Policy Terms and Conditions

MyHEALTH Health & Accident Insurance Policy

SOMPO | april International



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

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

I DEFINITIONS

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

A. **ACCIDENT OR ACCIDENTAL:** A sudden, unexpected and specific event, external to the body, beyond one's control, and directly leading to physical injury, which occurs at an identifiable time and place.

A. **ACTIVE CANCER TREATMENT:** A course of treatment intended to affect the growth of the cancer by shrinking the cancer, stabilising it or slowing the spread of disease, and not given solely to relieve symptoms or to prevent a recurrence. It also includes the first consultation with the oncologist after the last treatment in the last planned course of active cancer treatment, and any associated diagnostic scans and tests.

A. **ASEAN:** Brunei; Cambodia; Indonesia; Laos; Malaysia; Myanmar; Philippines; Singapore; Thailand; Vietnam

A. **ASSISTED CONCEPTION:** The use of medical technology to increase the number of eggs during ovulation or to bring a human sperm and an egg, or eggs, close together, thereby increasing the chance of conception. This includes but is not limited to Intra-uterine insemination (IUI), In vitro fertilization (IVF), intracytoplasmic sperm injection (ICSI) or the use of any form of treatment to induce or increase ovulation.

B. **BEHAVIOURAL OR DEVELOPMENTAL DISORDER:** A disability classified in categories F53 and F59 to F98 of the International Classification of Diseases 10th Revision (2025 version).

B. **BENEFITS SCHEDULE:** The schedule(s) showing each of the benefits available under this policy and the limit available for those benefits for each member.

C. **CHRONIC CONDITION:** A disease, illness or injury that has one or more of the following characteristics:
- it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests; or
- it needs ongoing or long-term control or relief of symptoms; or
- you need to be rehabilitated or specially trained to cope with it; or
- it continues indefinitely; or
- it has no known cure; or
- it comes back or is likely to come back.

C. **CLINIC:** Any medical centre which provides medical services without any overnight patients, and which holds a license or is registered as a "clinic" under the law in the locality where services are provided.

C. **CO-INSURANCE PERCENTAGE:** The share of expenses, in excess of deductible, if any, for which you are liable, shown on the benefits schedule.

C. **COMPLEMENTARY MEDICINE:** Therapeutic services rendered by one of the types of practitioner listed in the Complementary Medicine and Traditional Chinese Medicine section of the benefits schedule, other than yourself or someone related to you by blood, marriage or adoption, who is qualified by education and training and, if required or permitted to be licensed or registered by the laws of the place where service took place, is licensed or registered in that place, and who is performing such services is acting within the scope and training of that discipline.

C. **COMPLICATIONS OF CHILDBIRTH:** Any complications that arise during the delivery stage including emergency C-section. The coverage of the complication of childbirth is applicable to the mother and child.

C. **COMPLICATIONS OF PREGNANCY:** Only the complications that arise during the antenatal stage of pregnancy are covered. Any claims related to wholly or partially or arising directly or indirectly during the delivery stage, including complications arising from the delivery stage, shall not be covered. The coverage of the complications of pregnancy is applicable to the mother only.

C. **CONFINEMENT:** A medically necessary overnight stay as a registered bed patient in a hospital

C. **CONGENITAL CONDITION:** Any condition classified as a congenital anomaly in the International Classification of Diseases 10th Revision (2025 version).

C. **CONTINUOUS PERSONAL MEDICAL EXCLUSIONS:** Means that we apply the special underwriting terms of a preceding policy. Any pre-existing condition which would have been covered by the preceding policy shall continue to be covered under this Policy, but not to exceed the limits which would have been obtainable under the provisions of the Preceding Policy or the provisions of this Policy, whichever is lower.

C. **COSMETIC TREATMENT**: Surgery, chemical treatment, or other procedures performed to reshape or modify structures of the body or physical appearance, including treatment of any medical condition which arises in any way from cosmetic procedures.

C. **COUNTRY OF RESIDENCE:** The geographical country in which the policyholder or insured person, as the case may be, spends the greatest amount of time during the period of insurance.

C. **CUSTODIAL OR MAINTENANCE CARE:** Care provided mainly:
a. For personal needs, comfort or convenience for which specialised medical training or skills are not necessary; or
b. To maintain, rather than improve, a physical or mental function, or to provide a protected environment, including physician-prescribed bed rest.

D. **DEDUCTIBLE:** An amount shown on the benefits schedule corresponding to a benefit available under this policy. We are entitled to deduct this amount from any payment of expenses.

D. **DENTAL TREATMENT:** Evaluation, diagnosis, prevention, and surgical or non-surgical treatment of diseases, disorders and conditions of the oral cavity, maxillofacial area and the adjacent and associated structures.

D. **DENTIST:** A properly qualified practitioner other than yourself or someone related to you by blood, marriage or adoption, who is licensed by the competent authorities of the country in which treatment is provided to render dental treatment, and who in rendering such treatment is practicing within the scope of his or her licensing and training.

D. **DEPENDANT:** Your spouse under the law of your country of residence or your de facto partner. Each of your unmarried children, stepchildren or adopted children who are under twenty-three (23) years of age for all or part of the period of insurance.

D **DIAGNOSTIC SCANS AND TESTS:** Medically necessary tests and procedures, including surgery on the skin and subcutaneous tissue to treat an illness, prescribed by an attending physician, other than surgery following a confirmed diagnosis of cancer. This benefit also includes - unless otherwise stated on the benefits schedule: laboratory tests and pathology, CT scan, PET Scan, MRI, ultrasound, ECG, endoscopic exams such as laryngoscopy, nasopharyngoscopy and otoscopy (not including invasive endoscopic examinations), and x-ray.

D. **DISABILITY:** An illness or injury, and any symptoms, sequelae, or complications thereof. In the case of injury, it means all injuries arising from the same event or series of contiguous events.

E. **EFFECTIVE DATE:** The date specified on the policy pack document as the date on which the period of insurance in respect of any insured person commences under this policy.

E. **EMERGENCY:** A sudden change in your health as a result of an accident or acute exacerbation of a disability which requires immediate medical or surgical intervention within 24 hours to avoid permanent damage to your life or health.

E. **EXPENSES:** Amounts you incur during the period of insurance for a medically necessary service, and which fall within the categories of benefits shown on the benefits schedule.

E. **EXPERIMENTAL TREATMENT:** Treatment and drugs are deemed experimental if they have not been approved by the European Medicines Agency (EMA), and the Food and Drug Administration (FDA) despite the treatment is approved by the local governance. Approved treatment and drugs should be used within the terms of a valid license, it means that off-label drug will be considered as experimental.
Surgery, procedures are deemed experimental if they have not been recommended by international clinical guidelines and used within their indication. Clinical consensus is not considered as an international clinical guideline.
Should these agencies or guidelines have conflicting views or provide no guidance, APRIL medical team will make a decision based on published medical articles which are using a rigorous scientific method (including randomised controlled trial) to prove the safety and efficacy of the treatment and drug. This definition also includes medical equipment, technique or approach used for purposes other than those defined under their license or which is undergoing study, research or testing.

E. **EXTERNAL PROSTHESIS:** An artificial body part prescribed by an attending physician as part of treatment relating to a disability covered by this policy.

F. **FULL MEDICAL UNDERWRITING:** Means that you must provide us with a detailed medical history on the Full Medical Underwriting Application Form to enable us to decide whether to accept or decline your application and whether we need to apply any specific exclusions or loadings to your policy.

G. **GENERAL SERVICE RATE:** The rate of medical service fees or medical treatment fees of a hospital or a medical centre where the insured receives the medical treatment, which is not relatively higher than other patients who receive medical treatment in that hospital or medical centre at the same time.

H. **HEREDITARY CONDITIONS:** An illness caused by a genetic abnormality passed down from the parents' genes. Cancers that are present in combination with other symptoms of the hereditary condition are included in this definition.

H. **HIV/AIDS**: Infection with the Human Immunodeficiency Virus and any mutation thereof and/or Acquired Immune Deficiency Syndrome ("AIDS") and any symptoms relating thereto or illnesses arising therefrom. AIDS includes any cancer or infection in an HIV-infected person who, on or at any time before the date of service, had a CD4 T-cell count below 200 cells per microliter. HIV/AIDS costs may only be claimed under the HIV/AIDS section of the benefits schedule, and no other type of benefit under this policy provides coverage in connection with HIV/AIDS.

H. **HOME COUNTRY:** The country of the passport or identity document of insured persons listed on the application or notified to us under the terms governing material changes. For any dependant who does not hold a passport, it will be the home country of their policyholder.

H. **HOSPICE OR PALLIATIVE TREATMENT:** A program of medical, psychological, social, and spiritual care provided to persons who have been diagnosed as suffering from a terminal illness. Treatment must be prescribed by a physician and provided by a hospital or institution licensed by the competent medical authorities of the country in which care is provided and which, in providing care, is practicing within the scope of its license.

