

Healthcare Insurance Policy (Attach to Expat Care Plan)

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MEDICAL UNDERWRITING TERMS AND CONDITIONS

- **Moratorium:** if your application for this insurance has not been underwritten on any of the above terms a moratorium will apply. This means that any medical condition (with the exception of a chronic condition) which existed in the five years prior to the date of entry to this Plan will become eligible for cover 2 years after the member joins and shall cease to be excluded or be subject to any special terms specified on the Policy Schedule or endorsed on this Policy. (see General Condition 5.19)
- **Pre-existing Chronic conditions:** none of the above medical underwriting terms apply to pre-existing chronic conditions. Any chronic condition which existed prior to the date of entry of an insured person to this Plan is excluded under this policy (see Section 1.2 Specific Exclusion)

TRAVEL OUTSIDE THE SPECIFIED GEOGRAPHICAL AREA

When the insured person is travelling outside the countries of the geographical area specified on the Policy Schedule issued to the insured person we will pay for emergency treatment only. This emergency cover will only operate when the insured person does not travel for more than the number of days in total specified in the Table of Benefits in any one period of insurance.

Non-emergency treatment is not covered at all outside the geographical area specified on the Policy Schedule.

HOW THE HEALTHCARE PLAN OPERATES

This Policy describes the benefits which are available, but the cover which will be provided to each insured person will be in accordance with the plan selected that is specified in the Policy Schedule issued to the insured person and with the Table of Benefits which attach to and form part of this Policy. Any benefit not included in the plan selected and the Table of Benefits does not apply. Premium payments can be made to us in Baht or in any other major currency as agreed with us. Where the currency is other than Baht, the exchange rate must be provided by us.

The insurance is effective only after the applicant has been accepted for cover by the Insurer and becomes, and remains, insured in accordance with the terms, provisions, conditions and exclusions laid down in this Policy.

In the event of the insured person's incapacity or decease, his / her legal personal representative shall have the right to act for him / her or his / her estate.

Benefits are payable on behalf of the insured person to the licensed providers of the medical, maternity care and / or dental treatment and service insured under this Policy, or alternatively are reimbursable to the insured person.

Benefit payments shall be processed by claims administrators, specialised in the handling of medical claims, who are appointed by the Insurer.

DEFINITION

Wherever the following words and phrases shown below in CAPITALS appear in this Policy (and in the Policy Schedule AND Table of Benefits attaching to and forming part of the Policy) they will always have the meanings defined below.

ACCIDENT / INJURY means a sudden and unforeseen bodily injury caused by violent or external means.

ANNUAL LIMIT means the maximum benefit limit payable per person per policy year.

CHRONIC means an illness or injury which has one or more of the following characteristics:

- It has no known recognised cure
- It continues indefinitely
- It recurs or is likely to recur
- It is permanent
- Requires palliative treatment
- Requires long-term monitoring, consultations, check-ups, examinations or tests
- Requires rehabilitation or special training to cope with it.

COINSURANCE means the proportion of costs for which the insured person remains responsible, when specified in Policy Schedule. The insured person must pay the coinsurance in respect of each diagnosed medical condition covered under this Policy.

COMPANY means Pacific Cross Health Insurance PCL.

COMMENCEMENT DATE means the date on which this Policy becomes effective as specified in the Policy Schedule.

COUNTRY OF RESIDENCE OR RESIDENTIAL ADDRESS means the country or countries where the insured person has his / her primary and / or secondary home(s), as stated on the Application Form and specified in the Policy Schedule.

DATE OF ENTRY means the date that cover first starts for an insured person.

DAY-CASE shall mean treatment provided in a hospital where an insured person is admitted but is not required, out of medical necessity, to stay overnight.

DEDUCTIBLE means the fixed amount which the insured person must pay for each insured event as specified in the Table of Benefits or Policy Schedule, when specified in the appropriate Section of the Policy.

DENTAL PROSTHESIS means porcelain crowns, bridges, or dental implants.

DENTAL SURGERY means tooth extraction, and root canal treatment

DENTAL TREATMENT means an annual check-up and hygienist visit to the dentist in each period of insurance, including de-scaling and polishing treatment, X-rays, scans or moulds, filings using amalgam or composite materials, and treatment for the relief of an infection.

DEPENDANT means the insured person's legal spouse (or partner of the same or opposite sex who has been living with the insured person for more than 180 days continuous) who is not legally separated from the insured person, and his / her unmarried child, step-child, foster child or legally adopted child -provided that such child is less than 19 years old on the date the insured person is first included under this Policy or at any subsequent renewal of the Policy (or less than 25 years old if it can be demonstrated that the child is continuing in full-time education) and is financially dependent on the insured person for support.

ELECTED COUNTRY means the country within the geographical area specified in the Policy Schedule, pre-selected on the Application Form as the country where the insured person opts to receive any major intervention for covered medical treatment, or subsequently selected by the insured person for such major intervention in the event of a claim. The elected country must be approved by us as suitable for the provision of the required treatment.

