

THAI HEALTH INSURANCE
Individual Health Insurance Policy

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

SECTION 1. DEFINITIONS

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

1	COMPANY	refers to	Thai Health Insurance Co. Ltd.
2	POLICY	refers to	policy schedule, benefits schedule, insuring agreement, exclusions, conditions, specifications, endorsements, which are all regarded as being part of the contract.
3	INSURED	refers to	the person named as Insured in the policy schedule.
4	DEPENDENT	refers to	Dependents of the Insured who are named in the policy i.e. 1) spouse of the Insured who is less than 60 years old 2) legal children of the Insured or of the spouse from the age of 2 weeks but not over 20 years who is not yet married and is still attending school.
5	COVERED PERSON	refers to	the Insured and/or the Insured's dependent(s) who are named in the policy schedule.
6	ACCIDENT	refers to	an event which happens suddenly from external means giving rise to a result which is not intended or anticipated by the covered person.
7	INJURY	refers to	bodily injury which is caused directly and solely from an accident and is independent from other causes while this policy is in force.
8	SICKNESS	refers to	illness or disease contracted by the covered person while this policy is in force.
9	PHYSICIAN	refers to	a person licensed to practice modern medicine with the Medical Council who can render medical treatment and surgery within the territory he/she is licensed.
10	DENTIST	refers to	a person licensed to be a dentist with the Medical Council who can render dental treatment within the territory he/she is licensed.
11	SPECIALIZED PHYSICIAN	refers to	a person licensed to practice modern medicine with the Medical Council who is not the Insured's attending physician, but the physician who gives advice, consultation, or medical treatment in coordination with the Insured's attending physician.
12	NURSE	refers to	a person licensed to perform nursing duties with the nurse council.
13	NURSING CARE	refers to	expense that a hospital or a medical facility charged to an in-patient for nursing care provided while hospitalized.

14	INPATIENT	refers to	a person who is registered as an inpatient admitted to a hospital under the care of a licensed medical practitioner and who needs to be accommodated in a hospital bed (according to the medical necessity) for a minimum of 6 hours for medical treatment and also be appropriate in length of stay. This also includes the circumstance when an inpatient dies before 6 hours after hospitalized.
15	OUTPATIENT	refers to	a person who receives medical treatment in a clinic, hospital outpatients department, or emergency room or undergoes a procedure without the need (according to medical necessity) to be accommodated in a hospital bed.
16	HOSPITAL	refers to	a legally constituted institution which is open for medical treatment and can provide overnight accommodation to its patients including major surgery facility.
17	MEDICAL FACILITY	refers to	A legally constituted medical facility which is open for medical treatment and can provide overnight accommodation to its patients.
18	CLINIC	refers to	a legally constituted clinic which is open for medical treatment without overnight accommodation.
19	STANDARD OF MEDICAL PRACTICE	refers to	Medical practice which is accordance to the generally accepted standards, according to the medical necessity, and considered appropriate for treating the patient's illness, injury or for an autopsy (if any).
20	MEDICAL NECESSITY	refers to	medical treatment which meets the following conditions: 1) in accordance with the diagnosis, and treatment for such illness or injury; and 2) in accordance with medical indication of modern medicine; and 3) not primarily for the convenience of the patient or his/her family, physician; and 4) in accordance with generally accepted standard to care for the patients, and considered appropriate for the treating patient's illness or injury.
21	ALTERNATIVE MEDICINE	refers to	A variety of therapeutic or preventive health care practices, such as traditional Thai or Chinese herbal medicine, and similar which is not considered as modern medicine.
22	INJURY OR SICKNESS PER DISABILITY	refers to	This means that if a covered person receives continuous treatment in connection with or in relation to one previous injury or sickness arising from other causes occurred at the same time of one hospitalization, those treatments will be counted as the same disability unless such treatments occur not less than..... days(please specify but not over 90 days) after being discharged from hospitalization.