H. **HOSPITAL:** An institution licensed by the competent medical authorities of the country in which it is located to provide care and treatment of sick and injured persons as bed patients and which:

a. has full diagnostic, therapeutic and surgical procedures; and
b. provides 24 hour a day nursing services by registered graduate nurses; and is supervised by a staff of physicians; and
c. Is not primarily a clinic, an intermediate care facility or nursing home, a mental institution, a home for the aged, or a place for alcoholics or drug addicts.

I. **HOSPITAL ROOM AND BOARD:** Room and board and general nursing care, subject to the following accommodation levels as stated on the benefits schedule.
SINGLE OCCUPANCY ROOM: The base class of rooms having one (1) patient bed per room with an en-suite bath or shower room. Single occupancy room does not include higher-tier accommodations and luxury rooms such as suites, VIP rooms, or deluxe rooms.
DOUBLE OCCUPANCY ROOM: A class of room having two (2) patient beds per room and a shared bath or shower room, whether both beds are occupied or not.
WARD: A class of room having three (3) or more patient beds per room, whether all beds are occupied or not.
Room Category Coverage and Penalties: If a member is admitted to a higher category room than entitled to, a 50% co-payment penalty will be applied.

- In Hong Kong and Singapore, this penalty will be applied to the entire hospital bill.
- In other countries, the 50% penalty will be applied to all items impacted by the room type selected. This approach accounts for regional variations in healthcare practices and costs.

J. **HYPNOSIS:** Also referred to as guided hypnosis, is a form of psychotherapy that uses relaxation, extreme concentration, and intense attention to achieve a heightened state of consciousness or mindfulness.

H. **HYPNOTHERAPIST:** Qualified Hypnotherapists and Psychologists can administer hypnosis to individuals.

I. **ILLNESS:** A physical condition, including symptoms, sequelae, or complications, marked by a pathological deviation from the normal healthy state during the period of insurance

I. **INJURY:** Identifiable physical damage to your body which is caused by an accident solely and independently of any other causes, is not intentionally self-inflicted, and does not result from illness.

I. **INPATIENT:** A patient who, due to medical necessity, is admitted to a hospital or any medical facility to receive continuous treatment for an Injury or Illness for not less than 18 hours and is duly registered as an Inpatient. This includes cases where the patient is admitted but dies before completing the eighteen period.

I. **INSURED / INSURED PERSON:** The person/persons identified on the namelist.

I. **INTENSIVE CARE UNIT:** A class of room dedicated to the constant, close monitoring of the vital body functions of critically ill patients, which provides a high ratio of nursing staff to patients, and which has full facilities for the resuscitation of patients. This definition also includes a coronary care unit which has facilities not less comprehensive than those described above.

I. **INTERMEDIARY:** The authorised agent, broker or financial advisor who arranged this cover.

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

I. **INVASIVE ENDOSCOPIC EXAMINATION:** The following endoscopies: arthroscopy, colonoscopy, cystoscopy, enteroscopy, laparoscopy, mediastinoscopy, sigmoidoscopy, thoracoscopy/pleuroscopy, upper gastrointestinal endoscopy, ureteroscopy.

K. **KIDNEY DIALYSIS:** Hemodialysis and peritoneal dialysis. Kidney dialysis expenses may only be claimed under the kidney dialysis section of the benefits schedule if available, and no other type of benefit under this policy provides coverage in connection with kidney dialysis.

L. **LOSS OR DAMAGE:** Any bodily injury of the insured by an accident, which causes the insured to lose life, organ, sight or to sustain any disability or injury.

M. **MAJOR DENTAL TREATMENT:** Surgical removal of impacted, buried, or unerupted teeth/roots or odontomes; treatment of disorders of the temporomandibular joint (TMJ); orthodontics treatment commenced below the age of 16; dental implants; root canal therapy or apicoectomy; dentures (new/repair of old); gold, amalgam, composite or porcelain crowns and bridges; treatment by a dentist of illnesses of the oral mucosa and directly related laboratory tests or pathology services; antibiotics or medicines for pain management for which a prescription is required for purchase and which have been prescribed by a dentist; periodontics, deep oral prophylaxis or root planing.

M. **MEDICAL APPLIANCES:** The following items and their accessories if prescribed by a physician or a complementary medicine practitioner for a disability: cranial helmets, nebulisers, oxygen pumps and masks, hearing aids, corrective splints, insulin pumps, infusion pumps, glucose monitors and lancets, orthotics/orthopaedic braces, supports (addition) and boots, tracheo-esophageal voice prosthesis, compression stockings, arch support, diabetes consumables and ostomy supplies.

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

M. **MEDICAL TREATMENT:** The provision of medical and public health services for the purpose of diagnosis, treatment, relief, care and recovery of the capability medically necessary for health and the living.

M. **MEDICALLY NECESSARY:** Possessing an identifiable relationship to either a covered disability or symptom(s) of a disability which if existing would be covered under the policy. It refers to necessary and appropriate medical treatment, services or supplies, i.e.:

a. a therapeutic service required to treat or prevent damage to life or health where you have an illness or injury;
b. a diagnostic service to determine whether therapeutic services are necessary, where you have active symptoms, the cause of which are unknown, but which are suggestive of an illness or injury, or
c. A treatment or service required for reasons other than the comfort or convenience of you or physicians.

The term "appropriate" shall mean taking patient safety and cost effectiveness into consideration. It also includes the appropriateness of the type of service (outpatient/daypatient/inpatient) based on the medical standard. When specifically applied to inpatient request, we reserve the right to decline an inpatient stay for a procedure or treatment that is commonly prescribed as outpatient/daypatient.

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

M. **MENTAL AND NERVOUS CONDITION:** Any condition classified in categories F01 – F09, F20 – F48, F54 and F99 of the International Classification of Diseases 10th Revision (2025 version).

M. **MINOR DENTAL TREATMENT:** Dental check-up, x-ray, gold or amalgam or composite or porcelain inlays/onlays/fillings; routine tooth cleaning, scaling, and prophylaxis (including when done by an oral hygienist); simple extractions; mouth guard; and application of sealants.

M. **MOBILITY AIDS:** Crutches, canes, walkers, manual wheelchairs and non-motorised knee scooters.

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

- was foreseeable
- clearly showed itself
- you have had signs or symptoms, or you were aware of the condition
- you have received treatment for or sought medical advice for the condition or a related condition (including medical checkups)
- to the best of your knowledge that you were aware you had
- requires monitoring according to generally accepted medical advice or opinion.

These conditions may be covered after you have had continuous cover with us for 24 months during which you have not had any symptoms, sought advice, needed or received any medication, treatment for the pre-existing condition or any related condition. If the pre-existing condition recurs, then once you have completed a 24-month period where none of these apply, the medical condition may then be covered. Certain pre-existing conditions may never be covered under a moratorium policy. These include disabilities and chronic and incurable conditions; for example, diabetes, chronic hypertension (raised blood pressure), hyperlipidaemia (raised cholesterol levels), ischemic heart disease, cancer, thyroid disease, and auto-immune disorders. If you have suffered from any of these conditions, or any other condition for which it is generally accepted medical advice that it be monitored, then that condition may never be covered. Any condition related to an excluded condition will also be excluded from cover. Maximum entry age is 45 under Moratorium policies.

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

N. **NEONATAL DISABILITY:** A disability which existed during the neonatal period, and any disabilities directly or indirectly arising therefrom or relating thereto. It includes pre-term birth and any congenital conditions which are diagnosed or present symptoms of which medical professionals or parents are aware or reasonably should be aware of during the neonatal period.

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

N. **NETWORK PROVIDERS (formerly SPECIFIED INPATIENT PROVIDERS):** Medical providers within our network where full coverage is available, depending on your selected plan (Standard or Premium).

- **PREMIUM NETWORK:** Provides full coverage at all medical providers.
- **STANDARD NETWORK:** Provides full coverage at all medical providers, except for selected providers in Asia, where a 40% co-insurance applies.

For the list of these providers, please refer to your Benefits Schedule.

N. **NEWBORN INFANT:** A child under 28 days of age.

N. **NURSERY CARE:** Includes (i) accommodation for the child, (ii) customary examinations required to assess the integrity and basic function of the child's organs and skeletal structures (these essential examinations are carried out immediately following birth) and, (iii) further preventive diagnostic procedures, such as routine swabs, blood typing , and hearing tests, if they occur before the child's discharge and if they are performed within 7 days from the childbirth.

O. **ORAL HYGIENIST:** A properly qualified specialist of a dentist who is licensed, if required, by the competent medical authorities of the country in which treatment is provided to render services such as cleaning and anaesthesia, and who is rendering such treatment at the direction of, and under the direct supervision of a dentist.