EMERGENCY DENTAL TREATMENT means treatment necessary as a result of an accident/injury by an extra-oral impact, received within 48 hours from the date and time of the accident/injury for the immediate relief of pain caused by natural teeth being lost or damaged in an accident.

EMERGENCY MEDICAL TRANSFER or EVACUATION means the medically necessary expense of emergency transportation when approved by our 24-hour Assistance Centre, and medical care during such transportation, to move an insured person who suffers a critical medical condition to the nearest suitable hospital where appropriate care and facilities are available, which may not necessarily be in the insured person's country of residence.

EMERGENCY OUTPATIENT TREATMENT means treatment necessary as a result of an accidental injury, received in a Casualty/Emergency room within 48 hours of the accident or onset of the illness, but which does not require admission to hospital as an in- or day-case patient.

GEOGRAPHICAL AREA means the Area specified in your Policy Schedule. For which the appropriate premium has been paid and to which cover applies

- **AREA 1** Thailand only
- **AREA 2** Asia countries; India, China, Indonesia, Pakistan, Bangladesh, Japan, Philippines, Vietnam, Iran, Turkey, Thailand, Myanmar, South Korea, Iraq, Afghanistan, Saudi Arabia, Uzbekistan, Yemen, Malaysia, Nepal, North Korea, Syria, Sri Lanka, Kazakstan, Cambodia, Jordan, Azerbaijan, Tajikistan, United Arab Emirates, Israel, Laos, Kyrgyzstan, Turkmenistan, Singapore, State of Palestine, Lebanon, Oman, Kuwait, Georgia, Mongolia, Armenia, Qatar, Bahrain, Timor-Leste, Cyprus, Bhutan, Maldives, Brunei
- **AREA 3** Worldwide excluding USA

HOSPITAL means any institution under the constant supervision of a resident physician which is legally licensed as a medical or surgical hospital in the country where it is

ILLNESS means any sickness, disease, disorder or alteration in the insured person's medical condition as duly diagnosed by a physician.

IN-PATIENT means treatment provided in a hospital where an insured person is admitted and, out of medical necessity, occupies a bed for one or more nights but not exceeding 365 days in total for any one insured event.

INSURED EVENT means an accident or illness which arising during the period of insurance within the geographical area which entitles the insured person to receive treatment.

Note: Accident or illness arising during the period of insurance but in a country outside the geographical area for which the appropriate premium has been paid will be deemed to be an insured event for the purposes of emergency treatment only, and on condition that no more than the number of days in total specified in the Table of Benefits in any one period of insurance has been or will have been spent by the insured person outside the geographical area for which the appropriate premium has been paid.

INSURED PERSON means the individual who is included in the Plan subscribed to by the Policy Owner, together with any dependant, all of whom are described on a completed Application Form for this insurance and have been accepted for cover by us, and for whom the appropriate premium has been paid.

LIFETIME LIMIT means the maximum benefit limit payable throughout the duration of the policies.

LOCAL AMBULANCE SERVICES shall mean the necessary medical transportation to or from a local hospital.

MAJOR INTERVENTION means scheduled treatment:

- involving surgery under general or rachidian anaesthesia (excluding childbirth) which, according to our physicians, requires a minimum of 3 nights spent in hospital. OR
- for illness involving chemotherapy or radiotherapy. OR
- involving one or more of the following, subject to submission to us and with our prior approval:
 - exceptionally complicated surgical operations;

- high risk childbirth;
- examinations involving sophisticated technology and a highly specialised team;
- intensive medical therapies of a lengthy duration.

MEDICAL EXPENSES shall mean the usual reasonable and customary expenses incurred for treatment of an accident or illness as a result of an insured event.

MEMBERSHIP CERTIFICATE means the document attaching to and forming part of this Policy, stating amongst others the Policy Owner, the insured person, the geographical area of cover, the period of insurance, the plan and any Optional Extensions selected and any special terms and conditions or exclusions which apply to this Policy.

ORGAN TRANSPLANT means medical treatment incurred in respect of kidney, heart, heart-lung, liver, pancreas transplants, and does NOT include the implantation of an artificial heart.

ORTHODONTICS means the use of devices in order to rectify malocclusion and re-establish correct alignment and function of the teeth.

OUT-PATIENT SERVICES shall mean the medical treatment provided to the insured person or ordered by a physician when it is not medically necessary for an insured person to be admitted as an in-patient or day-case patient in a hospital or any other facility for medical care.

PALLIATIVE means treatment, the primary purpose of which is only to offer temporary relief of symptoms rather than to cure the illness or injury causing the symptoms.

PERIOD OF INSURANCE means the period of 12 consecutive months from the commencement date specified in the Policy Schedule for which the appropriate premium has been paid.

PERIODONTICS means treatment in respect of gum disease.

PHYSICIAN means a legally licensed medical practitioner who is a doctor recognized by the law of the country where treatment covered under this Policy is provided and who, in rendering such treatment is practicing within the scope of his / her license and training.

PHYSIOTHERAPY means treatment recommended by a physician for medical reasons following an insured incident and provided by a licensed Physiotherapist.