23	AIDS	refers to	Acquired Immune Deficiency Syndrome (AIDS) which is caused by the Human Immune-deficiency Virus (HIV). This also refers to any diseases or illnesses caused by AIDS or HIV such as Kaposi's sarcoma and other malignant neoplasm's, central nervous system lymphoma, encephalopathy (dementia) and opportunistic infections. Opportunistic infections include but not limited to pneumocystic carinii pneumonia, chronic diarrhea, chronic gastroenteritis (from any pathogens), viral infection, parasitic and disseminated fungi infection.
24	CUSTOMARY AND REASONABLE MEDICAL CHARGES	refers to	the charge for health care that is consistent with the average rate or charge for identical or similar services in the hospital, medical facility, or clinic the covered person receives treatment.
25	DEDUCTIBLE	refers to	the first fixed amount of eligible medical expenses per visit or per disability for which the covered person is responsible for paying as stated in the policy schedule.
26	CO-PAYMENT	refers to	the amount of eligible medical expenses for which the covered person is responsible for paying. The amount can be a fixed amount per visit or per disability or a percentage of the eligible expenses as stated in the policy schedule.
27	TERRORISM	refers to	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 including the intention to influence any government and/or to put the public, or any section of the public, in fear.

SECTION 2 GENERAL CONDITIONS

1. Insurance Agreement

This insurance agreement is based upon the information provided by the applicant in the form requesting insurance coverage, and the status of the health questionnaire signed by the applicant for the purpose of obtaining insurance coverage.

In the event that an applicant misrepresents or omits to inform the company of any relevant facts, the company when aware of the true situation, may decide to increase the premium level or void the policy as per clause 865 of the Civil and Commercial Code.

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

2. Incontestability Clause

The Company waives the right to dispute the validity of the insurance contract after 2 years from the first inception date, except when the premium is not received.

In case the Company knows of any information which may lead the insurance contract to void but does not exercise the right to void within 1 month after that information is known, the Company can no longer exercise the right to void this insurance agreement.

3. Changes to the Policy

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

4. Payment and Coverage

- 4.1 In the first year of the policy, the Insured must pay the premium before or on the effective date. The coverage will commence from the effective date stated in the policy schedule.
- 4.2 In subsequent renewal years the company will continue to cover the Insured provided that the premium is paid within 30 days of the policy expiry date. The coverage in the renewal year will be as follows:
- 4.2.1 Provided the Insured pays the premium within 30 days, the Insured will be continually covered and there will be no new pre-existing condition (Condition No.19) or no waiting period conditions (Condition No. 20) applied to the policy.
 - 4.2.2 If the Insured does not pay the premium within 30 days the Company will consider the policy to have expired on the expiry date.

5. Misrepresentation of Age or Gender

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

- 5.1 the Company to receive the premium less than what it should be, the Company shall pay the compensation equal to the coverage amount of which the previously paid premium can buy for the correct age or gender. If the correct age is not within the normal accepted risk for this insurance, the Company is not entitled to pay the benefit but will refund the paid premium.
- 5.2 If the premium received by the Company is more than the premium charged for the correct age and gender, the Company will refund the excess premium. However, this refund will not be calculated back to the expired policies.

6. Renewal of the Policy

- 6.1 This insurance policy can be renewed until the policy year when the insured reaches the age of 70 years without having to provide additional evidence. The Company reserves the right
- 6.1.1 To adjust the premium in accordance with the age and risk profile of the covered person(s).
 - 6.1.2 To adjust any term and conditions, coverage as necessary.
- 6.2 The Company reserves the right not to renew the policy but must inform the Insured in writing at least 30 days prior to the policy expiry date as stated in the policy schedule.

7. Premium adjustment

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

8. Changes or Upgrade of Benefits

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

- 8.1 If the covered person is sick or injured prior to the change, the maximum payable for those diseases causing the sickness or injuries will not be higher than the maximum payable under the old benefit entitlements prior to the change.
- 8.2 Any diseases or injuries for which benefits have already been paid prior to the upgrade will continue to be paid under the old benefit entitlement. This also applies to any conditions which have not been excluded from the Policy but existed prior to the upgrade and for which the covered person has not yet received treatment.

