for your expenses, including but not limited to a third party who is responsible for an injury, you must take all steps necessary to secure reimbursement from that other person or entity prior to claiming from April

20.3 As a condition precedent to liability you must not negotiate, settle, compromise, release or otherwise discharge any claim you may have against any third party who may have liability relating to your expenses without our prior written agreement. Failure to obtain our prior written agreement will result in us having no liability under this policy for expenses which might have been recoverable from that third party.

20.4 In the event of any payment under this policy, we shall be subrogated to your or any insured person's rights of recovery against any other person or entity. We may take proceedings in your name, but at our expense, to recover any amount we pay under this policy. Neither you nor any insured person shall do anything likely to prejudice such recovery, and instead shall take all reasonable steps to assist us in obtaining such recovery.

21 Right of Recovery

If we settle guarantee, or authorise claim costs, including if you obtain treatment through our direct billing network, and we later determine that you were not entitled to that payment/benefit for any reason, we reserve the right to claim the payment back from you.

22 Payment of Benefits

The Company will pay the eligible benefits to the covered person within 15 days of receipt of the completed documents.

In case of death, the benefit will be paid to the beneficiary. If the claim requires further investigation the Company has the right to extend the reimbursement date but no later than 90 days after the Company received the completed document.

If the Company cannot pay within the agreed dates, the Company will pay 15% annual interest starting from the date when the claims payment is due.

23 Change of Policy owner

If this insurance policy is terminated because the insured becomes deceased or from any other causes, the spouse or dependant may request continuation of cover and change the status to be the Insured within 90 days after the policy is terminated.

24 Cancellation of Insurance Policy

24.1 The Company may cancel this insurance policy by giving notice in writing and sending by registered mail to the Insured at the Insured's last given address no less than 30 days in advance. For any other premium payment mode other than annually the policy will then automatically expire as of the last due date that the premium was paid, and the Company will not refund any premium. For annual premium the Company will refund pro-rata premium to the Insured if there is clear evidence that the covered person is making fraudulent claims to benefit from this insurance. The Company is not responsible for any injury or sickness that occurs after the policy is cancelled.

24.2 The Insured can terminate this policy by giving written notice to the Company. For any other premium payment mode other than annually the policy will automatically expire as of the last due date that premium was paid, and the Company will not refund any premium.

For annual payment the Company will refund the premium as per the Short Rate Premium Table below:

Short Rate Premium Table

Insurance Period (months)	1	2	3	4	5	6	7	8	9	10	11	12
Percentage of full year premium charged	15	25	35	45	55	65	75	80	85	90	95	100

The cancellation of the insurance policy can be made for the whole policy, not only part(s) of coverage during the policy year. In case the claim paid over the premium received, no refund premium is allowed.

25 Arbitration

In case of argument, dispute or appeal under this policy between the person who is entitled for compensation versus the Company, and if so desired by that person to settle the disputed claim by use of arbitration, the Company must conform and allow the case to be judged by arbitration according to the Arbitrating Regulation governed by the Office of Insurance Commission (OIC).

26 Pre-existing Conditions

The Company will not pay any costs for pre-existing conditions i.e. any disease, illness or injury or symptoms (and complications thereof) for which the covered person was treated or knew about which is not completely cured before the commencement date of the first policy, except:

26.1 If the covered person has declared such conditions on the application form and the Company has agreed to cover them without any endorsement to exclude such pre-existing condition, or

26.2 After 3 years from the first policy commencement date, the Company cannot refuse to pay any claims for pre-existing conditions if such disease, illness or injury or symptoms and complications thereof do not manifest itself, treatment, diagnosis, or consultation by a physician during 5 years prior to the policy's first inception date.

27 Waiting Periods

27.1 Cover for the following benefits and disabilities will commence after an insured person has been covered for the following time periods after the first day of the period of insurance in respect of an insured person:

27.1.1 Maternity Benefits: 366 days prior to the date of service

27.1.2 Newborn Additions: 366 days prior to the date of birth

27.1.3 Major dental treatment: 300 days prior to the date of service

27.1.4 HIV/AIDS: Three years prior to your first positive HIV test result, or the date you received any treatment for HIV/AIDS (or following possible exposure to the virus), whichever is later.

27.2 If you have changed the cover for an insured person after the start of the first period of insurance, the benefits for any disability or service subject to a waiting period will be those shown on the benefit schedule for that disability or service on the first day of the waiting period, or those shown on the current benefits schedule, whichever is less.

