Individual Health and Accident Insurance Policy

International Exclusive

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Remark: The English version is a translation of the original in Thai for information purpose only. In case of a discrepancy, the Thai original shall prevail.

International Exclusive
Individual Health and Accident Insurance Policy

In reliance upon statements contained in the insurance application, which is an integral part of this Policy, and in consideration of the premiums payable by the Insured, and subject to the stipulations, general conditions, insuring agreements, exclusions, and attachments to this Policy, the Company agrees with the Insured as follows.

Section 1: Definitions

Unless specified otherwise in this Policy, words, or expressions to which specific meanings have been ascribed in any part of this Policy will have the same meaning wherever they appear.

Company	means	AXA Insurance Public Company Limited
Policy	means	the schedule, Table of Benefits, conditions, exclusions, provisions, attachments, special provisions, warranties and insurance application.
Insured	means	the person who owns the Policy and named as the Insured in the schedule.
Dependents	means	the following persons: 1. the legitimate spouse of the Insured who is aged at least 18 years old and not older than 80 years of age at point of application and 2. the legitimate children of the Insured, who are unmarried and unemployed, and are between the age of 15 days and 18 years, or up to 23 years old if he or she is a full-time student.
Covered Persons	means	the Insured and/or the Insured's eligible Dependents named in the schedule.
Table of Benefits	means	the table listing the maximum benefit amounts for the respective Covered Persons.
Plan	means	the coverage Plan of the International Exclusive Individual Health and Accident Insurance Policy.
Area of Cover	means	1. **Asia** means Bangladesh, Bhutan, Brunei, Cambodia, China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, the Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, and Vietnam. 2. **worldwide except the USA,** which means all countries around the world except the USA and its surrounding islands and 3. **worldwide,** which means all countries around the world.
Outside area of cover	means	the coverage that is provided only for Emergency Medical Treatment not arising during travel undertaken directly for securing Medical Treatment, or that is prepared while a Covered Person travels out of the Area of Cover.
Emergency	means	A sudden, serious, and unforeseen acute Medical Condition or injury requiring immediate medical treatment, that without treatment commencing within twenty-four (24) hours of the Emergency event could result in death or serious impairment of bodily function.
Main Country of Residence	means	the country in which a Covered Person resides for more than 185 days per year, that is specified as his or her address in the Policy.

Accident	means	a sudden event resulting from an external factor, which leads to an unintended or unexpected result to a Covered Person.
Injury	means	a bodily injury directly caused by an Accident arising separately from and independently of any other incident during the effectiveness of the insurance agreement.
Illness	means	an illness or disease suffered by a Covered Person during the effectiveness of the insurance agreement.
Congenital Condition	means	all kinds of congenital abnormalities, including physical anomalies happening during six months from birth, that are categorized as congenital malformations by the World Health Organization, and deformations or genetic abnormalities, including all kinds of hernia or epilepsy, except epilepsy caused by an Injury after the Covered Person has obtained the insurance.
Chronic Condition	means	a Medical Condition or Illness that is persistent and lasting, or continues indefinitely, as diagnosed and concluded by a Physician.
Physician	means	a person who has a medical degree and is duly registered with the Medical Council, and is licensed to practice the medical treatment profession in the locality in which the medical or surgical services are provided.
Dentist	means	a person who has a dentistry degree and is duly registered with the Dental Council, and is licensed to practice the dental treatment profession in the locality in which the services are provided
Traditional Chinese Medicine	means	a diagnosis, Medical Treatment, or prevention of disease by any means provided by a traditional Chinese physician in the locality in which the services are provided.
Physiotherapist	means	a person who is capable of practicing, and is licensed to practice, physical therapy.
Nurse	means	a person who is licensed to practice the nursing profession in accordance with the law.
Fees for Nursing Services	means	expenses regularly charged by a Hospital or medical center for services provided by professional Nurses to a Covered Person when the Covered Person is an inpatient.
Inpatient	means	a person who is treated in a Hospital and, according to a Physician's opinion, must be accommodated in the Hospital for at least six consecutive hours, and must be registered as an Inpatient.
Outpatient	means	a person receiving a Medical Service in an outpatient department or emergency room of a Hospital, medical center, or clinic, for a condition which, by diagnosis and indication according to the Medical Standards, does not require admission as an inpatient.
Clinic	means	a modern medical facility licensed under the law, that is operated by a Physician who provides Medical Treatment and diagnosis services, and is unable to accommodate overnight patients.
Medical Standards	means	the international medical basis or guidelines that give rise to an appropriate course of treatment for a patient, according to Medical Necessity and consistent with conclusions drawn from Injury records, findings, diagnosis results or any other reason.
Medical Necessity	means	any eligible Treatment, test, medication, or stay in Hospital or part of a stay in Hospital which:

		• is not being undertaken for the convenience of the Insured, the treating Physician, Hospital or Clinic; and • is required for the diagnosis, direct Treatment and medical management of an eligible Medical Condition suffered by the Insured as prescribed by his Physician; and • must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity; and • must conform to the professional medical standards widely accepted; and • shall be considered and approved by the Insurer and their medical advisors as the most appropriate, cost effective, Conventional Treatment and not of an Experimental, investigational, research or preventive nature.
Reasonable and Customary Charges	means	any medical expenses and/or reasonable costs comparing to those charged to general patients for services provided by a Hospital, or medical center or clinic where a Covered Person is treated. For the avoidance of doubt when comparing treatment, the Company will take into account the complexity of the procedure and the standard of the medical facility where the treatment is received.
Hospital	means	any medical facility that provides medical services and can accommodate overnight patients, with an adequate number of medical personnel and facilities, especially a major operating room, as well as a complete range of services, and is permitted to be registered as a hospital in accordance with the law on medical facilities in that locality.
Medical Condition	means	any disease, Injury, Illness, including mental Illness, that has been diagnosed and concluded by a Physician.
Pre-existing Condition	means	any Medical Condition preceding the Policy Commencement Date, or plan upgrade date, whichever date is later: • for which the Covered Person has been diagnosed; or, • for which the Covered Person has sought or received medication, advice, or Treatment, or, • which the Covered Person should reasonably, based on the Company's independent appointed Physician's opinion, have known about, or, • for which the Covered Person have experienced symptoms even if the Covered Person has not consulted a Physician or was not diagnosed before the start of the cover.
Associated Medical Condition	means	any symptom, disease, injury, or illness that is: • a medical condition caused by or related to directly or indirectly to a Pre-existing condition; or • a medical condition in which the underlying condition (disease, injury, or illness) is generally known to be same with the underlying disease that cause a Pre-existing condition; or • a risk factor that is generally or directly known to be a medical condition that may cause or is arising from a medical condition that may cause pre-existing condition.

Terrorist Act	means	the use of force or violence and/or threat thereof, by any person or group of persons, whether alone or on behalf of or in connection with any organization or government, that is done for political, religious, ideological or similar purposes, including the intention to put any government and/or the public, or any section of the public, in fear.
Prescribed Medicaments	means	medicines or dressings prescribed by a Physician for treating a Medical Condition covered under the Policy.
Surgery	means	a surgical procedure, or an insertion of any device into the body.
Medical Treatment	means	treatment by Surgery or medication that is provided by a Physician, including: 1. examination and diagnosis – the provision of advice and examination to diagnose the disease 2. inpatient treatment – a Medical Treatment that requires the Covered Person to stay in a Hospital for one night or more 3. outpatient Surgery or procedure – a Surgery or procedure that can be performed without requiring the Covered Person to be admitted as an inpatient in a Hospital and 4. outpatient treatment – a Medical Treatment in an outpatient department or emergency room of a Hospital, medical center, or clinic, for a condition which, by diagnosis and indication according to the Medical Standards, does not require admission as an inpatient.
Single Injury or Illness	means	any Illnesses for the same cause, including complications consequential to those Illnesses, or any Illnesses simultaneously occur for other causes during a confinement in a Hospital, provided that an Injury or Illness occurs later than 90 days, in the case of an inpatient, or 14 days, in the case of an outpatient, after the most recent Medical Treatment will be considered a new Illness or Injury.
Lifetime	means	the period in which a Covered Person is alive or until the Covered Person reaches the maximum age allowable under this Policy, whichever is earlier. This does not refer to the duration of the Policy.
Year	means	a period of 12 calendar months from the date the Policy comes into effect or is renewed.
Maximum Limit Per Year	means	the amount of benefits per year per Covered Person to be paid by Company.
Deductible	means	the first amount of the loss that a Covered Person must be liable to pay before benefits under the Policy are payable by the Company according to the terms of the insurance agreement. The Deductible is an amount per Covered Person per Policy Year.
Experimental	means	any Medical Treatment modality and medicines in the Company's reasonable opinion, whose efficacy and safety have yet to be established, that lacks the authoritative evidence-based clinical studies. These treatment modalities or medicines are generally not accepted by the medical community as proven to be effective or are not recognized by the professional medical organizations as conforming to accepted medical practice. This definition also refers to the use of off-label drugs, equipment used for purposes other than those defined under their license or which are undergoing study, research or testing.

Section 2: General Conditions

1. Insurance agreement

This insurance agreement is established based upon the Company's reliance on the Insured's statements in the insurance application, health declaration, and any other additional declarations that the Insured has signed in evidence of the acceptance of the insurance agreement. The Company therefore issues this Policy.

The Company will inform the Covered Persons of the date this Policy comes into effect and any special conditions applicable under this Policy or the Company may refuse to provide coverage to the insurance applicant.

If the coverage has been provided, but the Insured knowingly misrepresented the facts in the declarations under the first paragraph, or knew of any facts but failed to disclose them to the Company, whereby if the Company had known those facts, it might have been convinced to charge a higher premium or refuse to enter into the insurance agreement, this insurance agreement will become void in accordance with section 865 of the Civil and Commercial Code and the Company will be entitled to nullify this agreement.

2. Breach of the insurance agreement

If a Covered Person breaches any condition of the Policy, or dishonestly claims or attempts to claim compensation, the Company will:

2.1 refuse to pay the compensation and

2.2 refuse to renew the Policy or

2.3 specify the conditions of the Policy that are different from the original ones or

2.4 immediately revoke the Policy and the entire coverage.

3. Incontestability

The Company will not contest or challenge the validity of this insurance agreement if the Policy has been in effect for a period of two years or more from the date the Policy comes into effect or the date of the Company's approval of additional benefits under this Insurance Agreement, whichever happens later, except in the case of default of premium payment. However, upon the approval of additional benefits, the Company may dispute or object to the incompleteness of this Insurance Policy regarding such additional benefits only.