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

9. Termination of Contract.

9.1 The coverage for the Insured is terminated if any of the following incidents occurred, whichever comes first.

- 9.1.1 With effect from the policy expiry date if the covered person has reached the age of 71 years on the policy renewal date.
- 9.1.2 If the Insured is dead. The Company will refund the premium to the beneficiary on a pro-rata basis.
- 9.1.3 If the Insured has not paid the premium (per condition 4.2)
- 9.1.4 When the Company has paid claims up to the maximum payable as stated in the policy schedule.

9.2 The coverage for each dependent will be terminated if any of the following incidents occurred, whichever comes first.

- 9.2.1 With effect from the policy expiry date if the dependent no longer qualifies as a dependent under the aforementioned definition.
- 9.2.2 If the dependent is dead. The Company will refund the premium to the beneficiary on a pro-rata basis
- 9.2.3 If the policy is terminated according to condition 9.1 above.

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

9.4 The time on expiry date ends at 12:00 hrs, Thailand time.

10. Re-instatement

If this insurance policy is terminated because the Insured did not pay the renewal premium by the due date, the Insured may request the policy to be re-instated but only with the agreement by the Company within 90 days from the payment due date. In this case condition No 19 "pre-existing conditions" and No. 20 "Waiting Period" will not be re-applied.

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

11. Examination Rights

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

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

12. Notification of Claim

The covered person or the representative of the covered person must inform the Company of any sickness or injury which might result in a claim without delay. In case of death the Company must be notified immediately unless good reason with supporting evidence can be given in the case of delay.

13. Submission of Claims Documents

The covered person or their representative must submit the following documents at their own expense:

1. Completed claim form.
2. Medical certificate signed by the attending physician or doctor stating the symptoms, diagnosis and the treatment given.
3. Original receipt and invoice showing the itemized medical expenses.

The above documents must be submitted within 30 days of the discharge date or the outpatient treatment date. The receipt must be original and may be returned to the covered person on request. If the original receipt has been submitted to another third party for part payment of a claim the Company will accept a copy provided that the third party authenticates the receipt as being original and indicates the amount which has been paid to the covered person by the third party.

Failure to submit the documents within such time will not jeopardize the right to claim if sufficient reasons are given.

14. Payment of Benefits

The Company will pay the eligible benefits to the covered person within 20 days of receipt of the completed documents. In case of death, the benefit will be paid to the beneficiary.

If the claim requires further investigation the Company has the right to extend the payment date but not later than 90 days after the Company received the completed document.

If the medical expenses are in foreign currency, the Company will reimburse the expenses in Thai baht using the exchange rate as at the specified date on the receipt.

If the Company cannot pay within the agreed dates, the Company will pay 12% annual interest starting from the date the claims payment is due.

15. Change of Insured

If this insurance policy is terminated due to the Insured is dead or reaches the age of 71 years, the dependent may request continuation of cover and change the status to be the Insured within 90 days after the policy is terminated.

16. The dependent's right to continue the coverage.

If the Insured's spouse is no longer qualified because of a divorce or the children of the Insured is no longer qualified because he/she is over 20 years old or married, the spouse or children may request the Company to continue providing the coverage. If agreed, the Company will not re-apply Condition No. 2 (Incontestability Clause), No. 19 (Pre-existing Condition), and No. 20 (Waiting Period) subject to:

- 16.1.1 the request to continue the coverage is submitted to the Company within 90 days from the date the dependent's ineligibility.
- 16.2 The benefit requested is not more than the previous benefit.

17. Cancellation of Insurance Policy

17.1 The Insured can terminate this policy by giving notice to the Company in writing. In this event, the Company will refund the premium as per the short-rated schedule.

Short-rate schedule

Period (not over/month)	% of annual 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

17.2 The Company may cancel this insurance policy by giving notice in writing and send by registered mail to the Insured at the Insured's last given address not less than 30 days in advance if there is a clear evidence that the covered person is making fraud claims to benefit from this insurance. In this event the company will refund the premium on a pro-rata basis.

The Company is not responsible for any injury or sickness occurred after the policy is cancelled.

