



IMPORTANT RENEWAL ANNOUNCEMENTS

Dear Valued Policyholder:

DON'T MISS OUT! Make the transition from your current Blue Royale Premier Medical Plan to Blue Royale Medical Plan for more comprehensive coverage and peace of mind. As your Insurance Policy renewal draws near, please be reminded that your:



Blue Royale Premier Medical Plan will be discontinued after one (1) Policy year:

Pacific Cross is committed to offer better products and services that will be able to fulfill our clients' needs especially when they need it most. As previously shared, it was the Company's intent to discontinue some of our medical plans (including the Blue Royale Premier Medical Plan) and streamline our Blue Royale Medical Plan line – extending its maximum age of eligibility from 65 years old to 100 years old. Our Blue Royale Plans A, B and C were made available to Policyholders over 65 years of age – providing an all-inclusive medical and travel coverage to our senior-aged Policyholders. **If you opt to renew now under a more comprehensive plan, please refer to the Senior Plans Flyer for more details.**

However, if you choose to retain your Blue Royale Premier Medical Plan, you can continue to avail of this plan for one (1) more Policy year with the following plan updates:



Key Policy Changes: We have expounded on certain definitions, policy benefits and provisions for clarity and alignment. Please review this material to know what other changes to expect when you receive your Insurance Policy upon renewal.



General Price Adjustments: Our regular pricing review considers several factors such as the rising over-all company claims experience, economic inflation, as well as the increasing cost of medical treatment and advancement. These factors have constrained us to increase our premiums for Renewal Business effective 1 November 2025.

Pacific Cross Insurance, Inc.

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Free Unlimited 24/7 Teleconsultations: We are #HereForYou to help you get faster and easier quality healthcare access. In partnership with KonsultaMD, you can enjoy unlimited medical consultations whenever and wherever.



Value Plus Rewards Promo: It pays to pay on time with Pacific Cross! If you pay your Premiums on or before your renewal due date, Insured Persons under your Insurance Policy who are 18 years old and above become qualified for our Value Plus Promo. As you secure your health, you will also enjoy perks and rewards from us. Please refer to our promo flyer for more details.

For concerns or clarifications on any of these updates, please do not hesitate to reach out to us. Please refer to your Renewal Notice for your Renewal Officer's name and contact details. You can also get in touch with us through telephone number +63 2 8230-8533 or e-mail renewal@pacificcross.com.ph.

It has been our privilege to serve you this past year. We look forward to keeping you in our valued circle of Policyholders.

Thank you and we remain at your service.

Your Pacific Cross Renewal Team



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KEY POLICY CHANGES FOR BLUE ROYALE PREMIER (MAJOR AND STANDARD)



OTHER BENEFITS RECOVERABLE FROM OTHER INDEMNITIES

A statement was added, and examples were included to elaborate that the reference amount for claims payment is not the gross amount (i.e., it should exclude discounts and any amount that was not actually charged to the client.).

Schedule 3: Schedule of Benefits

The benefits in the Sub-Schedule are IN ADDITION TO any benefits recoverable from PhilHealth or any other insurances or indemnities; or from Insured's expense reduction through assistance or discounts provided by private or government institutions (such as but not limited to PCSO, Senior Citizen, Person with Disability and other discounts). Cost not actually incurred are excluded from the basis of claims adjustments and are not refundable.



COUNTRY OF RESIDENCE, COVERAGE ABROAD AND TREATMENT AREA LIMITATION

The Country of Residence was redefined into number of days instead of months. It was reiterated that the client's written advice is required at the time of application or renewal of the Policy in case of change of country of residence. If approved, the additional premiums must be paid before travelling.

Coverage Abroad was revised to clarify the overseas travel limits that should be aligned with the Country of Residence, i.e., the ninety (90) days per trip limit should not exceed the one hundred eighty (180)-day accumulated stay abroad per Period of Insurance.

Coverage Abroad and Treatment Area Limitation provisions were restructured to ensure continuous and related implications for a clearer provision. Extension beyond the *regular* number of days limit were also restructured for clarity.