If the Company becomes aware of any information based upon which the agreement can be nullified, but does not exercise its right of nullification within one month from the date that information is known to the Company, the Company may no longer nullify the validity of the agreement on these grounds.

4. Governing law

This Policy is governed by, and interpreted in accordance with, the laws of Thailand. The Insured and/or the Covered Persons agree that Thai law is the exclusive law for settling all disputes arising from or in connection with this Policy.

5. Amendment to the Policy

Any amendment to this Policy will be valid only if it is agreed to by the Company, and will become effective only after the Company, through its authorized person, records it on the Policy or issues an attachment.

The conditions, coverage, and exclusions under this Policy may be amended only on the renewal date of this Policy, subject to the Company's consideration and approval at that time. The Company will inform the Insured of any amendments in writing in advance, by sending written notice thereof to the address last given by the Insured at least 15 days before the expiration date of the Policy.

For the purposes of receiving notices from the Company, the Insured must inform the Company whenever the address of the Insured or any Covered Person changes.

6. Premium payment and commencement of coverage

6.1 Annual premium payment

6.1.1 In the first year of this Policy, the Insured must pay the annual premium before or on the inception date. The coverage will commence from the inception date as stated in the schedule and/or Renewal Certificate in the case of renewal.

6.1.2 In subsequent renewal years, the premium must be paid within 31 days from the expiry date stated in the schedule and as agreed upon by the Company, the Company will continue the coverage and the Company will not re-apply the conditions of Waiting Period and Pre-existing Conditions to the Policy.

6.1.3 If the Insured does not pay the premium within the specified period, it shall be deemed that the Insured does not wish to renew the Insurance Policy and the coverage hereunder shall expire as indicated in the schedule.

6. 2 Premium payment by instalment as specified in the Policy Schedule

6.2.1 In the first month, the insured must pay the premium immediately before or on the inception date. The coverage will commence from the inception date as stated in the schedule and/or renewal certificate.

6.2.2 In subsequent renewal years, the premium must be paid within 31 days from the due date. If the premium is paid, the coverage on this policy is deemed to have been continuously in force from the previous insurance period and the Company will not re-apply the conditions of Incontestability or objection of the completeness of the insurance contract, Waiting Period and Pre-existing Conditions to the Policy.

If the Company is unable to collect the insurance premium after this time, the Policy will be terminated on the last day of the paid to date of which the coverage has been paid.

6.3 In the event that there are claims to be paid during the 31 days from the payment due date and the Company is still unable to collect the premium, the Company will deduct the outstanding premium from the payable claim amount under this insurance policy and reimburse the remaining balance to the Insured or the beneficiary (in case of loss of life).

7. Misstatement of age or Main Country of Residence

If any Covered Person's age or Main Country of Residence is misstated, thereby causing the Company:

7.1 to receive a premium less than the prescribed rate, the amounts of benefits payable under this Policy will be adjusted to the amounts of protection that the premium received would have purchased at the Covered Person's actual age and/or Main Country of Residence, if the Covered Person is not eligible for the coverage under this Policy based on his or her actual age or Main Country of Residence, the Company will not pay any benefits but will return the premium paid hereunder in full, if the Company finds that there was a claim record under the prevailing Policy, the Company will return the premium based on the remaining period from the date the Company is aware of that cause, or

7.2 to receive a premium more than the prescribed rate, the Company will return the excess premium to the Insured and/or the Covered Person. However, this condition will not apply retroactively to the premiums paid for the past Policy Years.

8. Renewal of the Policy

The term of this Policy is one year. The Company may refuse renewal of this Policy by giving prior written notice at least thirty (30) days before the date this Policy comes to an end, provided that the Company gives the reason for its refusal.

Even if the Company will renew this Policy, the Company reserves its right to adjust the premium rates, to suitably reflect the risk levels and increased ages, based on the Covered Persons' qualifications according to the Company's insurance underwriting criteria and the prevailing premium rates.

9. Premium adjustment

The Company may adjust the premium for a Policy Year, to reflect the age ranges or experience in disbursement of total indemnities of the portfolio of this Insurance Policy or Increasing medical expenses, according to the rates approved by the registrar. The Company will give prior written notice thereof to the Covered Persons.

10. Termination of coverage

10.1 This Policy will automatically terminate upon the occurrence of any of the following events:

10.1.1 the Insured fails to pay a premium as specified in clause 6, premium payment and commencement of coverage, of the general conditions.

10.1.2 on the expiration date of the coverage as specified in the schedule at midnight, Thailand time, in the Policy Year when the Insured is 99 years of age.

10.1.3 on the date either party exercises its right to terminate the Policy according to clause 12, termination of the Policy, of the general conditions.

10.2 The coverage of each of the Covered Persons will automatically terminate upon the occurrence of any of the following events:

10.2.1 when the Covered Person dies of an illness, the Company will return the premium to the beneficiaries after deducting a proportionate amount thereof for the period during which this Policy is in effect, provided no claims was paid out for that Policy Year.

10.2.2 on the expiration date of the coverage as specified in the schedule, at midnight, Thailand time, provided that the Company has refused renewal of the Policy for the respective Covered Persons by sending a written notice to the last known address or email address at least thirty (30) days before the expiration of the Policy.

The coverage under each of the insuring agreements and/or attachments will terminate when the compensation paid by the Company reaches the maximum benefit limit specified therein.

11. Change of Main Country of Residence

The Insured must report to the Company if any of the Covered Persons changes his or her Main Country of Residence, which may affect his or her entitlement to the benefits under the Policy. If the Insured fails to do so, the Company will comply with the provisions specified in clause 7, misstatement of age or Main Country of Residence, of the general conditions.

12. Termination of the Policy

The Insured may terminate this Policy by sending written notice thereof to the Company. The Insured will be entitled to a refund of the premium for the unexpired term of insurance, after deduction of a proportionate amount of premium for the period during which this Policy is in effect, based upon the following short rate table.

Table of short rate premium	
Coverage period (not exceeding/month(s))	**% of the full-year premium**
1	15
2	25
3	35
4	45
5	55
6	65
7	75
8	80
9	85
10	90
11	95
12	100

The termination of the Policy by either party according to the conditions under this clause must be made for the whole Policy. Cancellation of certain parts of the coverage during a Year is not permitted. If the Company has paid compensation under this Policy during that Policy Year, no premium will be refunded. The Company will not pay any compensation after the termination of this Policy.

The Company may terminate this Policy by sending written notice at least 30 days in advance to the Insured by registered mail or electronic means in accordance with the law on electronic transactions to the address or email address last given to the Company. The Company will return the premium to the Insured after deducting a proportionate amount thereof for the period during which this Policy is in effect. The Company will not pay any compensation after the termination of this Policy.

13. Dispute settlement by arbitration

If there is any dispute, conflict, or claim under this Policy, between a person who is entitled to exercise a claim hereunder and the Company, and if that person wishes and deems it appropriate to settle the dispute by arbitration, the Company agrees to have the dispute settled by arbitrators in accordance with the rules of arbitration of the Office of the Insurance Commission (the **"**OIC").

14. Right of examination

The Company reserves the right to examine the medical history of the Insured as deemed appropriate for this Insurance Policy and may require an autopsy report if deem necessary and to the extent permitted by the law.

If the Covered Person fails to allow the Company to examine his or her records of Medical Treatment and diagnosis to support its consideration of benefit payment, the Company may refuse to provide coverage to that Covered Person.

15. Report and claim for benefits under the Policy

15.1 The Insured, a Covered Person, or his or her representative, as applicable, must report to the Company without delay in the case of an Injury or Illness that may be a cause of a claim for benefits under the Policy, or immediately in the case of death, unless it can be proven that the report is impractical due to any necessary and reasonable cause, but is made as soon as is practical.

15.2 Before a Covered Person will have Medical Treatment as an Inpatient, or a planned Surgery or procedure in a Hospital, the Covered Person, the Insured, or the Hospital must check with the Company to ensure his or her entitlement to the coverage according to the conditions of the Policy. The Company will issue a written confirmation specifying the following details:

15.2.1 that the course of treatment is suitable under the coverage provided by the Policy

15.2.2 that the course of treatment is indeed medically necessary

15.2.3 that the course of treatment will incur Reasonable and Customary Charges and

15.2.4 that the expenses incurred by the Medical Treatment do not exceed the remaining benefits under the Policy.

If there is an excess between the medical expenses covered by the Company and the medical expenses charged by the Hospital when the Covered Person is discharged, the Covered Person must pay it, including other expenses not related to the Medical Treatment, to the Hospital.

If the Covered Person needs to have Medical Treatment in a Hospital outside the Company's network, the Covered Person must check with the Company to ensure his or her entitlement to the coverage according to the conditions of the Policy, and must receive the Company's written confirmation, before receiving the Medical Treatment. If no confirmation is received from the Company, the Insured or the Covered Person must immediately contact the Company.

If the Medical Treatment is an Emergency and the Covered Person is thereby unable to contact and seek approval for the expenses from the Company, the Insured or the Covered Person, or his or her representative, or another person who can report the claim must contact and seek approval for those expenses from the Company as soon as is practical so that the Hospital will promptly contact the Company. In addition, the Insured or the Covered Person must present his or her membership card and/or citizen identification card and/or any identification evidence to the Hospital at the time of admission.

16. Submission of evidence to claim for benefits under the Policy

To claim for the benefits under this Policy, the Covered Person or his or her representative, as per the case may be, must submit the following evidence to the Company at his or her own expense:

1. a form of claim for Medical Treatment or other benefits as prescribed by the Company
2. an original medical certificate or medical report that specifies the significant symptoms, the diagnosis results, and the treatments and
3. the original and copy of receipt listing expenses.

The foregoing evidence must be submitted within 30 days from the date of discharge from a Hospital or medical center, or the date of treatment at a clinic. The receipt must be an original. The Company will return the original receipt, bearing the certification of the amount paid, to the Covered Person for use in a claim for a shortfall amount from another insurer. If the Covered Person is already compensated by government welfare or any other welfare, or other insurance, the Covered Person may submit a copy of the receipt bearing the certification of any amount paid by the government welfare or other agency in order to claim the shortfall amount from the Company.