28 Newborn Additions

28.1 A newborn infant born to a mother who has been covered under the policy for the period stated in section 27 may be added to the policy from birth without any medical underwriting as long as the newborn infant was not born following assisted conception.

28.1.1 You must provide us with a Newborn Additions Form within 28 days of birth of the newborn infant so that we can add the child to the policy. The premium for the newborn infant must be paid according to Section 10.

28.1.2 Your child's cover will match the cover provided to the mother of the child on the first day of the twelve month period preceding the child's birth, excluding any optional cover chosen for Maternity Benefits or Dental/Optical Benefits. Cover for neonatal disabilities will be limited to the neonatal disabilities limit shown on the benefit schedule.

28.2 A child not meeting the criteria under 28.1 must be added by Medical Questionnaire, including any child:

28.2.1 Whose mother has not been covered under the policy for 366 consecutive days;

28.2.2 When a Newborn Addition Form was not received by us within 28 days following birth

28.2.3 That was adopted or was carried by a surrogate

28.2.4 Who was born following assisted conception.

28.3 Our underwriting process will apply to an addition under Section 28.2, and we may decline - cover or may offer cover based on our terms. The cover must be equal to the cover provided to the mother excluding any optional Maternity Benefits or Dental and Optical Benefits.

29 Material Changes

29.1 As a condition precedent to liability, you must inform us as soon as reasonably possible of any change of your name, the country(ies) of which you hold a passport or citizenship, or your usual country of residence. If such notice is not given to us we will have no liability under this policy for expenses occurred after the date of such changes.

29.2 You must inform us as soon as reasonably possible of any change to your residential address or correspondence address. Until such notice is given, we may continue to send correspondence to the last address given to us by you, and we shall not bear any consequences if such correspondence is not received by you.

30 Fraudulent Claim

The Company shall not be liable to compensate the covered person or any other persons under this insurance policy that have made a fraudulent claim. The Company reserves the right to immediately cancel the Policy and will refund premium based on the Short Rate Premium Table under No.24.

31 Precedent Condition

The Company shall not be liable to compensate the covered person or other persons under this insurance policy unless the Insured, the Beneficiary or the Covered Person's representatives have complied with the insurance contract and the conditions of this policy.

32 Currency

Premium and any benefit under this policy will be paid in Thai Baht.

33 Law

This policy is governed under the Thai law.

34 Return of Membership Card

Where this insurance terminates for any reason the covered person must, within 30 days from the date of termination, return the membership card issued by the company for this insurance. If it is found that after the termination of this insurance policy, the membership card is used for any medical treatment and expenses are incurred, the covered person shall bear those costs at their own expense.

III GENERAL EXCLUSIONS

1. Pre-existing conditions and any related, associated or consequential disabilities which were not disclosed to us before the period of insurance and which we have not been agreed in writing by us to cover under this policy. This exclusion applies only to fully underwritten policies.
2. Any pre-existing or related medical condition which occurred or was treated within a 24-month period prior to your effective date or has one of the following characteristics will be excluded from cover:
    - Was foreseeable
    - Clearly presented itself
    - You have had signs/symptoms or you were already aware of the condition
    - You have received treatment for or sought medical advice on the condition or a related condition (including medical check-ups)
    - To the best of your knowledge you were aware you had
    - Requires monitoring according to medical advice or opinion

2.1 Any pre-existing medical condition or related medical condition may be covered after you have had 24 months' continuous cover under the plan and within that time you have not experienced signs or symptoms; asked for advice (including medical checkups); or required or received treatment, medication, monitoring, or a special diet.

2.2 If within a 24-month period following your effective date, in relation to a pre-existing condition you have experienced signs or symptoms; asked for advice (including medical checkups); or needed or received treatment, medication, monitoring or a special diet; then you will have to wait until you have completed a continuous 24-month period when none of these apply to you. Such pre-existing medical conditions or related medical conditions may then be covered.