POLICY SCHEDULE means the document attaching to and forming part of this Policy, stating amongst others the benefits provided under each of the available plan and Optional Extensions, and the maximum amounts payable in respect of those benefits.

POLICY OWNER means Individual who subscribes to this Plan and pays or undertakes to pay the appropriate premium on behalf of the insured person(s).

PRE-EXISTING MEDICAL CONDITION means a known medical or psychological condition from which the insured person has suffered or for which the insured person has received medical treatment (including prescription drugs) or of which symptoms have manifested themselves during the 24-month period prior to the insured person being first included for insurance under this Policy.

PRESCRIPTION DRUGS shall mean medications whose sale and use are legally restricted to the order of a physician. Items which may be purchased without a physician's prescription are not included in this Definition and are not covered by the insurance.

REHABILITATION means treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease so as to regain maximum self-sufficiency, form and function in a normal or as near normal manner as possible.

RENEWAL DATE means the annual anniversary of the commencement date.

TABLE OF BENEFITS means the document attaching to and forming part of this Policy, stating amongst others the benefits provided under each of the available plan and Optional Extensions, and the maximum amounts payable in respect of those benefits.

TREATMENT shall mean any medically necessary surgical procedure or medical intervention which is required to cure an accident/injury or illness or to provide relief of a chronic condition.

WE or Us means Pacific Cross Health Insurance PCL.

BENEFITS & SERVICES

We will pay costs up to the amount specified in the Table of Benefits for each insured person, each period of insurance, for treatment of an insured event which occurs and for which reasonable and necessary expenses are incurred during the period of insurance. We will not pay more than the amount specified in the Table of Benefits in respect of any single insured person, throughout the entire lifetime of that single insured person, regardless of how many periods of insurance that person is insured by us.

Our liability in respect of all claims will cease immediately upon termination of the Policy and/or deletion of an insured person from the Policy.

The General Conditions and Exclusions contained in Sections 5 and 6 respectively of this Policy apply to all parts of the Plan, including all sections of all plans.

SECTION 1 - MEDICAL & HOSPITAL BENEFITS

1.1 Hospitalisation Costs

We will arrange for the insured person's in-patient or day-case admission to the hospital recommended by our physicians. We will pay necessary costs, when approved by our physicians, for the following medical expenses and services:

- Hospital accommodation in a single-bedded room, meals, all hospital medical facilities, medical treatment and services ordered by a physician for in-patient or day-case admission, including Surgeon's and Anesthetist's charges, physician's charges, consultations, diagnostic procedures (including /CT, MRI and PET scans), surgical appliances and prostheses which are required intra-operatively, physiotherapy, and prescription drugs.
- Intensive care unit accommodation when medically necessary.
- Day-case surgery of a type form carried out on an in-patient basis.
- Emergency dental treatment as a result of an accident needing inpatient hospitalisation.
- Within 90 days period immediately following the insured person's discharge from an in-patient admission in a hospital, post-hospitalisation treatment received on an outpatient basis provided the insured person remains under the control and supervision of the treating physician or specialist consultant or such treatment has been ordered by the physician and for which treatments are directly resultant from the accident or illness for which the insured person was hospitalised.
- Treatment of mental illness, psychiatric and psychological disorders on an in-patient basis only, and for a maximum period of 30 days only, and in all during any one period of insurance

SPECIFIC CONDITIONS APPLYING TO SECTION 1.1

In the case of what our physicians deem to be an unreasonable length of stay or unreasonable hospital charges, we reserve the right to limit payment to what our physicians deem to be usual, reasonable and customary costs.

1.2 Chronic Conditions

From the date that an accident/injury or illness is deemed by our physicians to have become 'chronic' (See chronic definition), all and any subsequent cover for chronic episodes of the condition under this Policy shall be limited to the maximum benefit specified in the Table of Benefits each chronic condition, each period of insurance in respect of all necessary and reasonable treatment costs.

The first on set, or an acute exacerbation of a chronic condition will be covered under Section 1.1 of this policy, subject to the policy terms and conditions, to expedite a full recovery or return to previous state of health.

SPECIFIC EXCLUSIONS TO SECTION 1.2

- **Treatment for a chronic condition which existed prior to the date of entry of an insured person under this policy.**

1.3 Nursing at Home

Following a valid claim for hospitalisation under this Section, when the insured person has been discharged from an in-patient admission in a hospital, as agreed by us we will pay for necessary medical services of a licensed nurse in the insured person's home when prescribed by a physician and directly related to the insured event.

The maximum we will pay arising out of any one insured event is as specified in the Table of Benefits.

SPECIFIC EXCLUSION TO SECTION 1.3

- **Mental illness, psychiatric or psychological disorders.**

1.4 Maternity Care

Definition

NEWBORN LIMIT means the limit for each newborn child which applies to the first 15 days after birth (subject still to the Insured Person's Expected Delivery Date being at least 300 days after the initial Date of Entry) without notification.

Our liability is limited to the amount specified in the Table of Benefits in total for any newborn child who was not a named insured person at the commencement of the period of insurance.