Failure to submit the evidence within the prescribed time will be without prejudice to the right of claim, if it can be proven that the failure is justified and the evidence is submitted as soon as is practical.

17. Payment of benefits

The Company will pay the benefits and Reasonable and Customary Charges to a Covered Person within fifteen (15) days from the date on which correct and complete evidence of damage is received by the Company. If the Covered Person dies, the Company will pay them to his or her beneficiaries.

If there are reasonable grounds for suspecting that a claim for benefits under the Policy is not made in accordance with the insuring agreements hereunder, the Company may extend the payment period as necessary, but to no more than ninety (90) days from the date of its receipt of complete evidence of damage.

Benefits under this Policy will be paid in Thai currency. If the claimed compensation is in a foreign currency, the Company will pay benefits based on the exchange rate announced by the Bank of Thailand on the date specified in the receipt.

If the Company is unable to completely pay the benefits within the stipulated time, the Company is liable to pay interest at fifteen (15%) percent per annum on an amount payable by it, as from the due date of payment thereof.

If the Covered Person dishonestly claims benefits, the Company will not pay them. If the Company has paid the benefits before that dishonesty is discovered by it, the Company may demand that the benefits so paid be returned by the Covered Person or his or her beneficiaries. The Company may also exercise its right as specified in clause 2, breach of the insurance agreement.

18. Claim procedure

The Insured must report to the Company each claim that, in the knowledge of the Insured, can be exercised against any third party, company, or entity.

18.1 If a claim can be exercised under another insurance policy, the Company will contribute to the payment of compensation no more than the ratable proportion of coverage under this Policy.

18.2 If a claim for compensation is exercised as a result of an act by a third party, the Company will pay benefits as specified in the schedule (or according to the ratable proportion of coverage under this Policy, if a claim can also be exercised under another policy). Furthermore, the Company has the right to exercise a claim, or file a lawsuit, against any party for its indemnification in the interest of the Company on behalf of the Insured. In this regard:

18.2.1 the Insured must report the Injury or Illness caused by a third party to the Company as soon as is practical, and the Company will send a form to the Insured or the Covered Person or

18.2.2 if the Covered Person has not claimed compensation from any party, the Covered Person must cooperate with the Company to enable the Company to recover the compensation advanced by it according to the benefits specified in the Policy or

18.2.3 if the Covered Person fails to reimburse expenses for Medical Treatment, including interest claimed from any party, to the Company, the Company, either through its employee, its agent or broker, or an outsourced agent engaged by it, has the right to recover these expenses from the Covered Person.

19. Condition precedent

The Company may deny its liability under this insurance agreement, unless the Insured, the Covered Persons, or their beneficiaries or representatives, fully observe and comply with the insurance agreement and the conditions of this Policy.

20. Change of benefits and coverage

A Covered Person may increase the benefits and coverage at the renewal of the Policy, provided a written notice of that change is given by the Insured to the Company, and the Company agrees to underwrite the insurance so changed.

The Covered Person must declare his or her Medical Condition to the Company when requesting an increase of the benefits. If the Covered Person knows of, or sustains, any Injury or Illness before the increase of the benefits and coverage, the maximum limit of benefits to be reimbursed for Medical Treatment of that Injury or Illness sustained before the increase will not exceed the original maximum limit before the increase.

21. Addition or removal of Covered Persons

If the Insured wishes to add or remove Covered Persons, the Insured may do so immediately by completing an insurance application as required by the Company and submit it to the Company.

If the mother of a baby is the sole Covered Person under this Policy, the Insured may add the newborn baby as her Dependent within thirty (30) days from the date of the birth, provided that the

benefits and coverage of the mother who is the Covered Person under this Policy remain in effect.

If the mother of a baby is not covered under this Policy, the coverage for the baby can be obtained when the baby is discharged from hospital.

Addition or removal of the Covered Persons will be effective when written notice of that addition or removal is given by the Insured to the Company, and the Company agrees thereto with the premium proportionately adjusted.

22. Pre-existing Condition

The Company will not pay benefits under this Policy for any Chronic disease, Injury, or Illness (including any complication) not yet fully cured before the date this Policy first comes into effect, unless:

1. the Covered Person has declared that condition to the Company, and the Company agrees in writing to accept that condition when the Company accepts the insurance application without excluding the coverage
2. this Policy has been in effect for a continuous period of at least three years, and the Chronic Condition, Injury, or Illness (including any complication) has not appeared, or has not been treated, or diagnosed by a Physician, or no consultation or advice has been sought from a Physician during five years before the date this Policy first comes into effect, which would have been sufficiently crucial for an ordinary person to seek diagnosis, care, or Medical Treatment by a Physician, or for a Physician to provide diagnosis, care, or Medical Treatment.

23. Change of Occupation

If the Insured change his occupation, he will need to inform the Company. If the occupation is a declined risk, the Company will terminate the Policy and refund the premium to the Insured on a pro-rata basis as from the date of receiving such evidence of change. However, if there was a previous claim done within the Policy Year, no refund of premium will be provided.

Section 3: General Exclusions

This insurance does not cover any expenses arising from Medical Treatment, or damage arising from an Injury or Illness (including any complication), symptom, or irregularity, caused by or related to:

1. **a Pre-existing Conditions as defined, including any treatment and complication arising from the Pre-existing Condition, and its Associated Medical Conditions unless allowed for by the benefits table and accepted by the Company in writing;**
2. **treatment of a Congenital condition, whether or not manifested and/or diagnosed or known about at birth unless allowed for by the benefits table and accepted by the Company in writing;**
3. **treatment of physiological and/or all types of neurological development, cognitive development, developmental milestones, learning development problems or disorders, speech delays, educational problems, behavioural problems, physical development including assessment or grading of such problems;**
4. **any beautification treatment or cosmetic Surgery, or treatment of skin problems, acne, blemish, freckle, dandruff, hair loss, weight control, liposuction or removal of fat deposits, or elective Surgery, except for reconstructive Surgery due to a covered Accident with the Company's written consent;**
5. **pregnancy, childbirth, abortion, surrogacy (whether the Covered Person is acting as a surrogate or an intended parent), miscarriage (except due to an Accident), birth control, treatment of infertility or to promote conception (including medical investigation), sterilization or sterilization reversal, varicocele, impotence, or consequences thereof,**

circumcision, except due to Medical Necessity and as specified otherwise in this Policy;

6. **Human Immunodeficiency Virus (HIV) infection, acquired immune deficiency syndrome (AIDS), venereal diseases, or sexually transmitted diseases;**
7. **treatment, prevention or the usage of drugs or substances for anti-ageing or giving of replacement hormone during climacteric or menopause, corporal imbecility in a female or male, treatment of sexual disorder, gender confirmation or transgender Surgery;**
8. **routine medical examinations, requests for admission to a Hospital or medical center, or requests for Surgery, convalescence, rehabilitation or rest cures, diagnosis for any cause not directly related to the admission in the Hospital, medical center, or clinic, except as specified otherwise in this Policy;**
9. **checks and treatment for abnormality of vision, Lasik, expenses for a vision-aid device or for treatment of abnormality of vision, except as specified otherwise in this Policy;**
10. **treatment or Surgery related to teeth or gums, dentures, crowns, root canal treatment, fillings, orthodontics, polishing, extraction, or root implants except as necessary due to accidental Injury (excluding dentures, crowning, and root canal treatment or root implants), except as specified otherwise in this Policy;**
11. **treatment or therapy for drug addiction, smoking, alcoholism or use of psychoactive substances;**
12. **treatment of symptoms or diseases related to mental disorders, psychiatric diseases, behavioral or personality disorders, including attention deficit disorder, autism, stress, eating disorders or anxiety, except as specified otherwise in this Policy;**
13. **a treatment that is in a trial stage, that has not been established as being effective or which is Experimental or pioneering medical or any surgical techniques and medical devices not approved by the relevant authorities, government regulatory board, or the clinical trials for medicinal products which the Covered Person chooses to receive even though usual, customary, and Conventional treatment for the condition is available. However, the Company will pay if, before the treatment begins, it is established that the treatment is recognized as appropriate by an authoritative medical body and the Company has agreed in writing, with the Physician, what the fees will be. For established treatment, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced in published medical journals for specific purposes to be considered proven safe and effective therapies;**
14. **the use of a drug or any off-label drug which has not been established as being effective or has not been approved by Food and Drug Administration (FDA), or which is Experimental or within clinical trials, unless with the pre-approval in writing by the Company;**
15. **robotic surgery except for prostatectomy, partial nephrectomy and pyeloplasty using the Da Vinci Robot;**
16. **treatment for all types of sleep disorder including sleep apnoea, sleep study test or snoring;**
17. **any inoculations or vaccinations (excluding rabies vaccination after an animal attack and tetanus vaccination after an Injury), except as specified otherwise in this Policy;**
18. **treatment offering temporary relief of symptoms rather than dealing, when it is reasonable to do so, with the underlying condition, the prescription of medicine that does not immediately respond to or treat the Injury or Illness or the diagnosis of Injury or Illness or the treatment or diagnosis for cause that is not a Medical Necessity or in accordance with the Medical Standards, or is not directly related to the admission in the Hospital, medical center, or clinic;**
19. **treatment by an approach that is not a modern approach, including an alternative medical approach, except as specified otherwise in this Policy;**