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

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

P. **PANEL NETWORK:** Medical providers in our network who are indicated as panel network providers in our current Outpatient Direct Billing network list.

P. **PARENTAL ACCOMMODATION:** A fee for an additional bed in the same room for a parent or legal guardian staying with a dependant child below age 23 covered under this policy who is admitted as an inpatient in a hospital for the treatment of a covered disability.

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

P. **PHYSICIAN:** A doctor of western medicine (e.g. complementary and alternative medicines practitioners excluded) other than yourself or someone related to you by blood, marriage or adoption, who is licensed by the competent medical authorities of the country in which treatment is provided, and who in rendering such treatment is practicing within the scope of his or her licensing and training.

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

P. **POLICYHOLDER:** An individual or organisation that enters into an insurance contract with the insurer and pays the insurance premium. The policyholder has an insurable interest in the insured person. The policyholder may also be the insured person or the beneficiary.

P. **POLICY YEAR:** A period of 12 months from the first inception date and the subsequent annual anniversary thereafter.

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

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

P. **PRECEDING POLICY:** Means a long-term international health insurance policy covering illness and bodily injury which terminates no earlier than the day prior to the effective date in respect of an insured person, and a copy of which has been provided to us upon application. It must be of an equivalent class of cover as that being applied for and meet the acceptability criteria defined by us at the time of application.

P. **PRE-EXISTING CONDITION:** Any disability:

a. Which existed before the period of insurance, and which presented signs or symptoms of which you were aware or should reasonably have been aware of; or
b. For which you have sought or received treatment, medication, advice or diagnosis in the 24 months before the period of insurance; or
c. Which you knew to exist before the period of insurance and whether or not you sought or received treatment, medication, advice, or diagnosis for it.

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

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

P. **PREVENTIVE (PROPHYLACTIC) SURGERY:** Refers to surgical procedures performed to remove tissues, organs, or glands that have a high probability of becoming cancerous in the future, aimed at reducing the risk of future health issues. This includes, but is not limited to, procedures such as mastectomy or prophylactic oophorectomy when a parent, grandparent, sibling, or child has been diagnosed with a disease that is part of a hereditary cancer syndrome (such as breast cancer or ovarian cancer) confirmed by a genetic test. The surgery should be prescribed by a qualified medical professional and approved as medically necessary by our Medical Team or a qualified physician approved by us.

P. **PREVENTIVE TREATMENT:** Treatments that prevent occurrence or recurrence of a disability, injury or illness, rather than treating a disability.

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

P. **PSYCHOLOGIST OR PSYCHOTHERAPIST**: A psychologist / psychotherapist other than yourself or someone related to you by blood, marriage or adoption, who is licensed by the competent medical authorities of the country in which treatment is provided or in which the psychologist / psychotherapist finished the study, and who in rendering such treatment is practicing within the scope of his or her licensing and training.

R. **REASONABLE AND CUSTOMARY:** An amount comparable to that charged by others of similar professional standing in the same locality, for the same class of hospital room, for a person of similar sex and age, for a similar disability, without regard to ability to pay or the availability or adequacy of insurance. Where an insured person stays in a hospital room above the hospital room and board level shown on the benefits schedule, reasonable and customary charges will be limited to comparable charges for the highest class of room for which the insured person is covered.

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

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

R. **REHABILITATION CENTRE:** A facility specifically licensed to care for people who have suffered neurological, musculoskeletal, orthopaedic and other serious medical conditions and are not yet able to care for themselves at home. It must be:

- a unit within a hospital or a separate facility having accommodation for bed patients;
- organised to provide an intensive rehabilitation program to inpatients;
- under supervision of a physician; and
- staffed full-time by nurses working under the supervision of a registered nurse.

R. **REHABILITATION TREATMENT:** Treatment following a disability upon referral by an attending specialist to restore normal form/near to normal form or function to the body. In addition to room and board and general nursing fees, the following additional costs incurred while admitted to the rehabilitation centre will be covered under this benefit:

- occupational therapy fees
- special treatment room fees
- speech therapy fees

Rehabilitation centre services must be certified by a specialist as medically necessary. The factors to be considered in making such certification must include, but are not necessarily limited to,

- the type and severity of the illness or injury, and the insured person's overall state of health and prior treatment history;
- the amount of therapy expected to be performed every day;
- the risk of deterioration or non-recovery of function if therapy is not completed; and
- the extent to which the insured person will be able to perform activities of daily living during the rehabilitation period.

In all cases we reserve the right to require re-authorisation of rehabilitation centre services at any time upon notice to the insured.

S. **SEXUALLY TRANSMITTED DISEASE:** Illness classified as an infection with a predominantly sexual mode of transmission in the International Classification of Diseases 10th Revision (2025 version).

S. **SPECIALIZED PHYSICIAN / SPECIALIST:** A physician who holds a diploma or certificate as specialist in a particular field from the Medical Council or an equivalent institute under the law in the locality where services are provided, provided that he/she must not be the primary physician, but a physician who provides consultation, care or treatment in association with the primary physician.

S. **STANDARD OF MEDICAL PRACTICE:** Criteria or guidelines for medical treatment of injury or illness according to the technical basis in line with the standards in the locality where services are provided, as follows:

a. Professional standards and applicable professional regulations;
b. Medical centre standards;
c. Standards of medicine and medical appliances;
d. Non-discriminatory patient treatment practice

S. **STEM CELL TREATMENT:** Treatment for a disability where an immediate advantage compared to other forms of treatment can be identified and verified by us. It does not include preventive treatment.

S. **SUDDEN ILLNESS OR INJURY:** Either

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

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

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

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

T. **TERMINAL ILLNESS:** An illness that is approaching its final stages, for which treatment can no longer be expected to cure and will lead to death (life expectancy being a matter of months). In all circumstances, treatments for terminal illnesses must be pre-approved by us. We reserve the right to consider any treatment for a Terminal Illness as Palliative and to apply the corresponding limits of your benefits schedule.

T. **TERRORIST ACT:** An act, or acts, of any person, or group(s) of persons, committed for political, religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist act can include, but not be limited to, the actual use of force or violence and/or the threat of such use. Furthermore, the perpetrators of a terrorist act can either be acting alone, or on behalf of, or in connection with any organisation(s) or government(s).

T. **THERAPEUTIC ABORTION:** The termination of a pregnancy that is deemed medically necessary if there is an underlying or life-threatening condition which will endanger the mother's physical health or if there is a fetal abnormality.

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

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

W. **WAITING PERIOD:** A period during which related insurance benefits shall not be covered, including benefits for claims filed after the waiting period but medical expenses or consequences of medical treatment have been incurring during the waiting period.

W. **WAR:** War, whether declared or not, or any warlike activities, including use of military force by any sovereign nation to achieve economic, geographic, nationalistic, political, racial, religious or other ends.

W. **WE, US, OUR:** Sompo Insurance (Thailand) Public Company Limited

Y. **YOU, YOUR:** The policyholder and/or insured person and/or his or her dependants named on the namelist.

II GENERAL TERMS AND CONDITIONS

1. Insurance Agreement

This insurance agreement is issued by us based on the declaration made in the insurance application, health certificate or additional declarations (if any) signed by the Policyholder and/or the insured person, as applicable, as a precondition of the insurance agreement.
In the event that the Policyholder or the insured person knowingly makes false statements or fails to disclose true statements and we become aware of such information, we have the right to increase the premium or void the policy in accordance with Clause 865 of Civil and Commercial Code.
We shall not deny acceptance of responsibility except where there has been material misrepresentation in the aforementioned documents submitted by the applicant.

2. No Dispute or Objection to the Validity of the Insurance Agreement

We shall not dispute or object to the validity of this Insurance Policy when it has been in effect for two (2) years or longer from the effective date while the insured person remains alive, or when the insured person has maintained continuous cover with us for at least two (2) consecutive years, or from the date on which we approve any additional benefits under this Insurance Policy, whichever is later. Should we approve any additional benefits, we may dispute or object to the validity of this Insurance Policy only in respect of such additional benefits.
Should we become aware of any grounds to revoke the Insurance Policy under paragraph 1 but fail to exercise such right within one (1) month from the date such grounds become known to us, we may no longer revoke this Insurance Policy on that ground.
We shall not rely upon any facts other than those provided by the insurance application as the basis to challenge or object to the validity of this Insurance Policy under Paragraph 1 and Paragraph 2.
We shall not dispute or object to the validity of this Insurance Policy in the event that the insured suffers from an injury caused by accident, in which case, we shall pay such benefits under this Insurance Policy to the extent that we have received a claim for compensation under this Insurance Policy. Upon our approval for such payment of benefits for the occurrence of that accident, the coverage under this Insurance Policy shall cease from the day following the date of such claim under this Insurance Policy, and we shall refund the premium to the insured, less the part of the benefits under the insuring agreement which has been paid for that injury during the coverage period in proportion, while the premium in respect of the other coverages which have not yet been paid shall be fully refunded by us.