Provided your selected plan includes this benefit we will arrange and pay up to the maximum amount specified in the Table of Benefits for maternity care when the insured person's expected delivery date is at least 300 days after the date of entry to this Policy. This condition will not apply if the insured person becomes pregnant in the second or subsequent period of insurance following renewal of this Policy.

We will pay up to the maximum specified in the Table of Benefits in total each pregnancy (as agreed by our physicians as being usual reasonable and customary, for the following:

- Pre-natal examinations by a physician;
- All costs of normal childbirth.
- Post-natal examinations by a physician.
- Home Delivery
- Medical complications arise in connection with pregnancy or childbirth.

SPECIFIC EXCLUSIONS TO SECTION 1.4

- a) Terminations of pregnancy, other than miscarriage, ectopic pregnancy and stillbirth.
- b) Elective caesarean section deliveries not agreed by our physicians as being medically necessary and treatment consequent of such deliveries.
- c) Ante-natal classes, midwifery costs when not directly associated with the delivery.
- d) Complications which may arise during or as a result of a planned home birth delivery.

1.5 Emergency Dental Treatment

We will arrange and pay up to the maximum amount specified in the Table of Benefits for outpatient emergency dental treatment necessary as a result of an extra-oral impact and received within 48 hours from the date and time of the accident/injury for the immediate relief of pain the insured person suffers as the direct result of an accident occurring during the period of insurance.

SPECIFIC EXCLUSIONS TO SECTION 1.5

- a) treatment made necessary by the accident/injury if:
 - the injury was caused by eating or drinking anything, even if it contains a foreign body;
 - the damage was caused by normal wear and tear;
 - the damage was caused by tooth brushing or any other oral hygiene procedure;
 - the injury was caused by any means other than extra-oral impact.
- b) emergency dental treatment shall not include restorative or remedial work, the use of any precious metals, and orthodontic treatment of any kind or dental surgery performed in a hospital, unless dental surgery is the only treatment available to alleviate the pain.

SECTION 2 - OUTPATIENT CARE

We will pay necessary costs agreed by us up to the amount of Benefits for out-patient services, including

- physician's fees, and prescription drugs
 - laboratory and X-Ray fees, medical scanning, imagery services, and physiotherapy.
- Chiropractic, osteopaths, acupuncture and homeopaths fees shall be covered when referred and recommended by a physician.

In the case of medical necessity, as agreed by our physicians, we will pay up to the amount specified in the Table of Benefits for the purchase or hire of crutches, walkers, wheelchairs and basic orthopedic prostheses and equipment.

SECTION 3 – ROUTINE HEALTH CARE

Important note: Cover under this section is operative only if you have selected plan 3

3.1 Dental care

We will arrange and pay up to the maximum amount specified in the Schedule subject to all/any deductibles and/or coinsurance and/or waiting periods for the usual reasonable and customary cost of:

- Dental Treatment
- Dental Surgery
- Periodontics
- Orthodontics
- Dental Prosthesis

SPECIFIC EXCLUSIONS APPLYING TO SECTION 3.1

- a) Any claim for Orthodontics or Dental Prosthesis in the first 180 days from the date of commencement of this Policy or the date of entry of the insured person (whichever is the latter)
- b) Any claim for dental care if the insured person has not undergone all necessary treatment recommended by a dental practitioner prior to their date of entry to this Policy.
- c) Dental procedures other than those specified, the cost of precious metals in any dental procedure, dentures, surgery related to dental implants.

3.2 Optical Care

We will pay up to the maximum amount specified in the Table of Benefits, for the usual reasonable and customary cost of:

- One annual vision test in each period of insurance.
- Glasses or contact lenses prescribed by an ophthalmologist, subject to an overall maximum of the amount stated in the Schedule each insured person in total in any one period of insurance.

SPECIFIC EXCLUSIONS APPLYING TO SECTION 3.2

- a) contact lenses supplied for purely cosmetic purposes only.
- b) sunglasses of any kind, including prescription sunglasses.

3.3 Hearing care

We will pay up to the maximum amount specified in the Table of Benefits for the usual reasonable and customary cost of:

- One annual hearing test in each period of insurance.
- A hearing aid prescribed by a physician.

SECTION 4 - LOSS OF LIFE, DISMEMBERMENT, LOSS OF SIGHT OR TOTAL PERMANENT DISABILITY FROM ACCIDENT

Definition

Dismemberment refers to the loss of body organ from the wrist joint or the ankle joint, and also the loss of use of that organ, which according to the medical indication, will never be able to function at any time in the future.

Loss of sight refers to complete blindness, which is permanently incurable.

Total Permanent Disability refers to disability until unable to perform the normal duty in the Insured's regular occupation or any other occupation totally and permanently or inability to perform 3 or more activities of daily living on their own.