20. **expenses arising from Medical Treatment that a Covered Person, who is a Physician prescribes for himself or herself, including expenses arising from Medical Treatment by a Physician who is the Covered Person's employee, employer, business partners, or any person related by blood, marriage, or adoption to the Insured or Covered Person;**
21. **suicide, attempted suicide, self-inflicted Injury, or attempted self-inflicted Injury, whether by oneself or with the assistance of someone else, and while sane or insane, including an Accident caused by consumption or injection of a drug or poisonous substance, or drug overdose;**
22. **an Injury caused by the action of the Covered Person while under the influence of alcohol, addictive substances, or harmful narcotics to the extent of being unable to control one's mind. The term "under the influence of alcohol" means a blood alcohol level of 150 milligrams percent or more, according to the results of a blood test;**
23. **an Injury arising while the Covered Person is engaging in a brawl or fight, or taking part in inciting a brawl or fight;**
24. **an Injury arising while the Covered Person is committing an indictable felony, or is being arrested or is avoiding arrest;**
25. **any costs incurred as a result of any amateur or professional sports, engaging in, competing in or training for any sport for which the Covered Person receives a salary or monetary reimbursement, including grants or sponsorship (unless the Covered Person receives travel costs only);**
26. **an Injury sustained from playing professional sport or from taking part in dangerous sports or activities including but not limited to:**
    - **racing of any kind (except foot racing),**
    - **horse racing**
    - **skiing of any kind including jet skiing**
    - **base jumping, cliff diving,**
    - **flying in an unlicensed aircraft,**
    - **martial arts, boxing, free climbing, bouldering**
    - **mountaineering with or without ropes,**
    - **scuba diving to a depth of more than 10 meters, or to a depth of more than 30 metres if you hold an appropriate diving qualification or you are being instructed by an appropriately qualified diving instructor, for example an instructor recognised by PADI (Professional Association of Diving Instructors),**
    - **any activity at a height of over 5,000 metres above sea level,**
    - **trekking or mountain climbing to a height of over 2,500 meters above sea level,**
    - **bungee jumping,**
    - **hang-gliding, wingsuit jumping**
    - **paragliding or micro lighting,**
    - **parachuting,**
    - **potholing,**
    - **any other winter sports activity carried out off piste;**
27. **an Injury arising while the Covered Person is embarking on or disembarking from, or traveling in, an aircraft not registered for carrying passengers and operated as a commercial aircraft;**
28. **an Injury arising while the Covered Person is piloting or acting as a crew member in any aircraft;**
29. **an Injury arising while the Covered Person serves as a soldier, policeman or policewoman, or a volunteer, and engages in war or crime suppression;**

30. **war, invasion, acts of foreign enemies, warlike operations (whether declared or not), civil war, which means a war fought by people living in the same country, uprising, insurrection, Terrorist Act, riot, strike, civil commotion, revolution, coup d'etat, proclamation of martial law, or any events that result in the proclamation or maintenance of martial law or criminal acts, illegal acts;**
31. **radiation or radioactivity from any nuclear fuel or nuclear refuse arising from the combustion of nuclear fuel or any process of self-sustaining nuclear fission or fusion, radioactive explosion, or any nuclear component or harmful substance that may cause an explosion in a nuclear process;**
32. **all kinds of orthotics and prostheses, such as a walking stick, eyeglasses, lenses, hearing aids, speech devices, heart pacemakers, medical devices and durable medical supplies, respirators, oxygen machines, vital sign monitors (pulse, blood pressure, body temperature), support aids, wheelchairs, prosthetic parts, i.e. artificial limbs and artificial eyes, except heart valves, skull or hip prostheses, and knee prostheses;**
33. **cosmetic products or toiletries such as, but not limited to shampoos, soaps, tooth-pastes, mouthwash, lotions, moisturizers, cleanser, shower gels, regardless whether Medically Necessary or prescribed by a Physician or acknowledged as having therapeutic effects; contraceptives, proprietary headache and cold cures, artificial tear drop/ gel, vitamins or minerals which may be bought over the counter, products classified as organic substances, vitamins or minerals (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes), nutritional or dietary consultations and supplements, including, personal items such as but not limited to, telephone charges.**
34. **treatment during ninety (90) days after birth, for a child born from unnatural pregnancy or pregnancy by artificial insemination or any child conceived by assisted conception/assisted pregnancy;**
35. **expenses arising while premium payments under the Policy have not yet been received;**
36. **treatment in a health hydro, spa, or nature cure clinic;**
37. **psychiatric treatment with a total period of Medical Treatment in excess of 100 days in a Covered Person's Lifetime;**
38. **rehabilitation as an inpatient for a period in excess of 28 days;**
39. **cryopreservation, expenses for harvesting, acquiring and preserving organs or storage of stem cells as a preventive measure against possible disease/illness/injury; or any implantation or re-implantation of living cells or living tissue, whether autologous or provided by a donor unless this has been pre-approved and agreed by the Company in writing.**
40. **medical Treatment received Outside Area of Cover unless specified otherwise in this Policy, including travel against medical advice even if it is within the Area of Cover;**
41. **hormone replacement therapy unless there is a medical indication, excluding treatment of physical symptom. The Company will pay the cost of hormone implants or patches (excluding hormone tablets) up to a maximum of 18 months from the first date of treatment;**
42. **any natural catastrophic event, earthquakes, flood, volcanic eruption, landslide and other natural hazards or disasters or any similar event;**
43. **microbial studies or genetic testing, including any counselling made necessary following the tests, even when those tests are undertaken to establish whether or not the Covered Person may be genetically disposed to the development of a medical condition in the future.**

44. **treatment whilst staying in a hospital for more than ninety (90) continuous days for permanent neurological damage or if member is in a persistent vegetative state. Persistent vegetative state is defined as the condition of profound no responsiveness, with no sign of awareness or consciousness or a functioning mind, even if the person can open their eyes and breathe unaided, and the person does not respond to stimuli such as calling their name, or touching. This state must have remained for at least four (4) weeks with no sign of improvement or there could be no recovery;**
45. **treatment required as a result of negligence or malpractice. The Covered Person must take all reasonable steps to recover the loss from the third party or third-party insurer;**
46. **any treatment needed as a result of work-related accident or injury where the cost of such treatment is recoverable under a Workman's Compensation policy or similar cover required by Government Act prevailing in the country where the work-related accident or injury took place or elsewhere at the time of injury or accident.**
47. **any sanctioned countries and any country with whom at the date of commencement of Treatment, the insurer or reinsurer has prohibited trade to the extent that payments are illegal under the applicable law.**

Section 4: Insuring Agreement

While this Policy is in effect, subject to the conditions of the insuring agreements under this Policy, if a Covered Person sustains an Injury from an Accident or an Illness after the expiration of the waiting period causing him or her to receive Medical Treatment, the Company will compensate for the Reasonable and Customary Charges incurred thereby, in accordance with Medical Necessity and Medical Standards, as actually paid, but no more than the maximum benefits as specified in the schedule for the insuring agreements set out below.

Insuring Agreement - Hospitalization and Surgery

Additional Definitions

Intensive Care Unit	means	a section within a Hospital that is designated as an Intensive Care Unit, and is maintained on a 24-hour basis for treatment of patients in critical condition and is equipped to provide special nursing and medical services not available elsewhere in the Hospital.
Surgical Operation	means	a Surgery arising during the treatment, which is not excluded under this Policy.
Minor Surgery	means	the use by a Covered Person of a medical facility for performance of a Minor Surgery planned in advance, but excluding an overnight stay in a Hospital according to the foregoing definition of an Inpatient.
Organ Transplantation	means	the transplantation of bone marrow, heart, lung, liver, pancreas or kidney.
Day Surgery	means	a Major Surgery or procedure in lieu of Major Surgery or use of special treatment tool which can replace Major Surgery without the need of hospitalization as an Inpatient at the Hospital or Health Facility.
Day care Treatment	means	eligible Treatment at a hospital or day-care unit where the Covered Person needs a medically supervised recovery but does not occupy a bed overnight.

Insuring Agreement

While this Policy is in effect, if a Covered Person sustains an Injury from an Accident or an Illness to the extent that he or she needs to visit a Physician and, as diagnosed and advised by the Physician, must be treated in a Hospital as an Inpatient, or must receive Surgery as an outpatient without the need to stay overnight in the Hospital, the Company agrees to pay the benefits according to the expenses actually incurred, but not exceeding the maximum limit of benefits specified in the schedule.

For treatment that is not an Emergency Medical Treatment, the Covered Person should check his or her entitlement to the coverage according to the conditions of the Policy with the Company before having treatment as an Inpatient, or a Surgery as an outpatient without the need to stay overnight in the Hospital. The Company will issue a written confirmation of the Reasonable and Customary Charges to the Hospital, with the details as specified below.

1. **Room and board for a normal room and an Intensive Care Unit**

Expenses for a single room with the lowest room rate, including meals and general nursing services, as well as expenses arising during the treatment in an Intensive Care Unit of the Hospital.

2. **Miscellaneous expenses during the treatment in the Hospital, which includes:**
   - 2.1 medication and parenteral nutrition
   - 2.2 blood transfusion services and blood components
   - 2.3 ambulance service for medical Emergency
   - 2.4 laboratory tests, pathology, radiological test, other special diagnostics, and Physician's reading fees

2.5 medical equipment:

- medical tools and equipment outside the operating room
- medical consumables (medical supplies 1) and
- medical equipment or supplies that go inside the patient's body (medical supplies 3), except a defibrillator or peacemaker

2.6 physical therapy / occupational therapy:

physical therapy, occupational therapy, rehabilitation physician, or Physiotherapist, and essential facilities and equipment according to Medical Necessity, provided that the therapies are directly related and correlated the Injury or Illness

2.7 operating room and equipment:

operating room, operating equipment, facilities for anesthesia, observation room after Surgery, and staff in the operating room

2.8 anesthetists / anesthetic nurses:

physicians and nurses who perform anesthesia

2.9 surgical consultation fees where no Surgery is performed:

Surgical consultation fees based on the actual amount

2.10 take home drugs:

take home drugs according to Medical Necessity and actual amount paid after the date of discharging from a Hospital or medical center and

2.11 Emergency Medical Treatment:

expenses for Emergency Medical Treatment due to an Injury within twenty-four (24) hours after an Accident, after the first date of Medical Treatment for a Single Injury or Illness, not exceeding the actual amount paid.

3. Daycare treatment or procedures (not involving admission to a Hospital or medical clinic as an Inpatient)

4. Physician's bedside visit fees

Fees for Physician's daily bedside visits while the Covered Person is treated in a Hospital as an Inpatient.

5. Surgeon's fees

Fees for a Surgery performed by a surgeon, including surgeon's bedside visits and care after the Surgery.

6. Artificial organ/Prosthetic Organs

Artificial organ transplanted in the Covered Person's body.

7. Organ Transplantation

The Company will cover expenses for transplantation of bone marrow, heart, kidney, liver, or lung according to the actual amount, but no more than the maximum limit of benefits specified in the schedule, whichever is less. Expenses for acquiring an organ or other expenses relating to organ donor are not covered.

8. Parental accommodation expenses

Parental accommodation expenses while a dependent child under the age of 18 is treated in a Hospital within the Area of Cover, which will be paid by the Company under the child's benefits and coverage.

9. Cash Benefit

The Company will pay a daily compensation to the Covered Person on account of a covered treatment as an Inpatient within the Area of Cover, when the Covered Person does not claim payment for that Medical Treatment from the Company.