18. Arbitration

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

19. Pre-existing Conditions

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

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

19.2 After 3 years from the first policy commencement date, the Company cannot refuse to pay any claims for pre-existing conditions if such disease, illness or injury or symptoms and complications thereof do not manifest itself, no treatment or diagnosis, no consultation by a physician during 5 years prior to the policy's first inception date.

20. Waiting Period

20.1 The Company will not pay the benefits for any sickness during the first 30 days (The Company may apply less number of days) from the first policy commencement date.

20.2 The Company will not pay any benefits during the first 120 days (The Company may apply less number of days) from the first policy commencement date for the following diseases:

20.2.1 Benign or malignant tumor or cancer or cystic mass

20.2.2 Hemorrhoids

20.2.3 Hernias

- 20.2.4 Pterygium, pinguecula, cataract,
- 20.2.5 Tonsillectomy or adenoidectomy
- 20.2.6 Stones
- 20.2.7 Varicose Veins
- 20.2.8 Endometriosis

21. Precedent Condition

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

SECTION 3 GENERAL EXCLUSIONS

This insurance policy does not cover the cost of treatment or losses arising from injury or illness (complications thereof) symptoms or conditions arising from the following:

1. Pre-existing conditions, Congenital abnormalities, growth development abnormalities, and genetic disorders.
2. Any cosmetic surgery or beautification treatment including treatment of acne, freckles, dandruff, weight reduction and weight gain, hair loss. Reconstructive surgery is also excluded unless injury is sustained as a result of an accident.
3. Services in connection with infertility, pregnancy, childbirth, abortion or miscarriage, or any causes related to pregnancy, sterilization or investigation of sterilization
4. AIDS, related or sexually transmitted diseases (STD)
5. Treatment to relieve symptoms commonly associated with aging, menopause or precocious puberty, sexual dysfunction or sex change.
6. Health check ups, convalescent care including rest cures and rehabilitation. Any treatment, drugs or medical supplies which are not related to the diagnosis; and. diagnosis which is not related to the injury or illness or not according to the medical necessity and normal standard.
7. Eye examination and eyesight corrective surgery including lasik and other expenses associated with eyesight correction.
8. Treatment or surgery relating to dental or gum e.g. denture, crowns and bridges, root treatment, filling, orthodontic, scaling, extraction, except the necessary dental treatment after an accident. However, the coverage does not include the costs for crowns and bridges, root treatment, orthodontic services.
9. Medical treatment related to alcoholism, cigarette addiction, drug or other addicted substance.
10. Medical treatment related to the nervous disorders, mental disorder, anxiety, psychiatric problems, personality disorder, autism, stress, eating disorder.
11. Medical treatment which is in a trial stage or experiment, associated with disease or symptoms of sleep apnea, sleeping disorder, treatment to stop snoring.
12. Any inoculations or vaccinations, except rabies vaccine needed after an animal attack or tetanus shots needed after an accident or injury.
13. Treatment which is not considered a modern medicine, including alternative medicine.
14. Any medical treatment given by a medical practitioner who is the parent, spouse or child of the covered person. The covered person who is a registered medical practitioner may not be reimbursed for any self- administered treatment.
15. Suicide or suicide attempt, self inflicted injury or attempt of self-inflicted injury whether being his/her own action or allow others to perform while insane or not. This also includes the accident to the covered person due to consuming, drinking, or injection of toxic substance into the body or drug overdose
16. Any loss or injury arising from the action of the covered person whilst 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 and over.

17. Injury while the covered person is taking part in a brawl or taking part in inciting a brawl.
18. Injury while the covered person is committing a felony or while the covered person is being arrested, under arrest or escaping the arrest
19. Injury while the covered person is taking part in dangerous sports or activities including racing of all kinds including car, boat and horse racing, racing of water and snow ski-ing, including jet-ski, skating, boxing, parachuting jumping (except for the purpose of life saving), boarding or traveling in a hot air balloon, gliding, bungee jumping, diving with oxygen tank and breathing equipment under water.
20. Injury while the covered person is boarding or traveling in an aircraft which has no license for carrying passengers or does not operate as a commercial aircraft.
21. Injury while the covered person is piloting or working on board as an employee of an airline.
22. Injury while the covered person serves as a soldier, police, or a volunteer and participates in war or crime suppression.
23. War (whether declared or not), invasion, acts of foreign enemies, civil war, revolution, insurrection, civil commotion, popular rising against the government, riot, strike.
24. Terrorism
25. Ionising radiations or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
26. The radioactive toxic explosive or other hazardous property of any explosive nuclear assembly or nuclear component thereof.