3. Validity and Amendment of the Insurance Agreement

This Insurance Policy, including the insuring agreement and its attachments, shall altogether form the insurance agreement, and any amendment to the insurance agreement shall require our consent and must be recorded in this Insurance Policy or any attachment to be valid.

4. Free Look Period

Should the Policyholder wish to cancel this Insurance Policy for any reason, the Policyholder may return the Insurance Policy to us within 30 days from the date of receipt of the Insurance Policy from us, and we shall refund the remaining premium less the health checkup fees as actually incurred and our expenses at the rate of THB 500 per copy within 15 days from the date on which we have received such request for cancellation of the Insurance Policy.
Should any right of claim for compensation have been exercised under this Insurance Policy, the Policyholder shall not be entitled to cancel the Insurance Policy under this Section 4.

5. Co-Insurance and Deductibles

All expenses will be paid in excess of any deductible that applies and after we have applied any co-insurance percentage, also known as co-payment percentage.

6. Who is Covered?

6.1. Persons whose names appear on the namelist.

6.2. The maximum permitted age at the date of joining this policy is 65 years.

7. Where Are You Covered?

7.1. This policy covers services rendered within the area of cover stated in the benefits schedule.

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

7.2.1 commenced or continued against the orders or advice of any physician or other medical practitioner; or

7.2.2 undertaken in whole or in part for the purpose of obtaining medical care.

8. Period of Cover

The minimum initial period of insurance is twelve (12) months.

9. Premium Payment and grace period

9.1. We must receive the premium on or before the Due Date stated on the policy and/or the Debit Note.

9.2. For the first premium payment of each policy year (for Policyholders who have selected annual premium payment):

9.2.1. if the premium is received after the Due Date but before 11:59pm Thailand time on the 30th day following the Due date, the policy will automatically be reinstated. If the premium is not received within that Grace Period, the policy shall lapse;

9.2.2. if the payment is received after the 90th day following the Due Date (or, for the first payment, at any time after the Due Date), it will be treated as an application for reinstatement of coverage and additional proof of insurability may be required.

9.3. For mid-term premium payments (for Policyholders who have selected quarterly or semi-annual premium payment):

9.3.1. we must receive payment on or before the Due Date stated on the Debit Note.

9.3.2. In the event that mid-term premium payments remain unpaid on or before the Due date, we may provide notice of suspension of claim payments or other services provided under this policy and may lapse the policy. This is in addition to and not in lieu of our other rights or remedies under this policy.

9.4. If any of the premium payments are unpaid, we reserve the right to recover any claims already paid as per Section 21.

10. Misrepresentation of Age or Gender

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

10.1. We received the premium less than what it should have been, we 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, we will not pay the benefit but will refund the paid premium.

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

11. Renewal of the Policy

This Insurance Policy may be renewed on the anniversary of the Insurance Policy. Should we agree to renew the Insurance Policy, we reserve the right:

11.1. to adjust the premium rate as appropriate to the Insured Person's age and risk profile, whereby the adjusted premium shall fall within the range of the premium rates approved by the Insurance Commissioner; and

11.2. to change the underwriting conditions and the coverage conditions of the Insurance Policy in the renewal year as necessary, and we shall inform the Policyholder of such change, addition, or extension of any coverage of the general terms and conditions, exclusions, insuring agreement, attachments, or others which are material to the Insurance Policy;

11.3. to apply a co-payment to the covered expenses under the Insurance Policy in the renewal year as necessary, in accordance with the approved rate of co-payment and regulations by the Office of Insurance Commission. We shall inform the Policyholder of such change at least 15 days prior to the expiry date of the Insurance Policy.

11.4. not to renew the Insurance Policy in any of the following events:

11.4.1. In the event where there is evidence that the Policyholder and/or insured person does not provide the truth in the insurance application or the reinstatement application, the health condition declaration and any other additional statements relating to the health insurance policy, which are material to the extent that we may charge a higher premium or refuse to issue the insurance agreement or underwrite a conditional insurance.

11.4.2. The Insured Person claims any benefits for treatment of injury or illness without any medical necessity.

We reserve the right not to renew the policy with reason(s) for doing so by giving written notice to the Policyholder at least 30 days prior to the policy expiry date as stated in the policy schedule.

12. Premium adjustment

12.1 At renewal, we reserve the right to adjust premiums based on several factors, including changes in the age and risk profile of insured persons, as well as increased medical treatment costs or the overall claims experience of the insurance portfolio.

12.2 Any premium adjustment must be within the rates approved by the Insurance Commissioner.

13. Changes or Upgrades of Benefits during policy year or after policy expires

Should there be any upgrades of the benefits for any insured 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 month after the date that we have been informed of the change, subject to a waiting period if applicable. The following conditions will also apply:

13.1. If the insured person is sick or injured prior to the change, then the old benefit limit still applies;

13.2. Any diseases or injuries for which benefits have already been provided or paid prior to the upgrade will continue to be provided or 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 insured person has not yet received treatment.

The Policyholder must submit a request to us in writing for a change or upgrade of benefits for the insured person(s), subject to medical underwriting if applicable, and it will be effective once we agree to it.

14. Termination of Coverage

14.1. The coverage for the insured person terminates upon the first occurrence of any of the following incidents:

14.1.1. the Policyholder fails to pay the premium of this Insurance Policy within the specified periods stated in Section 9 Premium Payment and grace period. It shall be deemed that the coverage under this Insurance Policy shall cease on the last day on which the premium previously paid is able to purchase the coverage.

14.1.2. on the expiry date of the period of insurance as specified in the Schedule and/or the insurance certificate in the Insurance Policy year.

14.1.3. the Insured person passes away or is imprisoned in jail or prison. We will refund the premium to the Policyholder, minus the pro rata premium for the active period of the policy. This does not apply if we have already paid the maximum benefits for the policy year, as specified in the Schedule and/or the insurance certificate and/or the benefits schedule and/or the endorsement(s) (if any).

14.1.4. the dependant no longer qualifies as a dependant under the aforementioned definition, effective from the policy expiry date.

14.1.5. the Policyholder or we terminate the Insurance Policy under the Paragraph 24 Cancellation of Insurance Policy.

14.1.6. we do not renew this Insurance Policy under Paragraph 11 Renewal of the Policy, on the anniversary of the Insurance Policy. In such cases, we shall give prior written notice to the Policyholder by registered mail or by other means to which the Policyholder has given consent, at least 30 days prior to the date on which the coverage under this Insurance Policy shall cease, as specified in the Schedule and/or the insurance certificate and/or the endorsement(s) (if any).

14.1.7. we had paid claims up to the maximum payable as stated in the Schedule and/or the insurance certificate and/or the benefits schedule and/or the endorsement(s) (if any).

14.2. This Insurance Policy and all insurance under this Insurance Policy shall end at 11.59 pm at the time in Thailand on the expiry date of the Insurance Policy.

14.3. The end of this Insurance Policy shall not prejudice any claims accruing before the end of this Insurance Policy. Receiving any premium payment after the end of this Insurance Policy shall not create any liability on our part, but we shall return such premium accordingly.

14.4. We are not responsible for any injury or sickness that occurs after the coverage is terminated.

15. Reinstatement

15.1. Except as otherwise provided in Paragraph 9.2.2, if the coverage under this Insurance Policy ends due to the Policyholder's failure to pay the premium within the specified periods stated in Paragraph 9, the Policyholder may request to reinstate this Insurance Policy within 90 days from the policy expiry date, subject to our consent.

15.2. If we consent to reinstate this Insurance Policy upon the Policyholder's request, the coverage shall be effective for any injury or illness that occurs from the date of approval for renewal onwards. We shall not reset pre-existing conditions and waiting periods.

15.3. Upon our consent to reinstate this Insurance Policy, the Policyholder shall pay the premium proportionate to the coverage period starting from the date of our approval for renewal.

16. Medical History Examination Rights

16.1. We reserve the right to examine the historical medical treatment records and diagnosis of the insured person to the extent necessary for this Insurance Policy, conduct a physical examination of the insured person who is claiming benefits under this policy, and perform an autopsy in case of death, within the limits of the law. All expenses incurred for such examinations or autopsies shall be borne by us.

16.2. If the insured person does not consent to our examination of their claim, grant permission to access their medical records or diagnosis, or allow a physical examination or autopsy (where legally permitted), we reserve the right to decline such claims or benefits.

17. Notice and Claim

The insured or the beneficiary or the insured's intermediary, as the case may be, shall give notice to us without delay of such injury or illness on which a claim for the benefits under this Insurance Policy may be based, and in case of death, such notice must be given to us immediately, unless it is proven to have any reasonable cause which prevents such notice to be given to us as mentioned above, but the notice must have been given as soon as possible.