10. Pre and Post-hospitalization Benefit

The Company will pay for consultation, prescribed investigations and essential medications by a Physician received as an Out-patient within 90 days prior to a hospitalization, where such hospitalization is eligible for cover under Covered Person's Plan and where the need for such hospitalization has arisen as a direct result of the medical examination and investigation findings drawn from that consultation.

The Company will pay for follow-up Out-patient consultation and Medical Treatment following an eligible In-patient treatment or daycare surgery when such consultation is carried out by the in-patient treating Physician or a referred Physician and provided such consultation or treatment occurs within 90 days immediately following the date of discharge from hospital for which the member was confined as an in-patient or the date of the daycare surgery.

The total of the benefit payable for each Covered Person as specified in the Table of Benefits.

Exclusion:

This Policy does not cover benefits for any claims directly or indirectly arising from:

1. special nurse care, unless with the written consent of the Company and in accordance with the Medical Standard.

Insuring Agreement - Medical Treatment without Hospital Confinement (outpatient treatment)

Insuring Agreement

While this Policy is in effect, if a Covered Person sustains an Injury from an Accident or an Illness that necessitates treatment by a Physician, the Company agrees to pay the benefits for Medical Treatment as an Outpatient to the Covered Person according to the actual amount or the limit of liability per day, but not exceeding the maximum limit of benefits according to the entitlement as specified in the schedule, whichever is less. This coverage includes the following.

1. Physician's fees

1.1 The Company will pay the benefits for Medical Treatment as an Outpatient to the Covered Person who is treated by a Physician as a result of a Single Injury or Illness, but no more than the actual amount paid or the maximum limit of benefits specified in the schedule, as well as for the diagnosis by a Physician in order to obtain a second opinion. However, the Covered Person must obtain the prior consent of the Company for each of the diagnoses to be sought for the purpose of obtaining opinions from subsequent Physicians.

1.2 Fees for other examinations and tests, such as a laboratory test, x-ray, or ultrasound.

1.3 Outpatient medication, provided that the cost of medicines prescribed for a period in excess of 30 days requires the prior consent of the Company.

2. Computerized tomography

such as magnetic resonance imaging (MRI), positron emission tomography (PET), or gait scan, provided that the service is received as an Outpatient.

3. Radiotherapy or chemotherapy received as an Outpatient under the supervision of a Physician.

4. Chiropractic, acupuncture, homeopathy, osteopathy and physical therapy.

The Covered Person must obtain pre-authorization from the Company before receiving the therapy or treatment, and the therapy or treatment must be performed by a person licensed to practice in the field of the therapy or treatment received by the Covered Person, and must be under the control of a Physician who has conducted examination and diagnosis, and planned the course of treatment that clearly specifies the duration and the expected outcome of the treatment.

5. Treatment using Traditional Chinese Medicine

The Company will pay benefits for treatment by Chinese traditional medicine that is performed by a licensed Chinese traditional physician recognized by the Company, who has conducted the examination and diagnosis, and planned the course of treatment that clearly specifies the duration and the expected outcome of the treatment. Payment of this benefit will not exceed 20 times per year, and will not be in excess of the benefit payable for each Covered Person as specified in the Policy.

Insuring Agreement - Emergency Treatment Outside Area of Cover

Insuring Agreement

While this Policy is in effect, the Company will cover charges for Emergency Inpatient Treatment which occur outside the Covered Person's Area of Cover up to the amount shown in the Table of Benefits. The Company will, in consultation with the treating Physician, retain the right to determine what constitutes as an Emergency treatment. The benefit coverage as provided under the specific plan in the schedule pays up to a maximum period of 30 day per trip (inclusive of the treatment days) and within the maximum limit of benefits per Policy Year which includes Inpatient Treatment required in the event of an Accident, or the sudden illness which presents an immediate threat to the Covered Person's health. Treatment by a Physician must commence within twenty-four (24) hours of the Emergency event.

Once the Company has determined, in conjunction with the treating Physician that the eligible Medical Condition is stabilized or the health status of the Covered Person allows him to travel back into his Area of Cover, the Company will stop paying for Emergency treatment.

The Insured is advised to contact the Company if the Covered Person is moving outside Area of Cover for more than thirty (30) days.

Exclusion:

This Policy does not cover benefits for any claims directly or indirectly arising from:

1. any curative or follow-up non-emergency Treatment.
2. special nurse care, unless with the written consent of the Company and in accordance with the Medical Standards.
3. any charges which are incurred for social or domestic reasons or for reasons which are not directly connected with the Medical Treatment.
4. When the Covered Person is admitted as an Inpatient if these Medical Treatments are purely for the convenience of the Covered Person or the Physician and can be reasonably rendered in an Outpatient setting.
5. maternity, pregnancy, childbirth or any complications of pregnancy or childbirth.
6. Inpatient Hospice and Palliative Care.
7. Treatment for any Medical Condition if a Covered Person has travelled outside his Area of Cover to get treatment (whether or not that was the only reason) or for any Medical Treatment which was, or may have reasonably been known about, before travel commenced.

Insuring Agreement - Health Check-Up

Insuring Agreement

While this Policy is in effect, when the Covered Person has been insured for at least 12 months consecutive months and has renewed the Policy under the former plan, the Company will pay a health check-up benefit according to the actual amount, but not exceeding the maximum limit of benefits specified in the schedule.

Insuring Agreement - Pre-existing Conditions Benefit

Insuring Agreement

While this Policy is in effect, and after the expiration of a waiting period of 270 days from the date this Policy first comes into effect, the Company will pay medical expenses according to the actual amount but not exceeding the maximum limit of benefits specified in the schedule, that are incurred by the Medical Treatment of a Pre-existing Condition, including the Medical Treatment at the acute stage of the Pre-existing Condition, regardless of whether it is of a Chronic nature, provided that the Insured or the Covered Person has declared this condition to the Company in the insurance application, health declaration, and any other additional declarations, and the Company has accepted it when the Company accepts the insurance application. This coverage must also be specified or shown in the schedule.

Insuring Agreement - Maintenance of Non-Pre-existing Chronic Conditions Arising After Enrolment

Insuring Agreement

While this Policy is in effect, if a Covered Person suffers any Illness that leads to a Chronic Condition as diagnosed and concluded by a Physician, the Company will pay medical expenses for the treatment of one or more Chronic Conditions based upon the amount of benefits per year as specified in the schedule. Expenses for the initial examination and diagnosis, and the suppression of the Chronic Conditions that occur after the procurement of this insurance will be covered under the insuring agreement for hospitalization and Surgery, or the insuring agreement for outpatient treatment, as per the case may be. This includes expenses for hospice and palliative care of cancer, such as medicines for suppression of growth or division of cancer cells, hemodialysis, etc.

The Medical Treatment must be provided by Physicians, using the methods generally accepted, subject to Reasonable and Customary Charges.

Insuring Agreement - Oral and Maxillofacial Surgery

Insuring Agreement

While this Policy is in effect, if a Covered Person sustains an Injury from an Accident or an eligible Illness that necessitates Surgery by a Physician, the Company will pay the benefits according to the actual amount, but not exceeding the maximum limit of benefits specified in the schedule, for oral and maxillofacial Surgery as follows:

(a) Surgical removal of impacted/un-erupted teeth and buried teeth which are diseased or causing symptoms;

(b) Surgical removal of complicated buried roots which are diseased or causing symptoms;

(c) Enucleation (removal) of cysts of the jaw;

(d) Treatment of Cancers (for lesion or lump in the mouth);

Note: This benefit does not include costs for routine dental care or other medical expenses specified in the extended coverage for dental care.

Insuring Agreement - Emergency Assistance Service

Additional Definitions

Designated Physician	means	a Physician designated by the Company to provide advice on the Covered Person's Medical Condition, appropriateness, and Medical Necessity related to the Medical Treatment of the Covered Person in the country in which the Covered Person receives Medical Treatment.
Emergency Assistance Service Center	means	an office or organization appointed by the Company to be its representative to assist a Covered Person who sustains an Illness or Injury while travelling outside Thailand, according to the service the Company agrees to provide to the Covered Person as specified in the Policy.
Emergency Assistance	means	the evacuation of a Covered Person to another Hospital that has medical equipment, either in the country, or in another country near the country in which the Covered Person sustains an Injury or Illness, or the repatriation of the Covered Person to his or her Main Country of Residence
Home Country	means	the country that the Covered Person has declared to the Company as his or her domicile, from which the Covered Person holds a passport.

Insuring Agreement

While this Policy is in effect, if a Covered Person sustains an Illness or an Injury from Accident or becomes ill suddenly that necessitates an immediate treatment as an inpatient in a Hospital, the Company will pay expenses for the international Emergency Assistance Service as described below.

1. The Emergency Assistance Service will be operated by an international Emergency Assistance Service Center that provides this service on behalf of the Company.

2. The Emergency Assistance Service can be provided in the following situations:

2.1 the Covered Person is hospitalized as an inpatient while travelling outside his or her Main Country of Residence, and the Designated Physician is of the opinion that a medical care that is appropriate or adequate for her or her Medical Treatment is not available or

2.2 the Covered Person is hospitalized as an inpatient in his or her Main Country of Residence, and the Designated Physician is of the opinion that a medical care that is appropriate or adequate for his or her Medical Treatment is not available.

2.3 After the Emergency Assistance Service under 2.1 or 2.2 is provided until the Covered Person can be discharged from the Hospital, the Company will pay expenses for repatriating the Covered Person to his or her Main Country of Residence or home country (a country that the member holds a passport for) by a regularly scheduled commercial airline or any other mode of transportation the Company considers appropriate.

The Company will not repatriate the Covered Person to his or her Home Country if the Covered Person is treated in a Hospital in the Main Country of Residence.

The Company has the right to decide whether to use a regularly scheduled commercial airline or another mode of transportation, as the Company considers appropriate, including the date and time of repatriation of the Covered Person.

3. If the Designated Physician is of the opinion that the Covered Person who is under the age of 18 must be accompanied by a person who is at least 18 years old during a journey, jointly with the Emergency Assistance Service Center, the Company will pay Reasonable and Customary Charges for the travelling and accommodation of the accompanying person during an emergency evacuation of the Covered Person who is under the age of 18 until the emergency evacuation is completed.