2.3 This exclusion only applies to moratorium policies.

3. Treatment or cosmetic surgery or any cosmetic related complications, consequences
4. Reconstructive surgery except when required as a direct result of a disability covered under this policy
5. Dandruff, complications regarding hair loss, weight control pregnancy or childbirth, complications of pregnancy following assisted conception, other than services claimed under Maternity Benefits or Routine Outpatient Maternity when specifically provided on the benefit schedule
6. Venereal disease and sexually transmitted diseases
7. All investigations, treatments or preventions to relieve symptoms possibly related to ageing, premenopausal or menopause. Investigations or treatment for sexual dysfunction or sexual transformation
8. Assisted conception, contraception, sterilisation, fertility/infertility, prior history of miscarriages, hypogonadism or testosterone deficiency, sexual dysfunction, or abortions other than for therapeutic reasons
9. Congenital and hereditary conditions other than services claimed under the Congenital and Hereditary Conditions benefit when specifically provided on the benefit schedule
10. Terminal illness other than as provided under the hospice or palliative treatment benefit as shown on your benefit schedule
11. Routine physical examinations or medical check-ups.
12. Hospital inpatient treatment for convalescence, rehabilitation, supervision or which in the opinion of our medical advisor, could be treated as an outpatient
13. All investigations and treatments relating to eyesight or LASIK surgery
14. Glasses frames (applicable only when Optical benefits are available under the policy)
15. Defibrillator, Pacemaker or any external prosthetics, medical equipment such as oxygen tank, mask, hearing aid other than surgical implants, external prosthesis or medical appliances shown on the benefit schedule as covered by the policy
16. Special nurse fee
17. Medicine, treatment and any investigations that are not related to the diagnosis, or do not relate to sign and symptoms stated on the medical certificate.
18. Services rendered by a dentist other than services claimed under Dental Benefits where specifically provided on the benefit schedule
19. Orthodontic treatment that is commenced after the age of 16 (applicable only when Dental benefits are covered under the policy)
20. Dental treatment for purely cosmetic purposes (applicable only when Dental benefits are covered under the policy)
21. All treatments or therapy related to drug addiction, smoking, alcoholism, or use of any psychoactive substances
22. Behavioral and personality disorders, attention deficit disorders, autism, ADHD, stress, eating disorders
23. Outpatient treatment of mental and nervous conditions other than services claimed under the Outpatient Psychiatric benefit where specifically detailed on the benefit schedule
24. Any experimental investigations, treatments, and all medical expenses related to obstructive sleep apnea, sleeping disorders and snoring
25. Any inoculations and vaccinations other than services claimed under the vaccination benefit where specifically detailed on the benefit schedule
26. Any treatment which is not considered as standard modern medical treatment other than services claimed under the Complementary Medicine and Traditional Chinese Medicine section of the benefit schedule
27. Any medical treatment given by a medical practitioner who is the covered person himself/herself, the parent, spouse, child, or family members of the covered person.
28. Suicide, self-inflicted injury, illness or any related attempt whether self-inflicted or agreed with other persons even though the covered person has full consciousness or has mental disorders including those accidentally caused by any chemical or toxin substances intake or medicines overdose
29. Any loss or injury arising from the action of the covered person whilst under the influence of alcohol, addictive or psychoactive drugs, narcotic drugs to the extent of being unable to properly control one's mind.

29.1 The term "under the influence of alcohol" in the event of a blood test refers to a blood/alcohol level of 150 mg percent and over

30. While the covered person is engaging in a brawl / fight or taking part in initiating and/ or inciting a brawl/ fight
31. While the covered person is committing a felony or while the covered person is being arrested, under arrest or escaping arrest
32. Any loss or injury arising from the actions of the covered person involved in car racing or boat racing, horse racing, playing or racing all kinds of skiing including jet ski, skating, boxing, parachuting (except for life saving situations), boarding or traveling in a hot air balloon, gliding, bungee jumping, diving with air tanks and underwater breathing equipment,
33. Any loss or injury arising whilst boarding, leaving or traveling as a passenger in an aircraft which does not have a license for carriage of passengers, and does not operate as a commercial airline.
34. Any loss or injury arising whilst the covered person is enroute in a commercial airline or whilst serving as a crew member in any aircraft,
35. Any loss or injury arising whilst the covered person is performing duties as a member of the armed forces, police, as a volunteer and engaging in war or crime suppression.
36. War, invasion, acts on foreign enemies, war-like acts whether declared or not, civil war, revolution, insurrection, civil commotion, population rising against the government, riot, and strikes
37. Terrorism
38. Nuclear weapons, radiation or radio activity from any nuclear fuel or waste arising from the combustion of nuclear fuel and self-sustaining process of nuclear fusion,
39. Explosive radiation or any part of nuclear or dangerous objects that can explode
40. Vitamins, nutritional supplements, chelation therapy, bio resonance therapy or diagnosis, or colonic hydrotherapy
41. Services by a Psychologist or Counsellor
42. Elective caesarean section prior to the 38th week of pregnancy.
43. The cost of purchasing an organ for transplantation
44. Stem Cell Treatment
45. Home visits, delivery of medicine or other items, any services rendered at a person's home, office, hotel room, or similar place
46. Services or treatment whilst a bed patient at any facility that is not a hospital, including an institution such as an intermediate care facility or nursing home
47. Treatment outside your area of cover as stated on your benefits schedule except to the extent Out of Area Cover is provided for in your benefits schedule