18. Claim Submission and Proof of Claim and Cooperation

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

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

18.1.2 evidence of payment made by you.

18.2 We shall receive all evidence or necessary claim documents within 90 days. In the event that we request additional documents or evidence, such information must be delivered to us within 30 days from the request date. Failure to deliver such evidence within such period of time shall not prejudice the right of claim, provided that it is proven that there is a reasonable cause preventing such evidence to be delivered within the specified period, but such evidence must have been delivered as soon as possible, and provided that such documents must be delivered to us within 365 days from the date the insured incurred the expenses.

18.3 Claims can be submitted to us:

18.3.1 via the April Easy Claim smartphone app;

18.3.2 by email to Claims.th@april.com including copies of supporting documents; or

18.3.3 by mail to our address, attaching original documents.

18.4 If you submit claims by email or via the April Easy Claim smartphone app, you must retain a copy of the original documents for a minimum period of 1 year from when you submit the claim and must send the original documents to us upon request or when required by our claim instructions.

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

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

19. Process to obtain Pre-authorisation

19.1. As indicated in the benefits schedule, some services require pre-authorisation, such as but not limited to:
- hospital benefits
- cancer treatment
- surgery performed while a day-patient in a clinic or in a physician's office
- stem cell treatment
- rehabilitation treatment

19.2. Co-payment for pre-authorisation outside the USA:
- 20% co-payment for services not pre-authorised by us.

The co-payment for services that are not pre-authorised will not apply where you can show the services were medically necessary due to an emergency and you or the hospital contacted us within 24 hours after admission or as soon as reasonably possible.

19.3. Co-payment for planned hospitalisation or surgeries in the USA:
- 40% co-payment for services rendered outside our preferred USA network.

The co-payment for services that are rendered outside our preferred USA network will not apply where you can show the services were medically necessary due to an emergency and you or the hospital contacted us within 24 hours after admission or as soon as reasonably possible.

19.4. To obtain pre-authorisation, you must submit your request, via the April Easy Claim smartphone app or via provider.asia@april.com at least 5 working days in advance before admission or treatment.

19.5. Upon receiving your request, we will review the medical necessity and appropriateness of the requested service and within five working days will notify you of our decision to:
- grant pre-approval
- deny pre-approval / request further information

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

19.7. If we request further information you are required to provide any additional information we may require. Paragraphs 18.5 and 18.6 of this policy apply.

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

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

19.10. If pre-authorisation is denied, you may appeal the decision, and we will make a further determination or request additional information within 5 days of receiving your appeal. Only one appeal is permitted per service.

19.11. Particular provisions applicable to certain medical conditions:

19.11.1 In the case of treatments related to sleep disorders (for children and adults), our medical team retains sole discretion to determine whether a proposed treatment or surgical procedure is related to a sleep disorder, including but not limited to sleep apnea and chronic snoring, in both paediatric and adult cases. This determination may be made even in the absence of a formal sleep study. The absence of diagnostic testing shall not preclude the classification of a treatment as sleep disorder-related if clinical indicators and medical judgment support such a conclusion.

19.11.2 In cases of surgical procedures involving septoplasty and/or rhinoplasty, these procedures must be subject to a mandatory Second Medical Opinion (SMO) review conducted by Teladoc. Coverage will only be granted if the procedure is deemed medically necessary by both our medical team and Teladoc's SMO panel. Standardized clinical questions will be incorporated into the SMO report to ensure consistency and transparency in decision-making.

20. Claims against third parties or other insurance

20.1. If another medical or accident insurance covers you for expenses relating to a disability also covered by this policy, you should claim from such source or insurance first and we will only be liable for the excess of the amount recoverable from such other source or insurance. Amounts paid by another source or insurance are applicable to your policy deductible should you have any, and provided that a proof of payment is submitted to us.

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

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

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

21. Right of Recovery

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

21.2. If you have not paid the premiums as per Paragraph 9, we may deduct amounts from any claims or any sum then due or which at any time thereafter may become due to you under this policy, until the said outstanding have been fully satisfied. Exercise by us of our rights here shall be without prejudice to any other rights or remedies available to us under this policy, or otherwise howsoever, at law or in equity.

22. Payment of Benefits

22.1. We will pay benefits, indemnity, or service fees at general service rates within fifteen days from the date we receive complete and accurate evidence of loss or damage. If there is reasonable doubt about any claim for payment under this Insurance Policy, we may extend the payment period as necessary, but not beyond ninety days from the date we receive complete documentation.

22.2. In case of death, we will pay the benefit to the beneficiary. If the claim requires further investigation, we reserve the right to extend the payment date, but not later than 90 days after receiving the completed documents.

22.3. If we cannot pay within the agreed timeframes, we will pay annual interest at a rate of 15%, starting from the date when the claim payment was due.

22.4. If coverage is extended abroad and you receive medical treatment outside Thailand under this Insurance Policy, we will pay benefits using the exchange rate applicable on the date when you received the medical treatment or service.

23. Change of Policy owner

If this insurance policy terminates because the Policyholder dies or for any other reason, the spouse or dependant (if eligible) may request continuation of cover and a change of Policyholder within 90 days after termination, subject to our approval.

24. Cancellation of Insurance Policy

24.1. This Insurance Policy has a minimum term of 12 months. No refunds will be provided if the policy is terminated or cancelled before its expiration date.

24.2. We may cancel this Insurance Policy upon its expiry date by giving you written notice at least 30 days in advance.

24.3. For payment modes other than annual, if premiums are not paid within the agreed timeframe, the policy will automatically expire as of the last premium due date, and we will not refund any premium.

25. Arbitration and time limits

25.1. Should there be any dispute, controversy or claim under this Insurance Policy between the person with the right of claim under the Insurance Policy and us, and if the person with the right of claim wishes and considers it appropriate to resolve such dispute by arbitration, we agree to proceed with arbitration under the Office of Insurance Commission's regulations on arbitration.

25.2. Should the parties be unable to reach an agreement by arbitration within 30 days after the other party has received notice of arbitration, unless the parties agree to extend such period. The arbitrator(s) shall be selected in accordance with the regulations on arbitration of the Office of Insurance Commission (OIC) and may be of the same nationality as that of either party.

25.3. The party wishing to proceed with arbitration shall issue a notice of arbitration to the other party, describing the details of such dispute, provided that the notice of arbitration shall be given within the following periods:

25.3.1. for any dispute, controversy or claim relating to or in connection with our refusal or failure to pay the compensation: 365 days from the date on which we refuse to transfer the right of claim (or on the date of submission of the application, if such claim is not refused); and

25.3.2. for any other dispute, controversy or claim: 365 days from the last day of the period of insurance in which the first event occurs to give rise to dispute, controversy or claim.

25.4. The arbitrator(s) shall be empowered to resolve the dispute and render an award which shall be given in writing.

25.5. The arbitral award may be entered into any court of competent jurisdiction.

25.6. You may contact the Office of Insurance Commission at:
Office of Insurance Commission (OIC)
22/79 Ratchadaphisek Road, Chantharakasem Sub-District, Chatuchak District,
Bangkok 10900, Thailand
Telephone: +66 2515 3999
Hotline: 1186 (insurance complaint & enquiry)
Email: contact@oic.or.th
Website: https://www.oic.or.th

26. Pre-existing Conditions

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

26.1.1. If the insured person has declared such conditions on the application form and we have agreed to cover them without any endorsement to exclude such pre-existing condition, or

26.1.2. After 2 years from the first policy commencement date, we cannot refuse to pay any claims for pre-existing conditions if such disease, illness, injury, symptom, or complications (which occurred 5 years prior to the policy's first commencement date) thereof do not manifest itself.

27. Waiting Periods

27.1 Cover for the following benefits and conditions will commence after an insured person has been continuously covered under the policy and any renewal thereof for the following time periods in respect of an insured person:

27.1.1 Inpatient and Outpatient benefits: we will not cover the following illnesses within the first 120 days from the insured's initial coverage start date: tumors, cysts, or all kinds of cancer, haemorrhoids, all kinds of hernias, pterygium or cataract, tonsillectomy or adenoidectomy, all kinds of calculi, varicose veins, endometriosis; and

27.1.2 Maternity Benefits: 366 days prior to the date of service; and

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

27.1.4 HIV/AIDS: coverage will apply only if signs or symptoms are present for the first time after three years continuous coverage under the plan and any renewal thereof.

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

28. Newborn Additions

28.1. A newborn infant born to the mother who has been covered under the policy for more than 366 days may be added to the policy from birth without any medical underwriting as long as the newborn infant was not born following assisted conception.