4. If the Designated Physician is of the opinion that any Covered Person who has a Medical Necessity must be accompanied by a person who is at least 18 years old during a journey, jointly with the Emergency Assistance Service Center, after completion of the emergency evacuation, the Company will pay expenses for the traveling of the accompanying person back to his or her Main Country of Residence that is not the Home Country by a regularly scheduled commercial airline. The accompanying person must be related to the Covered Person, such as a family member of the Covered Person under the same policy, or his or her spouse, sibling, or parent.

5. If the Covered Person dies while he or she is outside his or her Home Country, the Company will pay expenses for repatriating the mortal remains to the Covered Person's Main Country of Residence or Home Country.

6. The Company will not be responsible for any delay or inability to provide the Emergency Assistance Service, provided that the delay or inability is not caused by negligence on the part of the Company, the Emergency Assistance Service Center, or the Company's representative.

7. The Company will not be responsible for any delay or inability to provide the Emergency Assistance Service due to any of the following events:

7.1 the Emergency Assistance Service is prohibited by the law of the country in which the service is about to be provided or

7.2 the delay or inability to provide the Emergency Assistance Service is due to an external factor beyond the control of the Company, such as riot, failure of aircraft, flight delay, or denial of visa and

7.3 the Company will not be responsible for the death of the Covered Person during the provision of an emergency evacuation service, unless the death is due to failure or negligence on the part of the Company, or an agent providing the service on behalf of the Company, or is covered under the insuring agreement for loss of life, dismemberment, loss of sight, loss of hearing, loss of speech, or permanent disability from Accident.

8. The benefits for medical expenses of the Covered Person after the emergency evacuation will be in accordance with the terms and conditions applicable to him or her.

Request for Emergency Assistance Service while the Covered Person is outside his or her Main Country of Residence

1. If the Covered Person sustains an Illness or Injury while he or she is outside the Main Country of Residence, the Covered Person must contact the Emergency Assistance Service Center.

2. The Emergency Assistance Service Center will evaluate the situation and give advice if it is necessary to evacuate the Covered Person.

3. If it is necessary to evacuate the Covered Person, the Emergency Assistance Service Center will coordinate the evacuation of the Covered Person to the nearest suitable place for the Covered Person to receive Medical Treatment under his or her insurance plan.

4. If the Covered Person is under the age of 18, or the Emergency Assistance Service Center considers it appropriate, the Covered Person can have a person who is at least 18 years old accompany him or her during the emergency evacuation service.

Request for Emergency Assistance Service while the Covered Person is in his or her Main Country of Residence

1. If the Covered Person sustains an Illness or Injury while he or she is in the Main Country of Residence, the Covered Person must contact the Emergency Assistance Service Center.

2. The Emergency Assistance Service Center will evaluate the situation and give advice if it is necessary to evacuate the Covered Person to a Hospital that is medically equipped.

3. If it is necessary to evacuate the Covered Person, the Emergency Assistance Service Center will coordinate the evacuation of the Covered Person to the nearest Hospital or country that is medically equipped.

4. After the Covered Person is evacuated to a medically equipped facility, the Covered Person will receive Medical Treatment under his or her insurance plan.

5. If the Covered Person is under the age of 18, or the Emergency Assistance Service Center considers it appropriate, the Covered Person can have a person who is at least 18 years old accompany him or her during the emergency evacuation service.

If the Covered Person dies while he or she is outside the Main Country of Residence:

- his or her family must contact the Emergency Assistance Service Center in order to repatriate the mortal remains of the Covered Person to the Main Country of Residence or Home Country.

The Emergency Assistance Service Center will evaluate the necessity of the Emergency Assistance Service, and manage the evacuation as suitable for the provision of service.

The Emergency Assistance Service does not cover the Covered Person's entitlement to Medical Treatment. The entitlement to Medical Treatment will be in accordance with the terms and conditions under the Covered Person's insurance plan.

The general exclusions according to the conditions of this Policy will not apply during the emergency evacuation.

Exclusions

This Policy does not cover benefits for any claims directly or indirectly arising from:

1. any Medical Conditions that do not necessitate an immediate Emergency Medical Treatment in a Hospital as an inpatient, or do not prevent the Covered Person from travelling or working.
2. any medical condition that is directly or indirectly caused by a deliberately self-inflicted injury, suicide or an attempt at suicide
3. any medical condition that is in any way connected with alcohol abuse, drug abuse or substance abuse
4. the medical condition is a result of engaging in or training for any sport for which you receive a salary or monetary reimbursement, including grants or sponsorship (unless you only receive travel costs)
5. the Covered Person's engagement in BASE jumping, wingsuit jumping, piloting an aircraft not registered for carrying passengers and operated as a commercial aircraft, aircraft piloting instruction, aircraft piloting course, martial arts, free climbing, mountaineering with or without ropes, bouldering, hiking, cliff diving, scuba diving to a depth of more than 10 meters, trekking to a height of over two thousand five hundred (2,500) meters above sea level, bungee jumping, canyoning,

rappelling, hang-gliding, paragliding or microlighting, piloting a small plane, parachuting, potholing, cave climbing, cliff skiing, or any winter sports involving cliff jumping, skiing off piste or any other winter sports activity carried out off piste

6. an evacuation of the Covered Person from a vessel, oil rig, or any offshore facility
7. any expenses without the consent of the Company, including an emergency evacuation arranged or undertaken by the Covered Person himself or herself without the consent of the Company.
8. any medical condition services that the Covered Person fails to report to the Company within 30 days of the condition becoming an emergency (unless this was not reasonably possible) from the date of occurrence of the Injury or Illness and
9. any medical condition is a result of nuclear, biological or chemical contamination, war (whether declared or not), act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed
10. while the Covered Person travels in a country or area listed as a prohibited area by the ministry of foreign affairs of the Main Country of Residence.

Insuring Agreement - Psychiatric Treatment

Insuring Agreement

While this Policy is in effect, if a Covered Person suffers from a psychiatric Illness, the Company will pay Reasonable and Customary Charges for psychiatric treatment as an In-patient Treatment, Daycare Treatment at a registered psychiatric unit of a Hospital providing 24-hour medical supervision and evidence-based Treatment according to the actual amount, but not exceeding the maximum limit of benefits specified in the schedule. The Covered Person must obtain pre-authorization from the Company before commencing Treatment, and the total period of this Medical Treatment must not exceed 100 days in a Covered Person's Lifetime.

This benefit includes Hospital accommodation, prescribed medicines, Medically Necessary Treatment under the direct control of a psychiatrist.

Insuring Agreement - Accidental damage to natural teeth

Additional Definitions

Natural Teeth	means	Teeth/ tooth that is free of active clinical decay, has no gum disease associated with bone loss, no caps, crowns or veneers, not a dental implant and functions normally in chewing.

Insuring Agreement

While this Policy is in effect, if a Covered Person sustains an Injury from an Accident, causing damage to his or her natural teeth, the Company will pay Reasonable and Customary Charges, based on Medical Necessity, for dental services resulting from an Accident within seven days from the date of occurrence of the Accident, to the Covered Person according to the actual amount, but not exceeding the maximum limit of benefits specified in the schedule.

Exclusion:

This Policy does not cover:

1. damage to teeth due to consumption of food or drink or any foreign bodies contained in such food or drink.
2. normal wear and tear of teeth.
3. tooth brushing or any oral hygiene procedure.
4. the injury was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn.
5. the damage is not apparent within seven (7) days of the impact which caused the Injury.
6. the injury was caused by any means other than extra-oral impact.
7. Damage sustained to crowns, dentures, bridge work, or existing false teeth.
8. Injuries caused by Accidents or events not covered by this Policy
9. Costs for Treatment that has not yet taken place, even if it is being provided as part of a treatment package.

Insuring Agreement - Prenatal and Postnatal Complications

Insuring Agreement

While this Policy is in effect and after the expiration of a waiting period of 280 days from the effective date of the Policy, the Company will pay Reasonable and Customary Charges, based on the Medical Necessity, for treatment of prenatal and postnatal complications sustained by the Covered Person and the unborn child until birth, excluding maternity expense, according to the actual amount, but not exceeding the maximum limit of benefits specified in the schedule. Thereafter, the Company will pay benefits to the Covered Person only.

If there is any change to the insurance Plan which results in an increased premium, the benefits and coverages will not be varied until the Policy continues to be in effect for at least 280 days after the change.

Terms and Conditions

1. This Benefit is only available for female Covered Persons over the age of 18 years and applies to the mother alone.
2. The post-natal complications benefit only pays for Treatment received within 90 days following the delivery of child.
3. This benefit will not automatically be upgraded to a higher level of Plan. In the case of an upgrade in cover these benefits will be restricted to the level of the original Plan until the Covered Person has been covered under the upgraded Plan for a period of not less than 280 consecutive days.
4. This benefit pays for treatment of an eligible medical condition which is due to, and occurs to, the female Covered Person during the pregnancy prior to the delivery or after the delivery of child. The list of eligible pre- and post-natal complications include the following:
   - 4.1. Antiphospholipid syndrome,
   - 4.2. Cervical incompetence,
   - 4.3. Ectopic pregnancy,
   - 4.4. Gestational diabetes (if the Covered Person has exclusions because of past medical history related to diabetes, then this will not be covered during pregnancy),
   - 4.5. Hydatidiform mole – molar pregnancy,
   - 4.6. Hyperemesis gravidarum,
   - 4.7. Obstetric cholestasis,
   - 4.8. Pre-eclampsia / Eclampsia,
   - 4.9. Rhesus (RH) factor,
   - 4.10. Miscarriage requiring immediate surgical treatment
   - 4.11. Post-partum hemorrhage,
   - 4.12. Retained placental membrane.

Exclusions

This benefit does not cover for any claims directly or indirectly arising from:

1. pre- and post-natal complications if the pregnancy was a result of assisted means or any form of assisted conception or elective/non-Medically Necessary caesarean section birth.
2. costs of delivery of any child whether such delivery is by normal, by caesarean section or by any other assisted means.

Insuring Agreement - Newborn Accommodation

Insuring Agreement

While this Policy is in effect, the Company will pay for the hospital accommodation of a baby under 16 weeks, to stay with the mother who is a Covered Person under this Policy, while the mother is receiving Treatment for an eligible Medical Condition as an inpatient in the same hospital, according to the actual amount, but not exceeding the maximum limit of benefits specified in the schedule.

The benefit pays for newborn nursery accommodation of a standard class, where the newborn only receives nursery care during the stay in the Hospital. This benefit is not payable if the newborn is hospitalized for Treatment of any eligible Medical Condition. This benefit is paid from the mother's benefits.