IV INSURING AGREEMENT

While this policy is in force and subject to the General Conditions, Insuring Agreements, Exclusions, and attached Endorsements of this insurance policy, if the covered person sustains injury from an accident or suffers from an illness after the waiting period resulting him/her to require medical care, the Company will pay for the customary and reasonable medical charges according to the medical necessity. The amount to be compensated is the actual expenses paid up to the maximum limit of benefit as stated in the Schedule in accordance with the attached insuring agreement.

1 HOSPITAL AND SURGERY

While the policy is still in force, if the Covered Person sustains injury from an accident or suffers from illness after the waiting period, which results in hospitalization, the Company will pay for reasonable and customary medical charges that are considered medically necessary and of medical standard. The company will pay the eligible amount of charges incurred or the applicable amount specified in the schedule whichever is the smaller. The amount of benefit paid with respect to each disability shall not be more than the amount specified in the Schedule.

1.1 Hospital Expenses

In the event of a covered person requiring hospitalization as an inpatient in a hospital, the Company will pay the eligible amount of charges incurred or the applicable amount specific in the benefits schedule, whichever is smaller, while the covered person remains hospitalised

a. Hospital room and board
b. Intensive care unit
c. Theatre fees
   In the event of a covered disability requiring surgery, theatre fees will pay for general fees required by the operating theatre, including equipment and room rental, and general support staff costs.
d. Blood, dressings, medicines and drugs
   The costs of administration and supply of blood, medicines and drugs.
e. Surgical implants
   The cost of surgical implants required during a surgery
f. Diagnostic scans and tests
g. Rental of mobility aids
h. Professional fees
i. Hospital treatment of mental and nervous conditions

1.2 Pre-hospitalisation Benefits

In the event of a covered confinement in hospital for a covered disability, the following expenses will be covered up to the limit stated on the benefit schedule for the following services received prior to admission to hospital:

a. Physician consultation fees
b. Diagnostic scans and tests
c. Medicines and drugs used as a direct consequence of the disability which led to confinement

Limitations:
- This benefit is not payable if the stay in hospital is less than 18 hours
- Expenses paid as post-hospitalisation benefits must be directly related to the disability that required confinement.

1.3 Post-hospitalisation Benefits

In the event of a covered confinement in hospital for a covered disability, the following expenses will be covered up to the limit stated on the benefits schedule for the following services received after discharge:

a. Physician consultation fees
b. Diagnostic scans and tests
c. Medicines and drugs
d. Physiotherapy, rental of mobility aids ordered/prescribed by a physician following confinement and used as a direct consequence of the disability which led to confinement.

Limitations:
- This benefit is not payable if the stay in hospital is less than 18 hours
- Expenses paid as post-hospitalisation benefits must be directly related to the disability that required confinement.

1.4 Organ Transplantation

In the event of a covered person requiring an organ transplantation, benefits and limits payable will be as per those listed in the Hospital Benefits, Pre-hospitalisation benefits and Post-hospitalisation benefits sections of the benefit schedule. In addition to these benefit items, direct costs for surgery to remove an organ for transplant from a donor will be paid. Benefits limits available for Donor Expenses will also be limited to those as listed in the Hospital Benefits, Pre-hospitalisation Benefits and Post-hospitalisation Benefits sections of the benefits schedule, up to the limit stated on the benefit schedule for Donor expenses.