28.1.1. You must notify us by submitting the Newborn Additions Form within 28 days of birth of the newborn infant so that we can add the child to the policy. The premium for the newborn infant must be paid according to Paragraph 9.

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

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

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

28.2.2. for whom a Newborn Addition Form was not received by us within 28 days following birth;

28.2.3. who was adopted or was carried by a surrogate; or

28.2.4. who was born following assisted conception.

28.3. Our underwriting process will apply to an addition under article 28.2, and we may decline to provide cover or may offer cover at terms we require. The cover must be equal to the cover provided to the mother (or the father if the mother is not covered under this policy), excluding any optional Maternity Benefits or Dental and Optical Benefits. The start date of coverage for the child will be the date on which the underwriting results are finalised.

29. Sanctions and Compliance with Laws

29.1 We reserve the right not to accept applications for cover or to cease providing cover if, in our opinion, doing so would expose us to the risk of breaching any applicable laws or regulations, including international economic sanctions, laws, or regulations.

29.2 For the avoidance of doubt, we shall not be deemed to provide cover and shall not be liable to pay any claim or provide any benefit under this policy to the extent that the provision of such cover, payment of such claim, or provision of such benefit would expose us to any sanction, prohibition, or restriction under United Nations resolutions or the trade or economic sanctions, laws, or regulations of the European Union ("EU"), United Kingdom ("UK"), United States of America ("USA"), France ("FR"), or any jurisdiction applicable to us.

30. Material Changes

30.1. Any amendment of this Insurance Policy shall be valid only when we approve such amendment, in which case, we shall issue a memorandum of amendment of the Insurance Policy or issue an attachment or endorsement of the Insurance Policy, as the case may be, to the insured.

30.2. As a condition precedent to liability, you must inform us as soon as reasonably practicable of any change relating to the Policyholder and/or the insured person, including name, occupation, country of passport or nationality, or country of residence or province. Failure to notify us of any change listed above may result in premium adjustment, coverage being terminated or declination of claims expenses incurred after the date of such change.

30.3. The insured shall give notice to us as soon as possible of any change in residential or correspondence address. Until such notice is given, we may continue to send correspondence to the last address given to us by you and shall not bear any consequences if such correspondence is not received by you.

31. Fraud or Non-Disclosure of Information

31.1. We may cancel this Insurance Policy and retain the premium under the terms of the Insurance Policy if:

31.1.1. you or an insured person or anyone acting on your or an insured person's behalf provided false information to us, or failed to disclose information to us, in connection with your application or any application for addition of an insured person, upgrade, or reinstatement, and the misrepresentation or nondisclosure was fraudulent; or

31.1.2. any claim is in any respect fraudulent or if fraudulent means or devices are used by you or an insured person or anyone acting on your or an insured person's behalf to obtain benefits under this policy.

31.2. If you and your dependants' coverage is cancelled due to the event of fraud or nondisclosure after claims have been paid, or after we have provided a guarantee of payment to a provider of services, we reserve the right to cancel any amounts paid or guaranteed or claim the payment back from you according to Paragraph 21. The outcomes described above are in addition to, and not in the place of, other rights we may have included those based on the contract, statute, or common law. We will not be bound to pay any claim (in whole or part) where you misrepresented facts in connection with that claim or related claims.

31.3. If nondisclosure is found after claims have been paid, or after we have provided a guarantee of payment to a provider of services, any non-covered amounts paid or guaranteed will become immediately repayable by you to us.

31.4. We reserve the right to reconsider our underwriting should any claim arise regarding a pre-existing condition that was not stated.
in the application for insurance.

32. Precedent Condition

We shall not be liable to compensate the insured person or other person under this insurance policy unless Policyholder, the beneficiary (if any), the insured person, or their legal representative(s) have complied with this insurance contract and the conditions of this policy.

33. Currency

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

34. Governing law

34.1. This policy is governed under the Thai law.

34.2. By subscribing to this policy, you give consent to Sompo Insurance Thailand Limited and third-parties including related entities, employees, agents, contractors & service-providers (collectively, "Appointees") to collect, use and disclose all personal data relating to you or other individuals that you have furnished via any means in the past, present & in the future, for one or more of the purposes described in Sompo Insurance Personal Information Collection Statement available at : https://www.sompo.co.th/about-us/privacy-center/privacy-policy

34.3. You warrant that all personal data you have provided is accurate and complete, and you shall inform Sompo Insurance of any changes to the personal data as soon as practicable.

III GENERAL EXCLUSIONS

This policy does not cover the following treatments, medical conditions, services or procedures. Any adverse consequences or complications thereof, are not covered, unless otherwise indicated in the benefits schedule:

1. Pre-existing conditions and any related, associated or consequential disabilities which were not disclosed to us before the period of insurance and which we have not agreed in writing to cover under this policy.
   This exclusion applies only to fully underwritten policies.

2. Any pre-existing or related medical condition which occurred or was treated within a 24-month period prior to your effective date or has one of the following characteristics will be excluded from cover:
   - Was foreseeable
   - Clearly showed itself
   - You have had signs or symptoms, or you were aware of the condition
   - You have received treatment for or sought medical advice on the condition or a related condition (including medical check-ups)
   - To the best of your knowledge that you were aware you had
   - Requires monitoring according to generally accepted medical advice or opinion

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

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

3. Treatment which is covered by insurance or a source of indemnity other than this policy.

4. Treatment outside your area of cover as stated on your benefits schedule, except to the extent Out of Area Cover is provided for in your benefits schedule.

5. Travel expenses incurred to obtain medical treatment other than in the course of an emergency medical evacuation we have approved in advance, or which has been approved by the emergency assistance provider.

6. Treatment, care or a test which is not medically necessary.

7. Hospital inpatient treatment for convalescence, rehabilitation, supervision, or which in the opinion of our medical advisor, could be properly treated as an outpatient;

8. Medicine, treatment or investigations that are not related to the diagnosis, or that are unrelated to signs and symptoms indicated in the medical certificate.

9. Services which have not been prescribed by your attending physician unless otherwise stated on the benefits schedule.

10. Routine physical examinations or medical check-ups, unless specifically covered under the benefits schedule.

11. Investigations, treatments or preventive measures intended to relieve symptoms possibly related to ageing, perimenopause or menopause.

12. Hormone replacement therapy, unless specifically covered under the benefits schedule.

13. Dental services, except where specifically covered under the Dental Benefits section of the benefits schedule.

14. Emergency Dental Treatment related directly or indirectly to biting, chewing or teeth grinding.

15. Reconstructive surgery except when required as a direct result of a disability covered under this policy.

16. Treatment involving transplant or harvesting of stem cells, unless specifically covered under the Stem Cell Treatment benefit in the benefits schedule.

17. The cost of purchasing an organ for transplantation.

18. External prosthesis except when required as a direct result of a disability first occurring during a period of insurance.

19. Purchase or rental of any devices including but not limited to prostheses, corrective devices, or durable medical equipment other than surgical implants, external prosthesis or medical appliances shown on the benefits schedule as covered by this policy.

20. Treatment, care or tests directly or indirectly related to:

20.1 assisted conception, contraception, sterilisation, fertility or infertility, prior history of miscarriages, hypogonadism or testosterone deficiency, sexual dysfunction, or abortion other than for therapeutic reasons

20.2 complications of pregnancy following assisted conception, other than services claimed under Maternity Benefits or Routine Outpatient Maternity where specifically provided on the benefits schedule;

20.3 pregnancy or childbirth other than services claimed under Complications of Pregnancy, Routine Outpatient Maternity or Maternity Benefits where specifically provided on the benefits schedule. For the purposes of this exclusion, the post-partum period is deemed complete 45 days after delivery of the baby.