SECTION 4. INSURING AGREEMENT

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

Insuring Agreement Inpatient hospitalization

The Company will pay for the following benefits when the covered person is hospitalized as an inpatient at a hospital or a medical facility as follows:

1. Room and board including nursing care

1.1 Non-intensive care room

The Company will pay the cost of room and board including nursing care and hospital daily charges not more than the amount paid by the covered person up to a maximum limit per day or the amount stated in the policy schedule, whichever is smaller, for a non-intensive care room. The maximum number of days is 60 days per disability.

1.2 Intensive Care unit or room

The Company will pay for the cost of room and board in an intensive care unit or room including nursing care and hospital daily charges not more than the amount paid by the covered person up to two times of the maximum limit allowed for room and board per day as stated in the policy schedule, subject to a maximum of 15 days per disability. The total maximum number of days including the non-intensive care room is 60 days per disability.

2. Hospital general expenses including

- 2.1 Costs of drugs and intravenous feeding
- 2.2 Costs of blood transfusion
- 2.3 Costs of ambulance for medical emergency but not exceeding 1,000 baht per disability
- 2.4 Costs of laboratory tests, pathology, radiological tests
- 2.5 Costs of medical equipment and supplies
 - 1) medical equipment used out of a surgical room
 - 2) non-reusable medical supplies
 - 3) medical equipment and supplies that go inside the patient's body (except defibrillator or pacemaker)
- 2.6 Physical therapy/occupational therapy – such therapy must be in accordance with the medical necessity and is needed for treating the injury or illness.
- 2.7 Cost of operating room, operating equipments, observe room after surgery, fees charged by all hospital staff in the operating room.
- 2.8 Anesthesiologist and nurse anesthetist
- 2.9 Specialist's consultation fees when no surgery is performed, but not more than 10 % of the maximum benefit per disability and not more than the amount actually paid or the maximum benefit stated in the schedule whichever is smaller.
- 2.10 Take home drugs prescribed by a physician on discharge but not more than 14 days supply from discharge date. The Company will pay this benefit according to the amount actually paid or the balance remaining for that Disability in the Hospital General Expenses schedule, which ever is smaller.
- 2.11 Cost of outpatient emergency treatment due to injury within 24 hours of the injury or accident occurring including 15 days follow up. The Company will pay this benefit according to the amount actually paid but not exceeding the maximum amount per disability or the maximum benefit stated in the schedule whichever is smaller.

- 2.12 Expenses relating to the following injury or illness (not required to be hospitalized as an in-patient)
- 1) ESWL : Extracorporeal Shock Wave Lithotripsy)
 - 2) Coronary Angiogram/Cardiac Catheterization)
 - 3) Extra Capsular Cataract Extraction with Intra Ocular Lens)
 - 4) Laparoscopic
 - 5) Endoscope
 - 6) Sinus Operations
 - 7) Injection or Rubber Band Ligation)
 - 8) Excision Breast Mass
 - 9) Bone Biopsy
 - 10) Tissue Biopsy
 - 11) Amputation
 - 12) Manual Reduction
 - 13) Liver Puncture/Liver Aspiration
 - 14) Bone Marrow Aspiration
 - 15) Lumbar Puncture
 - 16) Thoracentesis/Pleuracentesis/Thoracic, Aspiration/Thoracic Paracentesis)
 - 17) Abdominal Paracentesis/ Abdominal Tapping)
 - 18) Curettage, Dilatation & Curettage, Fractional Curettage)
 - 19) Calposcope, Loop diathermy
 - 20) Bartholin's Cyst (Marsupialization of Bartholin's Cyst)
 - 21) Gamma knife surgery

Nevertheless, if there is a surgery, the surgeon's fee will be based on the surgical benefit table attached.