Limitations:
- Human Organs Only
- Cornea, kidney, heart, liver, lung, or bone marrow only

Specific Exclusions:
- The cost of purchasing an organ for transplantation

1.5 Private Nursing and Home Nursing

Private Nursing and Home Nursing provides additional nursing services to a covered person in the event of a covered disability and upon the recommendation of a physician.

a. Private Nursing in hospital when certified necessary by attending physician
b. The cost of paying for an additional nurse to attend exclusively to the needs of the covered person while in hospital
c. Home Nursing prescribed by an attending physician: The cost of paying for a nurse to attend to the covered person in their home, while still suffering from or in recovery from a covered disability

1.6 External Prostheses

If the covered person requires a prosthesis due to a covered disability and upon the recommendation of a physician, the following aspects of treatment will be covered:

a. Cost of purchase of external prostheses
b. Any services relating to selection, fitting or repair

Limitations:
- No other section of the benefit schedule covers costs relating to external prosthesis

Exclusions:
- Defibrillator, Pacemaker, any external prosthetics, medical equipment such as oxygen tank, mask, hearing aid other than surgical implants, external prosthesis or medical appliances shown on the benefit schedule as covered by the policy

1.7 Surgery performed whilst a day-patient, in a clinic, or in a physician's office

Within the Hospital and Surgery Module, surgery as defined within the policy, is covered in any setting. Inpatient surgery benefits are available under the Hospital Benefits section. Surgery costs while not admitted to hospital are covered as per the following:

a. Professional Fees for surgery and one post-surgical follow up (further follow ups will be covered under the outpatient module if available to the covered person)
b. Hospital room and board on day of surgery
c. Theatre fees
d. Dressings: cost of the dressings and administration of the dressings
e. Medicines and Drugs: cost of the drug and administration of the drug
f. Pathology Fees
g. Surgical Implants

Limitations:
- This benefit does not cover the following unless Outpatient Benefits are purchased: Laryngoscopy, Nasopharyngoscopy, Otoscopy; any surgery on the skin and subcutaneous tissue for illness other than surgery following a confirmed diagnosis of cancer.

1.8 Cancer Treatment

Following a diagnosis of cancer, this benefit covers the following items :

a. Hospital Treatment of Cancer: As per the benefits listed in the Hospital Benefits section
b. Outpatient treatment of Cancer: Specialist consultations; diagnostic scans and tests; medicines and drugs; chemotherapy and radiotherapy related to active cancer treatment

1.9 Kidney Dialysis

In the event of a covered person requiring kidney dialysis for a covered disability, this benefit covers dialysis received while admitted to hospital as an inpatient or out of hospital

1.10 HIV/AIDS

Following a confirmed diagnosis of HIV/AIDS, the following services are covered on an inpatient and outpatient basis subject to the overall lifetime limit stated on the benefits schedule:

a. General Practitioner and Specialist fees
b. Antiretroviral treatment
c. Treatment of primary HIV
d. Testing and monitoring
e. Treatment of AIDS

Limitations:
- No other benefit provides cover for HIV/AIDS

Waiting Period:
- HIV/AIDS: Three years prior to your first positive HIV test result, or the date you received any treatment for HIV/AIDS (or following possible exposure to the virus), whichever is later.

1.11 Emergency Room Treatment

Emergency Room Treatment for covered disabilities, for treatment in the emergency department of a hospital, are covered, including:

a. Physician consultation fees
b. Diagnostic scans and tests and pathology
c. Medication

Limitations:
- Treatment must be for an emergency condition, where delay in seeking treatment will lead to life changing consequences

1.12 Emergency Dental Treatment

In the event of an accident and to the mouth area, leading to damage of teeth, Emergency Dental Treatment provides services to repair damage and relieve pain. :

a. Surgery fees from a physician or dental surgeon
b. Medication
c. Diagnostic Scans and Tests
d. Theatre Fees

Limitations:
- Must be to repair damage to sound natural teeth, and not to repair damage to pre-existing dental work, including but not limited to crowns, fillings, dental implants or root canals
- Treatment must be carried out within 14 days of accident

Exclusions:
- Emergency Dental Treatment related directly or indirectly to biting, chewing or teeth grinding