Schedule 3: Schedule of Benefits

Emergency Overseas Coverage

Overseas coverage is for up to 90 days per trip and 180 accumulated days overseas per Period of Insurance, except if Treatment Area Limitation (TAL) discount is selected

DEFINITION OF TERMS

Shall be each Insured Person's place of residence or place of employment for at least one hundred eighty five (185) days within the Period of Insurance. It is deemed to be the Philippines unless otherwise declared by the Policyholder and approved by the Company through an Endorsement, in which case coverage shall be governed by additional terms and conditions as specified in the Endorsement attached to the Policy.

COVERAGE ABROAD

Travel outside the Country of Residence to another foreign destination for more than ninety (90) consecutive days per trip or for a total of more than one hundred eighty (180) accumulated days within the Period of Insurance shall be deemed a change of Country of Residence for coverage purposes.

If the Insured Person plans to exceed the ninety (90)-day trip limit or one hundred eighty (180)-day accumulated overseas stay limit, the Company must be informed in writing at the time of application or renewal of the Policy, and the required additional premiums must be paid prior to travel. Failure to inform the Company and pay the applicable premium will result in ineligibility of benefits for claims incurred beyond the stated limits.

The benefits listed in Schedule 3 of the Policy apply to overseas medical treatment in the following situations:

- a.) Coverage remains active for Emergency conditions or Accidents that occur wholly while traveling on a non-medical related basis, for: up to ninety (90) days per trip, or up to one hundred eighty (180) accumulated days overseas within the Period of Insurance, or the approved stay period, whichever is shorter. If an extension of stay becomes necessary, overseas coverage may continue only if all of the following conditions are met:
 - i. The Insured Person did not travel abroad for medical treatment; and
 - ii. The Insured Person's prolonged stay is directly due to a covered Emergency or Accident that required Confinement, which began on or before the ninetieth (90th) day of the trip or the one hundred eightieth (180th) accumulated stay, or the end of the approved stay period.

The extended overseas coverage will cease once the Insured Person is discharged from the hospital, and all benefits remain subject to the limits in Schedule 3.

- b.) If the Insured Person's primary reason for going abroad is to seek medical treatment or non-emergency care, overseas coverage is strictly limited to ninety (90) days per trip and one hundred eighty (180) accumulated days per Period of Insurance. No extensions will be granted for such trips.

If there is an avilment of treatment for covered conditions, the Insured Person is required to pay for all related medical expenses and submit a reimbursement claim upon return to the Country of Residence. Reimbursement of medical expenses will be based on the normal and customary rate applicable in the geographical area where the treatment occurred, subject to the terms and limits of Schedule 3 of this Policy.

TREATMENT AREA LIMITATION

3.4.1 When a Treatment Area Limitation discount option is selected, limited benefits apply in the following countries: Canada; United States of America, its dependent territories, and the Caribbean Islands; Japan; People's Republic of China; Hong Kong and Singapore.

3.4.2 The limited benefits as referred to in 3.4.1 are the following subject to the terms and conditions of this Policy:

- a.) In-Patient/Hospitalization Benefits apply if the treatment is for an Emergency condition or Accident which occurs wholly while the Insured Person is traveling on a non-medical related basis, and

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provided the Insured Person was not symptomatic or suffering from the same condition or Injury prior to travel. Coverage is limited to thirty (30) days per trip, or until the condition can be safely treated in the Country of Residence, whichever occurs first.

Extension of coverage beyond the thirty (30)-day per trip limit may continue only if all of the following conditions are met:

- i. The Insured Person did not travel abroad specifically for medical treatment; and
- ii. The Insured Person's prolonged stay is a direct result of a covered Emergency or Accident which required Confinement that began on or before the thirtieth (30th) day of the overseas trip.

Coverage shall cease once the Insured Person is discharged from the hospital, and all benefits remain subject to the limits in Schedule 3.

- b.) Other applicable benefits (aside from Section 3.4.2a above) as specified in Schedule 3 of this Policy, excluding Maternity Benefit, may be availed only if the medical condition or Injury occurred wholly while traveling on a non-medical related basis, and the Insured Person was not symptomatic or suffering from the same condition or Injury prior to travel. Coverage is limited to thirty (30) days per trip. No extensions shall be granted.