Activities of daily living refers to activities of daily living 6 type. The diagnosis of muscular dystrophy must be unequivocal and made by a consultant neurologist as following;

- (1) Ability to do self-movement such as sitting in a chair and stand up without assistance from others or aiding equipment.
- (2) Ability to move from one room to the other by oneself without assistance from others or aiding equipment.
- (3) Ability to dress up such as to put on or to take off clothes by oneself without assistance from others or aiding equipment.
- (4) Ability to take a bath and to go in and out of the bath room by oneself without assistance from others or aiding equipment.
- (5) Ability to feed oneself without assistance from others or aiding equipment.
- (6) Ability to use toilet by oneself and to go in and out without assistance from others or aiding equipment.

Coverage

This insurance covers any losses or injuries to the Insured arising from bodily injury, which is caused by an accident during period of insurance, resulting to loss of life, dismemberment, loss of sight or permanent disability within 180 days from the date of the accident or the injury causes the Insured to receive continuous medical treatment as an in-patient in hospital and loss of life occurs later because of such injury, the Company will pay compensation in accordance with the sum insured stated in the Policy Schedule as follows:

1. 100% of the sum insured for loss of life.
2. 100% of the sum insured for permanent disability which continues not less than 12 months after the accident or if there is any medical indication that the Insured suffers a permanent disability.

- | | | |
|----|-------------------------|--|
| 3. | 100% of the sum insured | for loss of both hands from the wrist joint or both feet from the ankle joint, or loss of sight for both eyes. |
| 4. | 100% of the sum insured | for loss of one hand from the wrist joint and one foot from the ankle joint. |
| 5. | 100% of the sum insured | for loss of one hand from the wrist joint and loss of sight in one eye. |
| 6. | 100% of the sum insured | for loss of one foot from the ankle joint and loss of sight for in eye. |
| 7. | 60% of the sum insured | for loss of one hand from the wrist joint. |
| 8. | 60% of the sum insured | for loss of one foot from the ankle joint. |
| 9. | 60% of the sum insured | for loss of sight in one eye. |

The Company shall compensate only one item of loss which has the highest amount.

In the aggregate, the total compensation for this insuring agreement cannot exceed the maximum sum insured stated on the Policy Schedule. If the Company has not paid up to such maximum amount of sum insured of this coverage, the remaining benefit is still valid until the expiry of the policy period.

Claims for loss of life, dismemberment, loss of sight or total permanent disability from accident

According to Loss of Life

The beneficiary must send claims documents to the Company at their own expense within 30 days after the date of death as follow;

1. The Company Claims form.
2. Death certificate.
3. A Copy of perform postmortem report (Certified by the policeman or related organization).
4. A Copy of Police report (Certified by the policeman).
5. A Copy of the passport of the Insured showing the stamp for entry to Thailand.
6. A Copy of Beneficiary's passport.

According to Dismemberment, Loss of sight or Total permanent disability

The Insured and/or the beneficiary must send the following claims documents to the Company at their own expense within 30 days after the date of a physician's diagnosis

1. The Company Claims form.
2. Medical examination report certified by a physician
3. A Copy of the passport of the Insured showing the stamp for entry to Thailand.

Nevertheless, non-compliance within the specified time shall not jeopardize the right to claim if it can be proved that there is reasonable explanation why a claim could not be made in a timely manner and that the claim was filed as soon as possible.

Exclusions for loss of life, dismemberment, loss of sight or total permanent disability from accident.

This insuring agreement does not cover

1. Any Loss or Injury arising from/or in consequence of the following causes:
 - 1.1 Action of the Insured while under the influence of alcohol, addictive drugs, narcotic drugs to the extent of being unable to control one's mind. The term "under the influence of alcohol" in case of having a blood test refers to a blood/alcohol level of 150 mg percent and over.
 - 1.2 Suicide or attempted suicide or self-inflicted injury.
 - 1.3 Parasite infections except pyrogenic infection, tetanus, or rabies from a wound or cut suffered as a result of an accident.
 - 1.4 Medical treatment or surgical treatment except the necessary treatment for the injury which is covered under this insurance policy and occurring within the period of this insurance policy.
 - 1.5 Miscarriage and abortion.
 - 1.6 Food poisoning.
2. Loss or Injury which occurs:
 - 2.1 While the Insured is racing of all kinds of car or boat, horse racing, all kinds of skiing including jet skiing, skate racing, boxing, parachuting (except for the purpose of life saving), while boarding or traveling on the balloon or glider, bungee jumping or diving with oxygen tank and breathing equipment under water.
 - 2.2 While the Insured is taking part in a brawl or taking part in inciting a brawl.

Specific condition for loss of life, dismemberment, loss of sight or total permanent disability from accident.

The Company has the right to ask the Insured to get a physical checkup during the compensation's consideration including perform autopsy if necessary.

GENERAL TERMS AND CONDITIONS APPLYING TO WHOLE POLICY

SECTION 5 - GENERAL CONDITIONS

The following conditions apply to all parts of this Policy:

- 5.1 This insurance contract is established based upon the Company's reliance on the Insured's statement in the insurance application, and additional statements in relation to the insurance contract (if any) that the Insured has signed in evidence of acceptance of insurance contract, the Company therefore issues this Insurance Policy.