20.4 elective caesarean section prior to the 38th week of term;

20.5 sexually transmitted disease;

20.6 gender reassignment therapy and surgery;

20.7 congenital and hereditary conditions other than services claimed under the Congenital and Hereditary Conditions benefit where specifically provided on the benefits schedule;

20.8 terminal illness, other than as provided by the hospice or palliative treatment benefit as shown on your benefits schedule;

20.9 artificial life maintenance including mechanical ventilation where such treatment will not or is not expected to result in your recovery or to restore you to your previous state of health;

20.10 any treatment for weight loss or weight problems, other than the consultations and medicines provided by a dietician claimed under the Complementary Medicine Benefit (among others, claim related to bariatric procedures, diet pills or supplements, health club memberships, diet programs and residential eating disorder programs will not be covered);

20.11 cosmetic treatment, surgery or any direct or indirect complications or consequences related to cosmetic procedures;

20.12 obstructive sleep apnea, sleeping disorders and snoring;

20.13 contact lenses, spectacle lenses, spectacle frames, sunglasses, eyesight tests for long or short sightedness and treatment related to refractive error other than services claimed under Optical Benefits where specifically provided for on the benefits schedule;

20.14 LASIK surgery;

20.15 lenses other than monofocal lens following a cataract surgery;

20.16 preventive treatment except to the extent specifically stated in the benefits schedule;

20.17 dandruff and complications related to hair loss;

20.18 experimental investigations and treatment;

20.19 use of robotic surgery where it is not medically necessary and a conventional alternative is available. In such cases, reimbursement will be limited to the reasonable and customary cost of the equivalent conventional treatment;

20.20 the usage of non-medically necessary ultrasound scans, other than 2D ultrasounds (applicable when Maternity benefits are purchased in the benefits schedule);

20.21 non-western or non-allopathic treatment except to the extent specifically stated in the Complementary Medicine and Traditional Chinese Medicine section of the benefits schedule;

20.22 personality disorders, attention deficit disorders, autism, ADHD, stress, eating disorders, behavioural or developmental disorders other than where specifically provided on the benefits schedule under the Outpatient Behavioural and Developmental Disorders benefit (if any);

20.23 outpatient treatment of mental and nervous conditions other than services claimed under the Outpatient Psychiatric Benefit where specifically provided on the benefits schedule;

20.24 services by a psychologist or counsellor other than where specifically provided on the benefits schedule under the Outpatient Psychiatric Benefit

20.25 suicide or self-inflicted injury or illness, or any related attempt whether self-inflicted or agreed with other persons, even though you are fully conscious or have a mental disorder, including those accidentally caused by any chemical or toxin substances intake or medication overdose;

20.26 any loss or injury arising from your actions while under the influence of alcohol, addictive or psychoactive drugs, or narcotic drugs to the extent of being unable to properly control your mind;
The term "under the influence of alcohol" in the event of a blood test refers to a blood/alcohol level of 150 mg/dL or 0.15% and over;

20.27 any loss or injury arising from your own act: while under the influence of drugs or narcotics and incapable of staying conscious;

20.28 any loss or injury arising from your own act: while under the influence of liquor and incapable of staying conscious, in the absence of any measurement or blood alcohol content testing;

20.29 abuse of alcohol, illegal drugs, or medicines not prescribed to the insured person by a physician or taken in excess of prescribed quantities;

20.30 drug addiction, smoking, alcoholism, or use of any psychoactive substances;

20.31 smoking cessation, including but not limited to consultations, treatments, products, therapies, medications, and any other services or interventions aimed at quitting smoking;

20.32 injury related to participation in professional sports on a full time or part time basis; disability as a result of participation in mountaineering or trekking above 3,000 metres; caving or potholing; downhill off-piste skiing and snowboarding; riding on a snowmobile; motor sports on land; boating in vessels designed to travel at 30 knots or more; diving in excess of 12 metres below the surface of the water; rock climbing involving ropes or pitons; hunting; ice hockey; parachute jumping; wrestling; polo; water skiing or wake-boarding; boating activities beyond 5 kilometres from a coastline; aviation activities other than as a fee-paying passenger on a regular scheduled airline or licensed chartered aircraft; or deliberate exposure to exceptional danger except in an effort to save human life;

20.33 any loss or injury arising whilst boarding, leaving or travelling as a passenger in an aircraft which does not have a license for carriage of passengers and does not operate as a commercial airline;

20.34 any loss or injuries arising whilst driving under the influence of alcohol or driving without a legal or valid driving license in accordance with local regulations;

20.35 any loss or injuries arising whilst driving a motorcycle without wearing a helmet or without a legal or valid motorcycle driver's license in accordance with local regulations.

21 The following services, whether or not recommended or prescribed by a physician:

21.1 harvesting of stem cells for future, unplanned or unknown treatments;

21.2 any service rendered while an insured person is an inmate of a prison, jail or any correctional facility including halfway houses or similar facilities, or while a patient of any mental institution;

21.3 services or treatment while a bed patient at any facility that is not a hospital, including an institution such as an intermediate care facility or nursing home;

21.4 custodial or maintenance care or rest cures;

21.5 house calls, delivery of medicine or other items, or any service rendered at a person's home, office, hotel room, or similar place other than services claimed under Maternity Benefits where specifically provided for on the benefits schedule; Telehealth services are not part of this exclusion and will be covered provided that they are reasonable and customary and medically necessary.

21.6 Sleep medication, chelation therapy, bioresonance therapy or diagnosis, colonic hydrotherapy, as well as non-medicated pharmaceutical products, including but not limited to: pharmaceutical expenses, cosmetics, hygiene products, sunscreens and/or moisturisers, make-up, comfort care products, vitamins and minerals (except when medically prescribed in the case of a proven deficiency), probiotics, food supplements, dietetic products, baby foods, and mineral water.

21.7 any inoculations and vaccinations other than services claimed under the vaccination benefit where specifically stated on the benefits schedule as covered by the policy;

21.8 dental treatment utilising precious stones and orthodontic treatment that is commenced from the age of 16 (applicable only when Dental benefits are covered under the policy);

21.9 dental examination and treatment for cosmetic or decorative purposes unless specifically stated in the benefits schedule (applicable only when Dental benefits are covered under the policy)

21.10 Disability suffered while serving as a member of a police force or military unit of any country or international authority, or due to participation in war (whether declared or undeclared), civil war, invasion, insurrection, revolution, use of military power, usurpation of government or military power, or any known or suspected terrorist act, utilization of nuclear weapons, chemical or biological weapons of mass destruction

21.11 Participation in any illegal or criminal act or contravening clear and absolute government advisories to avoidance of disability.

21.12 While you are committing a felony or while you are being arrested, under arrest or escaping the arrest,

21.13 While engaging in a brawl / fight or taking part in initiating and / or inciting a brawl / fight;

21.14 Disability as a result of exposure:
- to ionising radiation or contamination by radioactivity from any nuclear fuel or from any nuclear waste from the combustion of nuclear fuel.
- the radioactive, toxic, explosive or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component thereof;
- any weapon of war employing atomic or nuclear fission and/or fusion or other like reaction or radioactive force or matter.
- any weapon of war employing chemical or biological force or matter

22 All expenses:

22.1 which are not reasonable and customary;

22.2 incurred in jurisdictions subject to sanctions, prohibitions, or restrictions under United Nations resolutions or the trade or economic sanctions of the European Union, the United Kingdom, or the United States of America.

22.3 for medical certificates or administrative fees such as a charge for providing a claim form or medical records;

22.4 incurred outside the period of insurance or in any period for which the appropriate premium has not been paid;

22.5 incurred during the period of insurance for drugs and/or medical services to be consumed or provided once the period of insurance has ended; or

22.6 for services performed or items sold by you, your parents, your children, or any entity in which you, your parents, or your children either are an employee or director or have a greater than 1% ownership interest.

IV INSURING AGREEMENT

While this policy is in force and subject to the General Terms and Conditions, Insuring Agreements, Exclusions, and attached Endorsements of this insurance policy, if the insured person sustains injury from an accident or suffers from an illness after the waiting period resulting him/her to require medical care, we 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 Benefits Schedule in accordance with the attached insuring agreement.

1. HOSPITAL AND SURGERY

While the policy is still in force, if the insured person sustains injury from an accident or suffers from illness after the waiting period, which results in hospitalisation, we will pay for the general service rate that are considered medically necessary and of standard of medical practice.
We will pay the eligible amount of charges incurred or the applicable amount specified in the Benefits Schedule whichever is the smaller.
The amount of benefit paid with respect to each disability shall not be more than the amount specified in the Benefits Schedule.

1.1. Hospital Benefits

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

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

Exclusion:
- Purchase or rental of any devices including but not limited to prostheses, corrective devices, or durable medical equipment other than surgical implants, external prosthesis or medical appliances shown on the benefits schedule.

1.2. Pre-hospitalisation Benefits

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

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

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

1.3. Post-hospitalisation Benefits

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

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

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

1.4. Organ Transplantation

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

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

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

1.5. Private Nursing and Home Nursing

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

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

Limitations:

- Home Nursing is covered under the post-hospitalisation benefits or Outpatient benefits (if applicable), following inpatient admission

1.6. External Prostheses

If the insured person requires a prosthesis due to a covered disability first occurring during a period of insurance and upon the recommendation of a physician, the following aspects of treatment will be covered:

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

Limitations:

- No other section of the benefits schedule covers costs relating to external prosthesis

Exclusions:

- External prosthesis except when required as a direct result of a disability first occurring during a period of insurance.
- Purchase or rental of any devices including but not limited to prostheses, corrective devices, or durable medical equipment other than surgical implants, external prosthesis or medical appliances shown on the benefits schedule.

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

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

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

Limitations:

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

1.8. Cancer Treatment

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

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

Limitations:

- This benefit only covers active cancer treatments.
- Where preventive medication is recommended by a physician following the completion of active treatment, the cost of specialist consultations and associated medicines or drugs will be covered under the Outpatient Benefits, if such benefits are included in the insured person's plan.