The Pre-Existing Condition and the Coverage Abroad provision as specified in Sections 3.1 and 3.3 of this Policy will still apply.



PRE-EXISTING CONDITIONS

Definition and Policy Benefits have been revised to impose a one-year waiting period on a defined list of six (6) illnesses that are chronic in nature. As a renewing client, the eligibility of your claim will still be evaluated based on your declarations in the original Application, Application for Reinstatement and all other subsequent declarations including but not limited to Application for Amendment and Declaration of Insurability.

DEFINITION OF TERMS

Any Disability:
(...)

Pre-Existing Conditions shall always include the following Disabilities along with their complications and sequelae even if the Insured Person was unaware of such Disability at the time of application for this Policy:

- a.) Mass/Tumors/Cyst of Internal Organs or on Skin, Muscular Tissue, Bone, or any form of Blood Dyscrasias, regardless of histopathological feature
- b.) Diabetes Mellitus, Hypertension, Cardiac and Vascular Conditions, and Cerebrovascular Diseases/Transient Ischemic Attack
- c.) Urinary Calculi/Gallbladder Stone, including Cholecystitis
- d.) Goiter and other Thyroid Disorders
- e.) Asthma/Chronic Obstructive Lung Disease
- f.) Degenerative Bone/Joint Disease including Gout, and Spinal Column Abnormalities

The Disabilities listed above, along with their complications and sequelae are covered only after a one-year waiting period from the Insured Person's inclusion in the Policy unless disclosed to and added by an Endorsement from the Company.

Diagnostic procedures undertaken to determine the existence of a Pre-Existing Condition is a covered expense provided that the result of the diagnostic procedure test is negative for the existence of the Pre-Existing Condition.

POLICY BENEFITS

Pre-Existing Condition declared to the Company and has been included by an Endorsement is covered according to the terms specified therein.

Unless disclosed to and added by an Endorsement from the Company, coverage for Disabilities listed in Section 1.44 shall be subject to a waiting period of one (1) year, even if the Insured Person was unaware of such Disability at the time of application for this Policy.

Pre-Existing Conditions shall only be covered if there is no failure to disclose, misrepresent or conceal material information in the original Application, Application for Reinstatement and all other subsequent declarations including but not limited to Application for Amendment and Declaration of Insurability.

Notwithstanding the disclosure by the Insured Person of a Pre-Existing Condition, the Company may permanently exclude from cover or restrict coverage for a specific medical condition or Disability upon written notice to the Insured Person. Any immediate coverage for Pre-Existing Conditions may be subject to additional premiums and/or limited coverage, subject to the conformity of the Insured.



FREE NEWBORN CHILD COVERAGE | LEVEL OF COVERAGE

The Level of Coverage available under Free Newborn Child Coverage was clarified in this provision.

The cover and the level of benefits under this Policy in respect of the child shall be the same as that of the Insured Person but subject to the eligibility age of such benefit. The Free Newborn Child Coverage does not include coverage for Optional Benefits or Riders which require separate application, declarations, underwriting and Policy issuance. If both parents are Insured Persons of the Company and each has different levels of benefits, then the level of benefits for the child shall be the lower level of benefit.
(...)



CLAIM SUBMISSIONS | PROOF OF CLAIM

The maximum prescriptive period to submit proof of claim was indicated.

(...)
Completed claim forms and written proof of loss must be received at the Head Office of the Company within ninety (90) days after the date of such loss. If it is not reasonably possible to give proof within this period, they must be received by the Company within three hundred sixty five (365) days from the date when the claim was incurred.

(...)



BENEFIT PAYMENT | PAYMENT OF BENEFITS

The sequence of claims computation was clarified.

If an Insured Person incurs eligible expenses during the Period of Insurance, the Company will pay benefits in accordance with the Schedule of Benefits in Schedule 3 of the Policy. The total amount payable will be determined by first applying the inner limits specified in the Schedule of Benefits. From this amount, any stipulated co-payment, deductible, co-insurance, and other applicable deductions will be subtracted. For the computation of Deductible, other HMO benefits and/or private insurance policies may be considered, subject to the submission of a claims adjustment report from the relevant HMO and/or private insurance providers.