In the event that the Insured is aware of certain declarations but still provides false statements in accordance with paragraph one (1) or is aware of certain facts but withholds them not to disclose to the Company and if the Company obtains such information, the Company may decide to increase the premium rate or refuse to execute the insurance contract. In this regard, this insurance contract shall become void as per Section 865 of the Civil and Commercial Code. The Company then has the right to cancel the policy.

The Company will not refuse the liability by using any other statements than those declared by the Insured in the documents under paragraph one (1).

- 5.2 The Company shall not dispute or object to the incompleteness of this Insurance Policy when this Insurance Policy has been effective while the Insured is alive for two (2) policy years and more from the first effective date hereof or when the Insured has made this Insurance Policy with the Company for at least two (2) consecutive years or the date of the Company's approval of additional benefits under this Insurance Contract, or date of reinstatement whichever happens later. 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 knows of any reason to terminate the Insurance Policy under the first paragraph but does not exercise its rights to terminate it within a period of one (1) month from the date of such awareness, then the Company will no longer be able to terminate the Insurance Policy in such cases.

The Company shall not rely on facts other than those stated by the Insured in the insurance application form and any additional statements relating to the insurance contract (if any) as a reason to dispute or object to the invalidity of the insurance policy under paragraph one or two.

The Company will not dispute or object to the incompleteness of this insurance policy in the event that the Insured is injured due to an accident. The Company shall pay the benefits under this insurance policy to the extent that the Company has been notified of the claim for reimbursement under this insurance policy. Upon the Company approves the payment for such accident, this Insurance Policy shall expire from the day following the date on which the claim arises. The Company shall return the premium to the Insured less the premium for the portion of the insuring agreement for which the benefit has been paid for the period in which the coverage has been provided. For other coverage that is not covered The Company will return the insurance premium in full.

- 5.3 The insured person must declare to us all facts which are likely to affect this insurance. Failure to do so may prejudice entitlement to claim. If the insured person is uncertain as to whether a fact is material, the insured person should declare it to us.

If you have been accepted for insurance under this Plan under full medical underwriting conditions you must have declared to us on the Application Form any and all known pre-existing medical conditions (as defined). Such pre-existing medical conditions as declared by the insured person are subject to the special terms, conditions, exclusions and/or limitations specified on the Policy Schedule or endorsed on this Policy.

- 5.4 The insured person must immediately inform us of any change in the information given on the Application Form, in particular relating to the insured person's address or country of residence, the birth or adoption of a child or any other change involving the insured person's dependant(s).
- 5.5 This Policy is subject to the Laws of Thailand.
- 5.6 The insured person must take all reasonable steps to avoid or minimise any claim. The insured person must act as if not insured
- 5.7 The insured person must avoid needless self-exposure to peril unless attempting to save human life.
- 5.8 Our help and intervention depends upon and is subject to local availability and has to remain within the scope of national and international law and regulations. Our intervention depends upon us obtaining the necessary authorisations issued by the various competent authorities concerned.
- 5.9 The insured person's full compliance with the terms and conditions of this Policy is necessary before a claim will be paid.
- 5.10 We are entitled to take over the insured person's rights in the defence or settlement of a claim, or to take proceedings in the insured person's name for our own benefit against another party and we shall have full discretion in such matters.
- 5.11 We may, at any time, pay to the insured person our full liability under this Policy after which no further liability shall attach to us in any respect or as a consequence of such action.
- 5.12 If another insurance company or a state scheme pays part of the insured person's claim the insured person must send us the original bill which clearly shows the amount paid by the insurer or scheme.
- 5.13 In case of argument, dispute or appeal under this policy between the person who is entitled for compensation versus the Company, and if so desired by that person to settle the disputed claim by use of arbitration, the Company must conform and allow the case to be judged by arbitration according to the Arbitrating Regulation governed by the Office of Insurance Commission
- 5.14 If any fraudulent claim is made or if any fraudulent means or devices are used to obtain any benefit under the insurance, such claims shall be forfeited and this policy may be voidable.
- 5.15 We shall not cancel this Policy for covered medical reasons, unless we decide not to continue to underwrite this type of insurance in the insured person's country of residence. If we do decide to cease underwriting in the insured person's country of residence, we shall give the Policy Owner not less than 120 days' notice in writing prior to this Policy's next annual renewal date.
- 5.16 The Policy Owner may terminate the entire insurance contract:
- after an initial period of 180 days following the commencement date of this policy; or
 - following any subsequent renewal.
- Termination of the insurance shall take effect from the date the notice is received or on the future date specified in the notice, whichever is the later.
- If premium has been paid for any period beyond the date of termination of this insurance by the Policy Owner, then (subject to no claim having been submitted) a pro-rata refund of premium will be made equivalent to the unexpired portion of the period of insurance less a ten per cent (10%) deduction for administration costs. No refund will be paid if the unexpired portion of the period of insurance is less than 60 days.
- 5.17 The insurance period is 12 consecutive months. We reserve the right to refuse to renew the insurance. If we offer renewal terms in writing this Policy shall automatically renew for a further 12 months on those renewal terms unless the Policy Owner has advised us within 14 days in writing of their unwillingness to renew on such terms.
- 5.18 At the renewal of this Policy pre-existing medical conditions prior to the date of entry of an insured person will continue to be excluded or be subject to the special terms specified on the Policy Schedule or endorsed on this Policy during the whole of the ensuing 12 months period of insurance.