Insuring Agreement – Vaccinations

Insuring Agreement

While this Policy is in effect and after the expiration of a waiting period of 12 months, and subject to the condition that the Insured has paid a renewal premium, the Company will pay Reasonable and Customary Charges for vaccinations received by the Covered Person, based on Medical Necessity, according to the actual amount, but not exceeding the maximum limit of benefits specified in the schedule.

Insuring Agreement - Hospice and Palliative Care

Insuring Agreement

While this Policy is in effect and after the expiration of a waiting period of 12 months, and subject to the condition that the Insured has paid a renewal premium, the Company will pay benefits for hospice and palliative care in a care center or facility where the Covered Person is admitted to, with a Physician's opinion, and the Company's written acknowledgment, that his or her Injury or Illness reaches its terminal stage. To receive benefit payment, the Covered Person must continue to renew this Policy every year, without decrease in the benefits. If the Covered Person fails to do so, the benefits will come to an end upon the expiration of the last Policy Year renewed by the Covered Person or when the amount of benefits paid by the Company reaches the maximum limit specified in the schedule.

If there is any change to the insurance Plan which results in an increased premium, the benefits and coverages will not be varied until the Policy continues to be in effect for at least 12 months after the change.

Insuring Agreement - Loss of Life, Dismemberment, Loss of Sight, Loss of Hearing, Loss of Speech, or Permanent Disability from Accident (PA.2)

Additional Definitions

Dismemberment	means	amputation of limb from the wrist or ankle, including the total loss of function of that part which, according to a clear medical indication, will be incapable of functioning again.
Loss of Sight	means	complete, permanently incurable, blindness.
Total Permanent Disability	means	disability to the extent of being unable to perform the normal duty in the Insured's regular occupation or any other occupation totally and permanently and such permanent disability prevent the Covered Person to perform 3 or more activities of daily living by himself/herself. Activities of Daily Living (ADL) means the ability to perform 6 types of daily self-care activities which is a term used in healthcare to assess the patient. The Activities of Daily Living consist of (1) The ability to move from chair to bed and vice versa without the help another person or equipment. (2) The ability to move from one room to another without the help of another person or equipment. (3) The ability to put on and take off clothes without the help of another person or equipment. (4) The ability to wash body in a bath or shower including the ability to get to and from the bathroom without the help of another person or equipment. (5) The ability to feed oneself without the help of another person or equipment. (6) The ability to get to and from the toilet, using it appropriately, and cleaning oneself without the help of another person or equipment.
Partial Permanent Disability	means	a disability that renders a permanent inability to perform any regular duties of one's own occupation, but does not prevent the engagement in other work for remuneration.

Insuring Agreement

While this Policy is in effect, if a Covered Person sustains an Injury from an Accident, causing him or her to die, or to suffer Dismemberment, Loss of Sight, loss of hearing, loss of speech, or Total Permanent Disability within 180 days from the date of the Accident, or if the Injury sustained by the Covered Person necessitates his or her continuous treatment as an inpatient in a Hospital and the Covered Person dies as a result of that Injury at any time, the Company will pay compensation as follows:

1.	100% of the sum insured	For loss of life
2.	100% of the sum insured	For Total Permanent Disability that continues for not less than 12 months after the Accident, or with a medical indication that the Covered Person will become a totally and permanently disabled person.

3.	100% of the sum insured	For the loss of both hands at or above the wrists, or the loss of both feet at or above the ankles, or the Loss of Sight of both eyes.
4.	100% of the sum insured	For the loss of one hand at or above the wrist and the loss of one foot at or above the ankle.
5.	100% of the sum insured	For the loss of one hand at or above the wrist and the Loss of Sight of one eye.
6.	100% of the sum insured	For the loss of one foot at or above the ankle and the Loss of Sight of one eye.
7.	60% of the sum insured	For the loss of one hand at or above the wrist.
8.	60% of the sum insured	For the loss of one foot at or above the ankle.
9.	60% of the sum insured	For the loss of sight of one eye.
10.	50% of the sum insured	For the loss of hearing in both ears or the loss of speech.
11.	15% of the sum insured	For the loss of hearing in one ear.
12.	25% of the sum insured	For the loss of a thumb (both phalanges).
13.	10% of the sum insured	For the loss of a thumb (one phalanx).
14.	10% of the sum insured	For the loss of an index finger (three phalanges).
15.	8% of the sum insured	For the loss of an index finger (two phalanges).
16.	4% of the sum insured	For the loss of an index finger (one phalanx).
17.	5% of the sum insured	For the loss of any finger (at least two phalanges) other than a thumb or an index finger.
18.	5% of the sum insured	For the loss of a big toe.
19.	1% of the sum insured	For the loss of any one toe (at least one phalanx) other than a big toe.

The Company will compensate for only one item of loss with the highest amount of compensation. In the case of a total permanent loss of a finger or toe under items 12 to 19, for which no compensation under items 1 to 9 is claimable, the Company will compensate for the respective items of the actual loss, provided that the aggregate amount of compensation will not exceed the insured sum as specified in the schedule.

In the case of a Partial Permanent Disability, other than the loss of taste or smell, for which no compensation as specified under items 2 to 19 is claimable, the Company will pay compensation according to the opinion of the Company's Physician, but no more than 50 percent of the insured sum specified in the schedule.

Throughout the insurance period, the aggregate amount of compensation paid by the Company for the consequences covered hereunder will not exceed the sum specified in the schedule. If the amount of compensation paid by the Company under this coverage agreement has not yet reached the full amount of the insured sum, the Company will provide coverage hereunder until the expiration of the insurance period, in accordance with the balance of the insured sum.

Claim for benefits for loss of life

The beneficiary, at his or her own expense, must submit the following evidence to the Company within 30 days from the death of the Insured:

1. a claim form as prescribed by the Company
2. a death certificate

3. a copy of the post-mortem report certified by the police officer in charge of the case or the agency issuing the report
4. a copy of the daily case report certified by the police officer in charge of the case
5. copies of the Insured's citizen identification card and house registration indicating the "deceased" status of the Insured and
6. copies of the beneficiary's citizen identification card and house registration.

Claim for Benefits for Total Permanent Disability, Dismemberment, Loss of Sight, loss of hearing, or loss of speech

The Insured, at his or her own expense, must submit the following evidence to the Company within 30 days after the date of a Physician's diagnosis that the Insured has suffered a Total Permanent Disability or Dismemberment:

1. a claim form as prescribed by the Company and
2. a medical report that confirms the Total Permanent Disability, Dismemberment, Loss of Sight, loss of hearing, or loss of speech.

Failure to submit the evidence within the prescribed time will be without prejudice to the right of claim, if it can be proven that the failure is justified and the evidence is submitted as soon as practical.

Endorsement - Maternity Benefit

Extended coverage

While the Policy is in effect and the waiting period has lapsed, the foregoing Policy will extend its maternity coverages and benefits. the Company agrees to pay maternity benefits that cover expenses incurred in a Hospital or medical center, and Physician's fees for each pregnancy and child delivery, according to the actual amount but not exceeding the maximum limit of benefits per year as specified in the schedule.

Terms and conditions

1. The Covered Person must have been covered under this benefit for at least 280 days, and is a female not under the age of 18.

Exclusions

This attachment does not cover benefits for any claims directly or indirectly arising from:

1. Medical Treatment as a result of unnatural pregnancy or pregnancy by artificial insemination, and
2. Medical Treatment Outside Area of Cover, even if it was due to an Emergency.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will prevail. All other terms, conditions and exclusions remained unchanged.

Endorsement - Dental Care Benefit

Additional Definitions

Dentistry means a practice done to human beings in relation to examination, diagnosis, curing, or treatment of teeth, organs related to teeth, dental organs, intraoral organs, jaw and maxillofacial bone, including surgical or any other procedures for the purpose of curing, restoring, and rehabilitating intraoral organs, jaw and maxillofacial bones, as well as intraoral dental services.

Insuring Agreement

While the Policy is in effect, the foregoing Policy will extend its dental care coverages and benefits.

The Company agrees to pay dental care benefits to the Covered Person for treatment performed by a Dentist as a result of dental disease diagnosis, according to the actual expenses necessarily and reasonably incurred, but not exceeding the maximum limit of benefits specified in the schedule. This extended coverage covers:

1. teeth polishing and scaling
2. tooth fillings and restoration
3. oral examination
4. dental x-rays
5. dental extraction
6. root canal treatment
7. bridgework and crowns and
8. treatment of gum disease.

Exclusions

This attachment does not cover benefits for any claims directly or indirectly arising from:

1. expenses for mouth guards, gum shields, or any dental appliances
2. a treatment by means of burial of any artificial device, including oral preparation before burial of artificial device or before crowning
3. teeth whitening and orthodontics
4. a request for treatment or dental Surgery that is not advised by a Dentist, any medical service not necessary for a treatment, including any treatment or cosmetic Dentistry for beauty only, and not for restoration of normal function of organs or for oral hygiene
5. a treatment by a specialist, that is not a Dentistry performed by a general Dentist
6. wisdom teeth extraction other than the extraction due to a Surgery
7. treatment, repair, or any Dentistry services relating to tooth jewellery
8. Dentistry treatment due to damage or an Injury arising from playing, training, or competing in contact and collision sports, such as boxing, martial arts, rugby, American football, hockey, or lacrosse, unless mouth protection is worn according to the type of the sports or sporting activity, and

9. expenses for all kinds of orthotics and prostheses, including dentures or any dental prosthetics.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will prevail. All other terms, conditions and exclusions remained unchanged.

Endorsement - Optical Care Benefit

Additional Definitions

Ophthalmologist means a person (other than the Covered Person, or his or her family member) who is duly registered with the Medical Council, and is licensed to practice the ophthalmology profession in the locality in which the services are provided.

Insuring Agreement

While the Policy is in effect, the foregoing Policy will extend its optical care coverages and benefits.

The Company agrees to pay benefits according to the actual expenses necessarily and reasonably incurred, but no more than the amount of benefits specified in the schedule, for an eye examination, visual acuity test, eyeglasses, and corrective spectacle lenses, performed and prescribed by an Ophthalmologist.