1.13 Local Transport By Ambulance

In the event of a covered person requiring local transport by road ambulance, and upon the recommendation of a physician, the following costs will be covered by this benefit:

a. Fee for use of ambulance
b. Associated ambulance staff costs

1.14 Hospice or Palliative Treatment

If a covered person is deemed by a physician to have entered the final stages of life, with no possibility of cure, Hospice or Palliative care provides cover for all costs associated with this stage of medical treatment, up to the overall lifetime limit stated on the benefit schedule:

a. Physician Fees
b. Hospital Expenses
c. Hospice costs, including accommodation, nursing fees, room and board or counselling
d. Palliative medications
e. Diagnostic scans and tests

Limitations:

- No other benefits cover palliative care

1.15 Special limits applying to certain disabilities

This section of the benefits outlines per disability and/or per period of insurance and/or lifetime limits for the stated disabilities. Cover for these disabilities is provided up to the limits stated on the schedule. Benefits provided for these disabilities are as per the detailed limits stated elsewhere on the benefits schedule of the covered person. If the covered person has selected Hospital and Surgery module only, then the cover will be provided as per the benefits listed in the Hospital and Surgery section. If Outpatient is also selected, then benefits will be provided as per the limits stated in the Hospital and Surgery AND Outpatient Benefits items.

The disabilities concerned are as follows:

a. Complications of Pregnancy
b. Congenital Conditions
c. Neonatal Disabilities

Neonatal disabilities limitations and guide

All benefits stated on the schedule (subject to the parent's plan choice) are eligible for settlement of neonatal disabilities, subject to the overall lifetime limit stated for neonatal disabilities

Special conditions for this coverage :

- This benefit is only available to children who are born during the policy year and subject to the following terms :

1.16 Newborn Additions

A newborn infant born to a parent who has been covered under the policy for the period stated in section 27 may be added to the policy from birth without medical underwriting as long as the newborn infant was not born following assisted conception.

A Newborn Addition Form must be completed and submitted within 28 days of birth of the newborn infant so that we can add the child to the policy. The premium for the newborn infant must be paid.

The child's cover will match the cover that was provided to the parent on the first day of the twelve month period preceding the child's birth, excluding any optional cover chosen for Maternity Benefits or Dental and/or Optical Benefits. Cover for neonatal disabilities will be limited to the neonatal disabilities limit shown on the benefits schedule.

The following instances of adding newborn children require medical underwriting:

a. When the parent has not been covered under the policy for 366 consecutive days
b. For whom a Newborn Addition Form was not received by us within 28 days following birth
c. When a child has been adopted or was carried by a surrogate
d. Born following assisted conception

Standard underwriting will apply in such situations, and cover may be declined or offered with any required terms deemed appropriate. The cover must be equal to the cover provided to the parent excluding any optional Maternity Benefits or Dental and/or Optical Benefits.

Limitations:

- Children who do not meet the requirements as described above are not eligible for the neonatal disabilities benefit and must be added by the completion of a medical questionnaire.
- The maximum benefit payable for neonatal disabilities is stated on the schedule and no other limit provides such cover.

Waiting Period:

- A parent must be insured for at least one-year prior tot the child's birth

2 OUTPATIENT BENEFITS

The Outpatient Benefits section provides covered persons with benefits to be administered whilst an outpatient, not while admitted to hospital.

2.1 Annual Limit for Outpatient Benefits

The limit stated in this benefit schedule is the overall combined annual limit for all benefits listed in the Outpatient Benefits section of the benefit schedule.

2.2 General Practitioner and Specialist Consultation Fees

The benefits listed here will cover consultation fees with outpatient physicians and physiotherapists.

a. Physician consultation fees
b. Specialist Fees
c. Physiotherapy

Limitations:
- Psychiatrists are not covered under this section. Psychiatric services are covered only under the Outpatient Psychiatric benefit
- A referral is required for physiotherapy

2.3 Outpatient Psychiatric Benefit

In the event of a diagnosis of a mental and nervous disorder, the insured is covered up to the benefit limits stated in this section of the schedule.

All of the following items may be provided/prescribed by a Psychiatrist, Specialist, or General Practitioner, as long as a mental or nervous condition is being treated.

a. Physician consultation fees
b. Diagnostic scans and tests
c. Medications prescribed by an attending physician

Limitations:
- No other benefits on the benefit schedule provide Outpatient cover for mental or nervous conditions

Exclusions:
- Outpatient treatment of mental and nervous conditions other than services claimed under the Outpatient Psychiatric benefit where specifically provided on the benefits schedule

2.4 Medications

Medications prescribed by a physician for covered disabilities are covered under this benefit.