- 5.19 If you have been accepted for insurance under this Plan under moratorium medical underwriting conditions, any pre-existing medical condition (with the exception of a chronic condition) which existed in the five years prior to the date of entry to this Plan will become eligible for cover 2 years after the member joins and will cease to be excluded or be subject to any special terms specified on the Policy Schedule or endorsed on this Policy.

SECTION 6 - GENERAL EXCLUSIONS

No part of this Policy shall apply in respect of the following.

- 6.1 Any payment in excess of the overall policy limits and the maximum amounts specified in the Table of Benefits.
- 6.2 The amount of any deductible and / or coinsurance specified in the Table of Benefits and / or Policy Schedule
- 6.3 Any claim arising from a medical condition known to the insured person and from which the insured person has suffered during the 2 years prior to first applying for insurance under this Policy, unless such condition has been declared to us and accepted in writing for insurance by us.
- 6.4 Medical treatment for alcoholism, narcotics, drug and substance abuse/ dependency or any addictive condition of any kind and any injury or illness arising directly or indirectly from such abuse or condition.
- 6.5 Self-inflicted injury, needless self-exposure to peril except in an attempt to save human life, suicide or attempted suicide.
- 6.6 Contraception, sterilisations (or its reversal), fertilisation, vasectomy, venereal disease, sexually transmitted diseases, gender reassignment or any other form of sexual related condition, infertility and any related condition or form of assisted reproduction.
- 6.7 Intentional or fraudulent acts on the insured person's part or their consequences.
- 6.8 Travel outside the geographical area specified on the Policy Schedule more than 30 days in any one period of insurance.
- 6.9 Any claim arising in the course of travel undertaken against medical advice.
- 6.10 Claims arising from birth injuries or defects, hereditary conditions or congenital illness or physical anomalies happening during 60 days from birth.
- 6.11 Artificial heart implantation.
- 6.12 Any costs arising after expiry of the current period of insurance, unless this Policy has been renewed for a subsequent 12 months.
- 6.13 The costs associated with locating a replacement organ or any costs incurred for the removal of the organ from the donor, transportation costs of the organ and all associated administration costs. All costs associated with organs not specified within the meaning of words of organ transplant.
- 6.14 Care or medical treatment which arises directly or indirectly from Human Immunodeficiency Virus or HIV related illness, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS related complex (ARC) and any similar infections, illnesses, injuries or medical conditions arising from these conditions, however caused.
- 6.15 Medical treatment and consequences of experimental and unproven medical treatment or drug therapy except in the attempt to save human life. Drugs and other medicines purchased without a physician's prescription and routine or preventative medicines, vaccinations and check-ups.
- 6.16 Cosmetic surgery or remedial surgery, removal of fat or other surplus body tissue and any consequences of such medical treatment, weight loss or weight problems/eating disorders, whether or not for psychological purposes, unless required as a direct result of an accident or surgery for cancer which occurs during the period of insurance.
- 6.17 Surgery to correct short or long sight or any other eye defect, unless caused as a result of an accident or illness occurring during the period of insurance.
- 6.18 Investigations into or treatment of sleep apnoea, snoring, or other sleep-related problems

- 6.19 Medical treatment performed by a medical practitioner, physician or consultant who is related to the insured person, unless previously approved by us.
- 6.20 Medical treatment associated with cryopreservation, implantation or reimplantation of living cells or living tissue whether autologous or provided by a donor, other than for tissue transplants as defined, and not exceeding the maximum amount specified in the Table of Benefits.
- 6.21 Mortal remains shall not include the costs of a religious practitioner or floral tributes.
- 6.22 Claims arising as a result of the insured person's participation in professional sport (not including recreational or amateur participation) or any hazardous sport or activity such as (but not limited to) the following: motor sports, aerial sports, scuba diving below 30 meters or where a PADI Certificate is not held, any sport involving animals, speed competition, skiing of piste and racing of any form (other than on foot). If a hazardous sport or activity is not specified in this list, the insured person must contact us to ascertain if it is acceptable for insurance before cover will apply.
- 6.23 Any claim arising when the insured person is under military authority or is engaged in activities involving the use of firearms or physical combat or in an area of military conflict, except in connection with tourist trips made on a private basis during leave.
- 6.24 Any expenses relating to search and rescue operations to find an insured person in mountains, at sea, in the desert, in the jungle and similar remote locations including air/sea rescue charges for evacuation to shore from a vessel or from the sea.
- 6.25 Any expense not specifically stated in this Policy as being insured.
- 6.26 Accommodation and treatment costs in a nursing home, hydro, spa, nature clinic, health farm or the like or a hospital where the establishment has effectively become the insured person's home or permanent resident and the admission is arranged wholly or partly for domestic reasons.
- 6.27 Rehabilitation unless it forms an integral part of medical treatment received as an in-patient and is under the control or supervision of a specialist and is undertaken in a recognised rehabilitation unit.
- 6.28 Medical treatment for learning difficulties, hyperactivity, attention deficit disorder, speech therapy, behavioral problems or child development.
- 6.29 Medical treatment for mental or nervous disorders, psychiatric treatment and the costs of a psychotherapist, psychologist, family therapist or bereavement counselor (other than 30 days in-patient stay).
- 6.30 Evacuation costs where the insured person is not being admitted to a hospital for medical treatment or where costs have not been approved by us prior to travel commencing.
- 6.31 The transfer of a pregnant woman to hospital to give routine childbirth, unless agreed by our physicians as necessary due to medical complications.
- 6.32 Any costs which in the opinion of our physicians are unnecessary or excessive
- 6.33 Any claim in any way caused or contributed to by the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent.
- 6.34 Any claims whatsoever resulting from war, invasion, act of foreign enemy, hostilities (whether war be declared or not), act of terrorism, civil war rebellion, revolution, insurrection, military or usurped power or taking part in civil commotion or riot of any kind.
(For the purpose of this exclusion, an act of terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious, ideological or similar purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear.)
- 6.35 Any expense which at the time of happening is covered by, or would, but for the existence of this Policy, be covered by any other existing insurance certificate, policy, or state scheme. If there is any other cover in force which may pay in