1.9. Kidney Dialysis

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

1.10. HIV/AIDS

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

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

Limitations:

- No other benefit provides cover for HIV/AIDS

Waiting Period:

- HIV/AIDS: coverage will apply only if signs or symptoms are present for the first time after three years of continuous coverage under the plan and any renewal thereof

1.11. Emergency Room Treatment

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

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

Limitations:

- To treat Injuries or acute exacerbation of a disability only
- Treatment must be for an emergency condition, where delay in seeking treatment will lead to life changing consequences

1.12. Emergency Dental Treatment

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

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

Limitations:

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

Exclusions:

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

1.13. Local Transport by Ambulance

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

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

1.14. Hospice or Palliative Treatment

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

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

Limitations:

- No other benefits cover palliative care

1.15. Cash Benefit

The following benefits are payable up to the limit stated in the benefits schedule:

a. Hospital Cash benefit

Where an insured person is hospitalised for a covered confinement at no cost to us. Hospital cash benefit is not available if the insured persons claim for services rendered during the hospitalisation.

b. Return home cash benefit

Where the insured person requests to travel out of Thailand to receive medically necessary inpatient or day patient treatment in his/her Home Country, we will make a cash payment directly to the insured person. In addition, for the return journey to the insured person's Home Country outside Thailand, we will pay the reasonable cost of an economy-class air ticket.

Limitations:

- These benefits are not payable for any pre-existing conditions or exclusions.

Limitations for the Return home cash benefit:

- All treatment must be approved in advance by us and must be cost effective compared to receiving the treatment in Thailand.

1.16. Rehabilitation Treatment

Where rehabilitation treatment is required as a result of a covered disability and follows a covered confinement, this benefit covers treatment received while admitted to a rehabilitation centre. Treatment must be prescribed by a specialist. The following costs incurred during admission to the rehabilitation centre will be covered, up to the limit stated in your benefits schedule:

a. Room and board
b. General nursing fees
c. Occupational therapy fees
d. Special treatment room fees
e. Speech therapy fees

Limitations:

- Admission to the rehabilitation centre must take place within 2 weeks of discharge from hospital following a covered confinement.
- No other benefit provides cover for rehabilitation treatment.

1.17. Special limits applying to certain disabilities and treatments

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

The disabilities concerned are as follows:

a. Complications of Pregnancy
b. Congenital and hereditary Conditions
c. Neonatal Disabilities
d. Reconstructive surgery
e. Stem Cell Treatment including harvesting immediately prior to a treatment and if is associated with a bone marrow or peripheral stem cell transplant
f. Chronic conditions

Neonatal disabilities limitations and guide:

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

Special conditions for the Neonatal disabilities' coverage:

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

A newborn infant may be added to the policy from birth without medical underwriting:

a. if the mother has been covered under the policy for at least 366 days, and
b. the newborn infant was not born following assisted conception, and
c. a Newborn Addition Form has been completed and submitted within 28 days of birth of the newborn infant, and
d. the premium for the newborn infant has been paid.

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

The following instances of adding newborn children require medical underwriting:

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

Standard underwriting will apply in such situations, and cover may be declined or offered with any required terms deemed appropriate. The cover must be equal to the cover provided to the mother (or the father if the mother is not covered) excluding any optional cover chosen for Maternity Benefits or Dental and/or Optical Benefits.

Limitations:

- Children who do not meet the requirements as described above are not eligible for the neonatal disabilities benefit and must be added by the completion of a medical questionnaire.

The maximum benefit payable for neonatal disabilities is stated on the benefits schedule and no other benefit provides such cover.

Waiting Period:

- The mother must be insured for at least one-year prior to the child's birth

1.18. Medical CheckUp

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

a. Medical Checkup: Diagnostic check of body function and system in order to check the status of the body, in the absence of a diagnosis. Checkup can either be in the form of a check-up package or standalone medical/ diagnostic test.

Limitations:

- For members who buy an Outpatient module, cover for this benefit will be provided as per the sum stated on the Outpatient module.

2. OUTPATIENT BENEFITS

While the policy is in force, if an insured person receives medically necessary treatment as an outpatient (i.e. without being admitted to hospital), we will reimburse reasonable and customary charges for eligible services. Reimbursement will not exceed the applicable outpatient benefit limit or any sub-limits specified in the benefits schedule. Where a co-payment option has been selected, the co-payment amount will be deducted from the eligible reimbursement.

2.1. Annual Limit for Outpatient Benefits

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

2.2. General Practitioner, Specialist Consultation Fees and Physiotherapist fees

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

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

Limitations:

- Psychiatrists are not covered under this section. Psychiatric services are covered only under the Outpatient Psychiatric benefit
- A referral is required for physiotherapy. Treatment is limited to 10 sessions per referral after which a new referral and medical report must be submitted.

2.3. Outpatient Psychiatric

In the event of a diagnosis of a mental and nervous disorder, the insured is covered up to the benefit limits stated in this section of the benefits schedule. All of the following items may be provided/prescribed by a Psychiatrist, Specialist, or General Practitioner, as long as a mental or nervous condition is being treated.

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

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

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

2.4. Medicines and Drugs

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

Limitations:
- A prescription must be required for purchase

2.5. Hormone replacement therapy

Medicines and drugs prescribed by a physician for hormone replacement therapy. Coverage is provided for Hormone Replacement Therapy (HRT) when deemed medically necessary to treat conditions such as premature ovarian insufficiency or failure.

a. Medications prescribed by an attending physician

Limitations:
- A physician's prescription and supporting medical documentation are required for coverage.
- No other benefits on the benefits schedule provide Outpatient cover for Hormone Replacement Therapy

Exclusions:
- This benefit does not extend to HRT primarily intended to manage symptoms related to natural aging processes or gender reassignment.

2.6. Diagnostic Scans and Tests

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

2.7 Medical Appliances and Mobility Aids

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

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

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

Exclusions:
- Purchase or rental of any devices including but not limited to prostheses, corrective devices, or durable medical equipment other than surgical implants, external prosthesis or medical appliances shown on the benefits schedule.

2.8 Complementary Medicine and Traditional Chinese Medicine

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

Combined Limit for all benefits in Complementary Medicine and Traditional Chinese Medicine section: The overall annual maximum combined for all services listed in this section

a. Consultation fees for following Complementary Medicine practitioners: Chiropractor, dietician, osteopath, podiatrist, speech therapist.
b. Consultation fees and medicine/ consumables dispensed or used by the following practitioners during the course of treatment: Acupuncturist, homeopath, bone setter, Chinese medicine practitioner

Limitations:
- Only one consultation per day allowed for Acupuncturist, homeopath, bone setter, Chinese Medicine Practitioner
- No other benefits on the benefits schedule provide cover for Complementary Medicine and Traditional Chinese Medicine

2.9 Medical Checkup and Vaccinations

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

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

b. Vaccinations: any form of inoculation for the prevention of disease.

Limitations:

- For vaccinations, the benefits only cover the cost of vaccination. Associated consultation costs are covered under the General Practitioner consultation fees benefit.

3. DENTAL AND OPTICAL MODULE

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

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

Limitations:

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

Waiting Periods:

- Major Dental Treatment: 300 days prior to the date of service

4. MATERNITY MODULE

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

4.1. Pre- or Post-natal Services

The following prenatal and post-natal services up to 45 days following birth: Physician consultation fees, diagnostic scans and tests, medicines and drugs, licensed midwifery and certified doula services, vitamins and supplements, complementary maternity therapies (without referral).

4.2. Delivery

Expenses incurred for natural delivery, elective or emergency caesarean delivery, and up to seven (7) days of nursery care.

a. Hospital room and board
b. professional fees
c. midwife fees
d. theatre fees
e. nursery care

4.3. Complications of pregnancy following assisted conception

4.4. Complications of childbirth

4.5. Therapeutic abortions

Limitations:

- Available to women between 19 to 45 years of age
- The post-partum period is deemed complete 45 days after delivery of the baby
- Elective and non-elective caesarean sections, as well as complications of childbirth and complications of pregnancy following assisted conception are covered under this benefit
- No other section of the benefits schedule provides cover related to pre, post-natal services and childbirth
- The Maternity Module must be purchased and renewed in order to cover the pregnancy after the waiting period

Exclusions:

- Pregnancy or childbirth, or complications of pregnancy following assisted conception, other than services claimed under Maternity Benefits where specifically provided on the benefits schedule
- assisted conception, contraception, sterilisation, fertility or infertility, prior history of miscarriages, hypogonadism or testosterone deficiency, sexual dysfunction, or abortion other than for therapeutic reasons
- Elective caesarean section prior to the 38th week of pregnancy

Waiting Period:

- One year from the date of purchase of the Maternity Module

MH TH 2026/05

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