Limitations:
- A prescription must be required for purchase

2.5 Diagnostic Scans and Tests

Diagnostic scans, tests, pathology and lab work on an outpatient basis for covered disabilities are covered under this benefit.

2.6 Medical Appliances and Mobility Aids

Medical devices and durable medical equipment is covered under this benefit when relating to covered disabilities and as per the limitations shown in the benefit schedule.

a. Purchase or rental of mobility aids
b. Slings and bandages
c. Rental of medical appliances
d. Purchase of medical appliances

Limitations:
- A maximum of two mobility aids per disability are allowed per policy year
- Items not listed in the definition are not covered

Exclusions:
- Defibrillator or Pacemaker or any external prosthetics, medical equipment such as oxygen tank, mask, hearing aid other than surgical implants, external prosthesis or medical appliances shown on the benefits schedule as covered by the policy

2.7 Complementary Medicine and Traditional Chinese Medicine

This section of the benefits schedule provides cover for the listed practitioners for alternative/non-allopathic treatment of eligible disabilities.

a. Combined Limit for all benefits in Complementary Medicine and Traditional Chinese Medicine section: The overall annual maximum combined for all services listed in this section
b. Physiotherapy without referral from attending physician
c. Consultation Fees for following Complementary Medicine practitioners: Chiropractor, dietician, homeopath, osteopath, podiatrist, speech therapist.
d. d. Consultation fees and medicine/ consumables dispensed or used by the following practitioners during the course of treatment: Acupuncturist, bone setter
e. Chinese medicine practitioner

Limitations:
- GP referral is required for Chiropractor, dietician, homeopath, osteopath, podiatrist, speech therapist
- Only one consultation per day allowed for Acupuncturist, bone setter, Chinese Medicine Practitioner

2.8 Follow up Cancer Care

If following the completion of active cancer treatment, a physician recommends preventive medication in order to prevent another occurrence of cancer, this benefit shall cover the specialist consultations and associated medication costs.

Limitations:
- This benefit is only included if the covered person has selected Outpatient Benefits
- This benefit is not included under the Hospital and Surgery Cancer Treatment benefit

2.9 Medical Check up and Vaccinations

All items in the benefits schedule require a diagnosis, to treat a disability, this is the only benefit where an exception is made and no diagnosis/ disability is required. Medical Check up and Vaccinations are covered up to the items stated in this section of the benefits schedule:

a. Medical Check up: Diagnostic check of body function and system in order to check the status of the body, in the absence of a diagnosis. Check up can either be in the form of a check-up package or standalone medical/ diagnostic test.
b. Vaccinations: any form of inoculation for the prevention of disease.

3 DENTAL AND OPTICAL MODULE

The Dental and Optical Module provides cover for services provided by a Dentist/ Optician and the cost of purchasing lenses and testing for refractive defects of the eye.

a. Minor Dental Treatment
b. Major Dental Treatment
c. Eye examinations, prescription lenses, and prescription contact lenses

Limitations:
- Orthodontic treatment must be commenced before the attained age of 16.
- No other sections of the benefits schedule provides treatment provided by a dentist, except for the Emergency Dental Treatment benefit.

Waiting Periods:
- Major Dental Treatment: 10 months

4 MATERNITY MODULE

The maternity module provides cover for pre-natal, post-natal and delivery of babies. Cover is provided up to the stated per pregnancy limit.

4.1 Pre or Post-natal Services

Physician consultation fees, diagnostic scans and tests, medicines and drugs, vitamins and supplements.

4.2 Delivery

Including elective and emergency caesarean sections and up to seven (7) days of nursery care.

4.3 Complications of pregnancy

Following assisted conception.

4.4 Therapeutic abortions

Limitations:
- No other section of the benefit schedule provides cover for pre, post-natal and childbirth
- The Maternity Module must be purchased and renewed in order to cover the pregnancy and cover the waiting period.
- Elective and non-elective caesarean section are covered under this benefit

Exclusions:
- Dandruff, complications regarding hair loss, weight control Pregnancy or childbirth, or complications of pregnancy following assisted conception, other than services claimed under Maternity Benefits or Routine Outpatient Maternity where specifically provided on the benefits schedule
- Elective caesarean section prior to the 38th week of pregnancy.

Waiting Period:
- One year from the date of purchase of the Maternity Module

For more information, contact your insurance consultant :

Underwritten by:

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