respect of the event for which the insured person is claiming, the insured person must tell us at the time he / she first contacts us.

- 6.36 Costs which would have been payable if the event being the subject of a claim had not occurred.
- 6.37 Consequential loss of any kind arising from the provision of, or any delay in providing, the services to which this Policy relates, unless negligence on our part can be demonstrated.
- 6.38 Any claims directly or indirectly caused by or aggravated by the actual or potential inability of any computer, data processing equipment or media, microchip, integrated circuit software or stored programme to correctly recognise any date as its true calendar date of to continue to function correctly in respect of or beyond that date.

SECTION 7 - PRE-AUTHORISATION AND CLAIMS PROCEDURES

MEDICAL EMERGENCY HELPLINE 24 HOURS A DAY, 365 DAYS A YEAR

The following explains what to do if an emergency Medical Transfer or emergency Medical Treatment is needed. To ensure the most appropriate care possible the insured person should contact us on the telephone number shown below, giving us a telephone, fax or telex number where we can contact the insured person or leave messages at any time of day or night.

FOR EMERGENCY EVACUATION, REPATRIATION, OR FOR REFERRAL TO A MEDICAL PRACTITIONER OR A HOSPITAL PLEASE CALL (Pacific Cross Health Insurance PCL. Tel 02 401 9188)

The insured person must bear in mind that to comply with the terms and conditions of the insurance we must be contacted for our pre-authorisation before the insured person incurs costs for treatment of any kind which are likely to exceed the amount stated in the Schedule on completion of treatment. This sum includes in-patient, day-case and out-patient treatment, as well as transportation and ancillary costs.

In the event the treatment scheduled is eligible for cover, we can confirm the level of benefit applicable to the medical provider/s and authorise treatment, subject to the terms and conditions of the policy. When the claim is subsequently fully validated, we will arrange for costs to be settled direct to the medical provider/s.

It is important to note that if we authorise treatment which ultimately transpires to have been related to a condition excluded by the policy, for example, treatment for an undeclared and unaccepted pre-existing medical condition, the insured person will be responsible for all costs, including those settled by us. In such cases, the insured person must repay us all costs we have paid.

In case of an emergency, if the insured person is physically prevented from contacting us immediately, the insured person or someone designated by him / her must contact us within 48 hours. The insured person must make no admission of liability, offer, promise or payment without our prior consent. We must be telephoned first.

In the case of hospital charges guaranteed by us prior to the insured person receiving treatment, the insured person agrees to reimburse us with the amount of the deductible and any coinsurance specified in the Policy Schedule, at the time we are required to guarantee such hospital charges.

In respect of any other costs, the insured person will be required to reimburse to us, within one month of our request to the insured person, any costs or expenses we have paid out on the insured person's behalf which are not covered under the terms of the insurance.

The insured person must give us written details of any claim within 28 days of our request to the insured person to do so. As often as we require the insured person shall submit to medical examination at our expense. In the event of the death of an insured person we shall be entitled to have an autopsy carried out at our expense (where this is not forbidden by local law). The insured person must supply us with a written statement substantiating the insured person's claim, together with (at his / her own expense) all original invoices, certificates, information, evidence and receipts that we require.

Where you receive treatment as an out-patient, and where costs are below the amount stated in the Schedule and do not require pre-authorisation, all costs must be paid for in full by you at the time of receiving the treatment. You must then submit a claim to us for reimbursement. Please ensure that a claim form is fully completed by the insured person and the treating physician. Submit this with the original receipts and all other information supporting your claim, including but not limited to x-rays, test results, medical reports etc.

We shall not be liable to indemnify the insured in respect of any expense for which there are no original documents, and where the invoice is received by us more than 60 days after the occurrence of the insured event, unless specifically agreed by us.