Limitation:

The Company limits the maximum of medical expenses provided for bone marrow transplant, organ transplant, and kidney dialysis to be a maximum of 10% of the **General Expense (GE)** stated in the plan per each disability.

Exclusions

The Company will not pay for the following:

1. **Drugs, treatment, or diagnosis which is not related to the symptoms, injury or sickness as stated in the physician's report.**
2. **Defibrillator or pacemaker**
3. **Artificial aids, durable medical device i.e., hearing aids, eyeglasses, contact lens, breathing aid device, oxygen generated device, vital signs monitoring device (pulse, blood pressure, temperature), supporting device i.e. crutches, wheelchair, artificial organ i.e. prostheses, lens.**
4. **Special nursing care**

Insuring Agreement Surgical Care

The Company will pay for the following surgery benefits when the covered person requires a surgical procedure as follows

1. Surgeon's operation fee

The Company will pay the fee charged by a surgeon or physician for a surgical operation or invasive procedure resulting from injury or sickness as follows:

- 1.1 For any one operation, not more than the surgical fee actually incurred or the applicable amount specified for that operation in the schedule of surgical benefits, whichever is smaller.
- 1.2 For one surgery benefit, reflecting the one which provides the highest benefit when more than one operation is performed through the same incision
- 1.3 For all operations performed during one disability, the Company shall not pay more than the maximum benefit stated in the policy schedule.

2. Surgical consultation

For a consultation with a specialist in connection with an operation, the Company agrees to pay benefits to the covered person as follows:

- 2.1 not more than the actual fee incurred or the surgical benefit maximum stated whichever is smaller.
- 2.2 the consultation fee shall be included in the surgical fee and the company shall not pay more than the applicable amount specified in the schedule whichever is the smaller.

Limitation:

The Company limits the maximum of medical expenses provided for bone marrow transplant, organ transplant, and kidney dialysis to be a maximum of 10% of the [General Expense \(GE\) stated in the plan](#) per each disability.

Exclusions

The Company will not pay for the following:

1. **Drugs, treatment, or diagnosis which is not related to the symptoms, injury or sickness as stated in the physician's report.**
2. **Special nursing care**

Insuring Agreement Physician care

The Company agrees to pay for care given by a physician visiting the covered person occupying a bed in hospital (in-patient) in connection with the treatment of injury or sickness.

The amount of benefit paid with respect to each disability shall not be more than the actual amount of charges incurred or the applicable amount specified in the schedule whichever is the smaller. The number of visits shall not exceed the number of days the Insured is hospitalized.

Limitation:

The Company limits the maximum of medical expenses provided for bone marrow transplant, organ transplant, and kidney dialysis to be a maximum of 10% of the [General Expense \(GE\) stated in the plan](#) per each disability.

Exclusions

The Company will not pay for the following:

- 1. Drugs, treatment, or diagnosis which is not related to the symptoms, injury or sickness as stated in the physician's report.**
- 2. Special nursing care**

Insuring Agreement Outpatient Care

The Company agrees to pay benefits to the Insured or covered person for treatment by a physician as a result of accident or sickness as follows:

1. Outpatient Care

The amount paid will not be more than the actual amount paid or the limit per visit or the maximum benefit stated in the schedule whichever is smaller.

The maximum number of visits allowed per day is 1.

The maximum number of visits allowed per year is 30

The maximum number of visits per disability will be 7.

If further treatment is required for the same condition or symptoms this will only be considered as a new disability provided that 14 days has elapsed.

2. Medicine for Outpatient

Medicine must be prescribed by the physician and for usage of not more than thirty days after outpatient treatment date.

Limitation:

The Company limits the maximum of medical expenses provided for bone marrow transplant, organ transplant, and kidney dialysis to be a maximum of 10% of the [General Expense \(GE\) stated in the plan](#) per each disability.