Exclusions

This attachment does not cover benefits for any claims directly or indirectly arising from:

1. cost of tinted lenses, sunglasses, non-corrective contact lenses, irrespective of whether they are prescribed by an Ophthalmologist or
2. Lasik or any similar treatment.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will prevail. All other terms, conditions and exclusions remained unchanged.

Endorsement - Co-Payment

Additional Definitions

Co-payment means liability shared between the Company and the Covered Person for medical expenses payable pursuant to a benefit amount after deduction of the Deductible (if any). The Covered Person's Co-payment will be determined in terms of an amount per time, or an amount for a single Illness, or a percentage of the covered expenses as specified in the schedule.

Insuring Agreement

While the Policy remains in effect, the foregoing Policy will include an additional co-payment condition. The Company agrees to pay benefits to the Covered Person according to the co-payment conditions.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will prevail. All other terms, conditions and exclusions remained unchanged.

Endorsement - No Claim Discount In case of Good Claim Record

Insuring Agreement

It is hereby agreed that during the period of this Policy being in force and while this insurance Policy is effective.

In the conclusion of compensation claims under this insurance Policy (a full period of 1 year or more), if the Company has not paid claims for compensation under the insurance agreement during the preceding full year of insurance, and the Insured has renewed the Policy of the previous policy, the Company will reduce the renewal premium subject to the agreed no claims discount rate as 5% of the renewal premium provided there has been no requests for compensation under the insurance agreement during the preceding full year of insurance.

Any existing no claim discount rate is lost:

- when there is an eligible claim made under the policy; or
- if the Insured cancels a plan and reapplies for a new plan.

The no claim discount is not transferable.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will prevail. All other terms, conditions and exclusions remained unchanged.

Summary of Terms and Conditions
International Exclusive Individual Health and Accident Insurance Policy

Definitions

Area of Cover	means	1. **Asia** means Bangladesh, Bhutan, Brunei, Cambodia, China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kirghizstan, Laos, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, the Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, and Vietnam. 2. **worldwide except the USA,** which means all countries around the world except the USA and its surrounding islands and 3. **worldwide,** which means all countries around the world.
Outside area of cover	means	the coverage that is provided only for Emergency Medical Treatment not arising during travel undertaken directly for securing Medical Treatment, or that is prepared while a Covered Person travels out of the Area of Cover.
Emergency	means	A sudden, serious, and unforeseen acute Medical Condition or injury requiring immediate medical treatment, that without treatment commencing within twenty-four (24) hours of the Emergency event could result in death or serious impairment of bodily function.
Main Country of Residence	means	the country in which a Covered Person resides for more than 185 days per year, that is specified as his or her address in the Policy.
Congenital Condition	means	all kinds of congenital abnormalities, including physical anomalies happening during six months from birth, that are categorized as congenital malformations by the World Health Organization, and deformations or genetic abnormalities, including all kinds of hernia or epilepsy, except epilepsy caused by an Injury after the Covered Person has obtained the insurance.
Chronic Condition	means	a Medical Condition or Illness that is persistent and lasting, or continues indefinitely, as diagnosed and concluded by a Physician.
Medical Standards	means	the international medical basis or guidelines that give rise to an appropriate course of treatment for a patient, according to Medical Necessity and consistent with conclusions drawn from Injury records, findings, diagnosis results or any other reason.
Medical Necessity	means	any eligible Treatment, test, medication, or stay in Hospital or part of a stay in Hospital which: • is not being undertaken for the convenience of the Insured, the treating Physician, Hospital or Clinic; and • is required for the diagnosis, direct Treatment and medical management of an eligible Medical Condition suffered by the Insured as prescribed by his Physician; and • must not exceed the level of care necessary to provide safe, adequate, and appropriate medical care in scope, duration, or intensity; and • must conform to the professional medical standards widely accepted; and

		• shall be considered and approved by the Insurer and their medical advisors as the most appropriate, cost effective, Conventional Treatment and not of an Experimental, investigational, research or preventive nature.
Reasonable and Customary Charges	means	any medical expenses and/or reasonable costs comparing to those charged to general patients for services provided by a Hospital, or medical center or clinic where a Covered Person is treated. For the avoidance of doubt when comparing treatment, the Company will take into account the complexity of the procedure and the standard of the medical facility where the treatment is received.
Medical Condition	means	any disease, Injury, Illness, including mental Illness, that has been diagnosed and concluded by a Physician.
Pre-existing Condition	means	any Medical Condition preceding the Policy Commencement Date, or plan upgrade date, whichever date is later: • for which the Covered Person has been diagnosed; or, • for which the Covered Person has sought or received medication, advice, or Treatment, or, • which the Covered Person should reasonably, based on the Company's independent appointed Physician's opinion, have known about, or, • for which the Covered Person have experienced symptoms even if the Covered Person has not consulted a Physician or was not diagnosed before the start of the cover.
Associated Medical Condition	means	any symptom, disease, injury, or illness that is: i. a medical condition caused by or related to directly or indirectly to a Pre-existing condition; or ii. a medical condition in which the underlying condition (disease, injury, or illness) is generally known to be same with the underlying disease that cause a Pre-existing condition; or iii. a risk factor that is generally or directly known to be a medical condition that may cause or is arising from a medical condition that may cause pre-existing condition.

General conditions

Incontestability

The Company will not contest or challenge the validity of this insurance agreement if the Policy has been in effect for a period of two years or more from the date the Policy comes into effect or the date of the Company's approval of additional benefits under this Insurance Agreement, whichever happens later, except in the case of default of premium payment. However, upon the approval of additional benefits, the Company may dispute or object to the incompleteness of this Insurance Policy regarding such additional benefits only.

If the Company becomes aware of any information based upon which the agreement can be nullified, but does not exercise its right of nullification within one month from the date that information is known to the Company, the Company may no longer nullify the validity of the agreement on these grounds.

Governing law

This Policy is governed by, and interpreted in accordance with, the laws of Thailand. The Insured and/or the Covered Persons agree that Thai law is the exclusive law for settling all disputes arising from or in connection with this Policy.

Termination of coverage

1. This Policy will automatically terminate upon the occurrence of any of the following events:

1.1 the Insured fails to pay a premium as specified in, premium payment and commencement of coverage, of the general conditions.

1.2 on the expiration date of the coverage as specified in the schedule at midnight, Thailand time, in the Policy Year when the Insured is 99 years of age.

1.3 on the date either party exercises its right to terminate the Policy according to, termination of the Policy, of the general conditions.

2. The coverage of each of the Covered Persons will automatically terminate upon the occurrence of any of the following events:

2.1 when the Covered Person dies of an illness, the Company will return the premium to the beneficiaries after deducting a proportionate amount thereof for the period during which this Policy is in effect, provided no claims was paid out for that Policy Year.

2.2 on the expiration date of the coverage as specified in the schedule, at midnight, Thailand time, provided that the Company has refused renewal of the Policy for the respective Covered Persons by sending a written notice to the last known address or email address at least thirty (30) days before the expiration of the Policy.

The coverage under each of the insuring agreements and/or attachments will terminate when the compensation paid by the Company reaches the maximum benefit limit specified therein.

Submission of evidence to claim for benefits under the Policy

To claim for the benefits under this Policy, the Covered Person or his or her representative, as per the case may be, must submit the following evidence to the Company at his or her own expense:

1. a form of claim for Medical Treatment or other benefits as prescribed by the Company
2. an original medical certificate or medical report that specifies the significant symptoms, the diagnosis results, and the treatments and
3. the original and copy of receipt listing expenses.

The foregoing evidence must be submitted within 30 days from the date of discharge from a Hospital or medical center, or the date of treatment at a clinic. The receipt must be an original. The Company will return the original receipt, bearing the certification of the amount paid, to the Covered Person for use in a claim for a shortfall amount from another insurer. If the Covered Person is already compensated by government welfare or any other welfare, or other insurance, the Covered Person may submit a copy of the receipt bearing the certification of any amount paid by the government welfare or other agency in order to claim the shortfall amount from the Company.

Failure to submit the evidence within the prescribed time will be without prejudice to the right of claim, if it can be proven that the failure is justified and the evidence is submitted as soon as is practical.

Pre-Existing Conditions

The Company will not pay benefits under this Policy for any Chronic disease, Injury, or Illness (including any complication) not yet fully cured before the date this Policy first comes into effect, unless:

1. the Covered Person has declared that condition to the Company, and the Company agrees in writing to accept that condition when the Company accepts the insurance application without excluding the coverage

2. this Policy has been in effect for a continuous period of at least three years, and the Chronic Condition, Injury, or Illness (including any complication) has not appeared, or has not been treated, or diagnosed by a Physician, or no consultation or advice has been sought from a Physician during five years before the date this Policy first comes into effect, which would have been sufficiently crucial for an ordinary person to seek diagnosis, care, or Medical Treatment by a Physician, or for a Physician to provide diagnosis, care, or Medical Treatment.

General Exclusions

Described in this Insurance Policy such as congenital disorders, treatment under trial, fertility and infertility treatment (including investigation and treatment), convalescence or rest for rehabilitation or rest cure, and so on and any exclusions or non-coverage as indicated in each coverage agreement.

Insuring Agreement

1. Hospitalization and Surgery
2. Medical Treatment without Hospital Confinement (outpatient treatment)
3. Emergency Treatment Outside Area of Cover
4. Health Check-Up
5. Pre-existing Conditions
6. Maintenance of Non Pre-existing Chronic Conditions arising after enrolment
7. Oral and Maxillofacial Surgery
8. Emergency Assistance Service
9. Psychiatric Treatment
10. Accidental damage to natural teeth
11. Prenatal and Postnatal Complications
12. Newborn Accommodation
13. Vaccinations
14. Hospice and Palliative Care
15. Loss of Life, Dismemberment, Loss of Sight, Loss of Hearing, Loss of Speech, or Permanent Disability from Accident (PA.2)

Endorsement

1. Maternity Benefit
2. Dental Care Benefit
3. Optical Care Benefit
4. Co Payment
5. No Claim Discount In case of Good Claim Record

Remarks

This document only serves as a summary of important information. Full details of general conditions, insuring agreements and exclusions of the Insurance Policy is to follow the Policy Wording for International Exclusive Individual Health and Personal Accident Insurance Policy which has been approved by the Office of Insurance Commission (OIC). The Company has the right to select coverages/ endorsement for product packaging.

This document is a summary of essences and some parts of coverage conditions and exclusions only.

Please carefully read and understand all details in this Insurance Policy.

Contact our Agent / broker

Contact us

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