Exclusions

The Company will not pay for the following:

- 1. Drugs, treatment, or diagnosis which is not related to the symptoms, injury or sickness as stated in the physician's report.**
- 2. Defibrillator or pacemaker**
- 3. Artificial aids, durable medical device i.e., hearing aids, eyeglasses, contact lens, breathing aid device, oxygen generated device, vital signs monitoring device (pulse, blood pressure, temperature), supporting device i.e. crutches, wheelchair, artificial organ i.e. prostheses, lens.**

EXTENDED CLAUSE MAJOR MEDICAL

Notwithstanding anything contained herein to the contrary, it is hereby agreed and noted that the Company will indemnify the covered person for the following major medical benefits:

1. MAJOR MEDICAL BENEFITS

The Company will pay 90% of the eligible expenses resulting from sickness or injury in excess of the deductible as stated in 2.

2. DEDUCTIBLE

The deductible is the amount for which each Insured or covered person has to be responsible for up to an agreed limit stated in the schedule. It applies to the actual amount of the eligible expenses for a period of not over six consecutive months whilst the policy is still in force. The benefits under Insuring Agreement – Inpatient hospitalization, Surgical care and Physician Care may be used in contribution towards the payment of the deductible.

3. MAXIMUM AMOUNT OF BENEFIT

The maximum amount to be paid under this agreement to the Insured or covered person in respect of eligible expenses for injury or sickness arising out of the same cause, for one or more benefit periods, will be the maximum amount specified in the schedule.

4. BENEFIT PERIOD

The Company shall pay benefits for eligible expenses in connection with injury or sickness arising out of or related to the same cause, starting from the date the eligible expenses exceed the deductible and continue from that date up to one year. The benefit period will end on

- 4.1 The day that the insured or the covered person recovers from such injury or sickness or
- 4.2 The day that the maximum limit for such disability becomes payable or
- 4.3 The day that the coverage for the covered person is terminated.
- 4.4 The expiry date of the policy as stated in the policy schedule and the Insured does not confirm the policy renewal. In this case and if a Covered person is hospitalized on or before the policy expiry date, cover for that person will terminate on his or her discharge date from hospital and the cost of that treatment will only be paid up to the maximum benefit shown in the policy schedule whichever happens first.

5. ELIGIBLE EXPENSES

Eligible expenses mean all necessary expenses incurred for medical treatment or diagnosis provided by the physician and such expenses must not be in excess of the usual and customary charges in the geographical area in which the service or supply is furnished. Eligible expenses shall be deemed to be incurred on the date on which services or supplies are rendered or obtained and the following expenses will be treated as eligible expenses:

- 5.1 the expenses as per the insuring agreement Inpatient hospitalization regarding No. 1 (Room and board including nursing care) except the portion in excess of the daily limit stated in the schedule.
- 5.2 The expenses as per insuring agreement Inpatient hospitalization regarding No. 2 (Hospital general expenses), Surgical Care, and Physician Care

EXCLUSIONS

The Company will not pay for the following treatment

- 1. Organ transplant and kidney dialysis**
- 2. Treatment or surgical operation which has not been recommended by a Physician or a surgeon and any treatment which has been recommended by a Physician or a surgeon but there is medical evidence that such treatment is unnecessary.**
- 3. Special Nursing Care**
- 4. Defibrillator or Pacemaker**
- 5. Artificial aids, durable medical device i.e., hearing aids, eyeglasses, contact lens, breathing aid device, oxygen generated device, vital signs monitoring device (pulse, blood pressure, temperature), supporting device i.e. crutches, wheelchair, artificial organ i.e. prostheses, lens.**

Personal Accident (PA 2)
Accidental Death, Dismemberment and Disability Coverage
(This is separate coverage that is totally unrelated to the treatment coverage)

1. The Company affords coverage only for the insuring agreement which has an amount of liability stated in the schedule for that item.

This insurance pays a lump sum figure for any losses or injuries to the covered person arising from bodily injury, which is caused by an accident, giving results as follows:

No.1. Loss of life, Dismemberment, Loss of sight or Permanent Disability

If the covered person sustains injury and it causes loss of life, dismemberment, loss of sight, loss of hearing, loss of speech, or permanent disability within 180 days from the date of the accident or the injury causes the covered person to receive continuous medical treatment as an inpatient 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 schedule as follows:

- 1.1. 100% of the sum insured for loss of life.
- 1.2. 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 covered person suffers permanent disability.
- 1.3. 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.
- 1.4. 100% of the sum insured for loss of one hand from the wrist joint and one foot from the ankle joint.
- 1.5. 100% of the sum insured for loss of one hand from the wrist joint and loss of sight in one eye.
- 1.6. 100% of the sum insured for loss of one foot from ankle joint and loss of sight in one eye.
- 1.7. 60% of the sum insured for loss of one hand from the wrist joint.
- 1.8. 60% of the sum insured for loss of one foot from the ankle joint.
- 1.9. 60% of the sum insured for loss of sight in one eye.
- 1.10. 50% of the sum insured for permanent loss of hearing or speech.
- 1.11. 15% of the sum insured for permanent loss of hearing in one ear.
- 1.12. 25% of the sum insured for loss of a thumb (two joints)
- 1.13. 10% of the sum insured for loss of a thumb (one joints)
- 1.14. 10% of the sum insured for loss of an index finger (three joints)
- 1.15. 8% of the sum insured for loss of an index finger (two joints)
- 1.16. 4% of the sum insured for loss of an index finger (one joints)
- 1.17. 17.5% of the sum insured for loss of each finger (not less than two joints) other than a thumb and an index finger.
- 1.18. 5% of the sum insured for loss of a big toe.
- 1.19. 1% of the sum insured for loss of each toe (not less than two joints) other than a big toe.

Permanent dismemberment refers to the loss of body organ from the wrist joint, 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. For any one event, the company shall compensate only one item under the schedule, being that item has the highest limit except

in the case of loss of fingers or toes according to item No. 1.12 to 1.19 and where the covered person cannot claim on items 1.1 to 1.9 in any event or policy period, all items combined cannot exceed the limit of liability stated in the schedule.

In case a **Partial Permanent Disability** is incurred by the covered person which could not be compensated under item no. 1.2 to 1.19, and it is not either loss of taste or loss of smell, the company will compensate in accordance with the opinion of the company's appointed doctor and in no case will compensation exceed 50% of the sum insured specified in the schedule.

Exclusions This insurance does not cover

1. Loss or Injury arising from/or in consequence of the following causes:

- a) Any loss or Injury arising from the action of the covered person whilst 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. and over.
- b) Suicide or attempted suicide or self-inflicted injury.
- c) Infections except pyogenic infection, tetanus, or rabies from a wound or cut suffered as a result of an accident.
- d) 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.
- e) Miscarriage and abortion.
- f) Dental care or root canal treatment unless the treatment is obtained within 7 days from the date of having the accident.
- g) Replacement of or new sets of dentures and crowns.
- h) Food poisoning.
- l) Backache as a result of Herniated Disc, Prolapsed Disc, Subluxation or Spondylolisthesis, Degeneration or Spondylosis except if there is a fracture or dislocation of spinal cord as a result of an accident.
- j) War (whether declared or not), invasion, acts of foreign enemies, civil war, revolution, insurrection, civil commotion, popular rising against the government, riot, strike, terrorist.
- k) Nuclear weapons, radiation or radioactivity from any nuclear fuel or

2. Loss or Injury which occurs:

- a) While the Insured is hunting for animals, racing of all kinds of car or boat, horse racing, ski playing or racing, skate racing, boxing, parachute jumping (except for the purpose of life saving) , boarding or traveling in a hot-air balloon, gliding, bungee jumping, mountain climbing with equipment, or diving with oxygen tank and breathing equipment under water.
- b) While the Insured is boarding or traveling in an aircraft which has no license for carrying passengers or does not operate as a commercial aircraft.
- c) While the Insured pilots or works as a crew in any aircraft.
- d) While the Insured is taking part in a brawl or taking part in inciting a brawl.
- e) While the Insured is committing a felony or while the Insured is being arrested, under arrest, or escaping the arrest.
- f) While the Insured serves as a soldier, police, or a volunteer and participates in war or crime suppression. If the time served is more than 30 days, the Company shall refund the premium from the date of service until such service is ended. After such time, the Insurance shall become effective again until the expiry date shown on the Schedule.