

# UltraCare Plan guide

Group plans



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## Your Plan Guide

We would like to welcome **you** and thank **you** for choosing an **UltraCare plan**. We aim to provide **you** with an International Healthcare **Plan you** can rely on. To do this, it is important that **you** fully understand how **your plan** works. This **Plan** guide, together with **your** Table of **benefits**, explains what is, and is not, covered under the **UltraCare plan** and any of the following add-on **plans** that have been chosen:

- Personal Accident Add-on **plan**

Different terms and conditions apply to different underwriting terms. See the 'Definitions' section for more information on **your** underwriting terms, as shown on **your** Certificate of insurance. Also see **benefit** exclusions BE1 and BE2 for more information.

This **Plan** guide will also give **you** important information about managing these **plans**.

Please spend some time reading carefully through this **Plan** guide to make sure that **you** are completely satisfied with the cover **we** are providing and that the cover meets **your** needs. If **you** have any questions about the information in this **Plan** guide or any questions **you** think it does not answer, please contact **us** and **we** will be more than happy to help.

Some words and phrases used in this **Plan** guide and **your** Table of **benefits** have specific meanings that are relevant to **your plans**. **We** have highlighted them in bold print and defined them in the 'Definitions' section of this **Plan** guide.

This **plan** is insured by Allianz Ayudhya General Insurance Public Company Limited.

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The **plan** terms apply to **you** and the **planholder**.

**You** must read the Group **member** application (if this applies), Table of **benefits**, Certificate of insurance, membership cards and this **Plan** guide.

The Group application, Group **member** applications (if these apply), Group declaration of health (if this applies), Group membership census, Corporate agreement, Table of **benefits**, Certificates of insurance and this **Plan** guide form the contract of insurance between **us** and the **planholder**. The **planholder** must read these together.

The currency of the **UltraCare plan** and any add-on **plans** will be Thai Baht. Premiums must be paid in the same currency as **your plans**.

**We** can change any of the general conditions, **benefit** conditions, **benefit** exclusions or other terms and conditions in this **Plan** guide at the beginning of the **plan year**. **We** can also change the premiums and any discounts or surcharges at the beginning of the **plan year**. **We** will tell the **planholder** about any changes before the **plan renewal date**.

## Definitions

Wherever **we** use the words 'including', 'include', 'in particular', 'for example' or any similar expression any following information is given as an example only, not a full list, and will not limit the sense of the words, description, definition, phrase or term before those words.

**Abuse** – the excessive use of alcohol, drugs or any other intoxicating substance. This includes use of drugs in a manner or in quantities other than as directed or prescribed on medical authority or for a reason other than that for which it was originally prescribed.

**Accident** – any involuntary, sudden or unexpected event resulting in a **bodily injury** to **you**.

**Acute** – a **medical condition** that responds to **treatment**, which aims to return **you** to **your** previous state of health or leads to **your** full recovery.

**Area of cover** – the geographic area or areas of the world in which **you** must receive **treatment** or services for **your plan** to apply. **Your area of cover** is shown on **your** Certificate of Insurance.

**Benefit** – the cover provided by **your plan** and any extensions or restrictions shown **your Plan** guide, Certificate of insurance or Table of **benefits**.

**Birth defect** – any deformity, abnormality or disability, or caused during childbirth.

**Bodily injury** – any physical harm or damage to **you**.

**Business colleague** – an associate who is employed by the same company as **you**.

**Card** – Visa or MasterCard.

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**Chronic** – a **medical condition** that has one or more of the following characteristics:

- needs ongoing or long-term monitoring through consultations, examinations, checkups or tests;
- needs ongoing or long-term control or relief of symptoms;
- needs rehabilitation or special training to cope with it;
- continues indefinitely;
- has no known cure;
- comes back or is likely to come back.

**Claim** – when **you** or **your** agent, personal representative, assignee or trustee in bankruptcy seek payment or settlement under the terms and conditions of the **plan**.

**Close family member** – a son, daughter, stepson, stepdaughter, legally adopted son, legally adopted daughter, husband, wife, partner, parent, step-parent, legally adoptive parent, parent-in-law, grandparent, grandchild, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law or legal guardian.

**Co-insurance** – the percentage of costs that **you** must pay for a covered **claim**.

**Congenital abnormality** – a **medical condition** that is present at birth or is believed to have been present since birth, whether it is **inherited** or caused by an environmental factor.

**Country, where you live, country where a member lives** – the country **you** live in for most of the time, usually for a period of at least six months during a **plan year**.

**CPME, Continuation of Personal Medical Exclusions** – continuation of the same underwriting terms, including any special exclusions, that applied to **you** with a previous insurer. The underwriting terms with **us** can be **CPME** previously **moratorium** or **CPME** previously **FMU**. **You** will not be subject to any new personal underwriting terms. Cover will still be governed by the **benefits**, terms and conditions of **your plan** with **us**. See the 'Transfers' section and the **CPME** previously **moratorium** and **CPME** previously **FMU** definitions in this **Plan guide** for more information.

**CPME previously FMU** – continuation of **your** full medical underwriting terms with a previous insurer. **You** will not be subject to any new personal underwriting terms. Cover will still be governed by the **benefits**, terms and conditions of **your plan** with **us**, including **benefit** exclusion BE2. **Benefit** exclusion BE1 will not apply.

**CPME previously moratorium** – continuation of **your moratorium start date** if **you** had **moratorium** underwriting terms with a previous insurer. **You** will not be subject to any new personal underwriting terms. Cover will still be governed by the **benefits**, terms and conditions of **your plan** with **us**, including **benefit** exclusion BE1. **Benefit** exclusion BE2 will not apply.

**Critical** – a **medical condition** that is unstable and serious, where the outcome cannot be medically predicted, prognosis is uncertain and the person may die.

**Date of joining** – when **you** first became a **member** on the **plan**.

**Daycare treatment** – **treatment** at a **hospital** or daycare unit when medical supervision is needed for four or more hours for recovery, but **you** do not stay overnight.

**Deductibles** – any **co-insurance** or **excess** that applies to **your plan**.

**Dental** – that which affects the teeth and gums.

**Dependant** – a **planholder**, employee or affinity **member's**:

- husband, wife or partner;
- unmarried child, stepchild or legally adopted child under the age of 18;
- unmarried child, stepchild or legally adopted child aged 18 to 24 who is in continuous full-time education. **We** may need written proof from the educational facility where they are enrolled.

**Diagnostic tests and procedures** – a **medically necessary** test or examination to investigate the cause of **your** symptoms.

**Emergency** – a sudden, unexpected **acute medical condition** or an unexpected **acute** episode of a **chronic medical condition** that, without **treatment** within 48 hours of onset, could result in death or serious damage to bodily functions.

**End date** – the last day **you** have cover under a **plan**.

**Excess** – the amount **you** must pay towards the cost of a covered **claim** as shown on your Table of **benefits**.

**FMU, Full Medical Underwriting** – the process that **we** use to assess **your** medical history and decide the special terms **we** offer **you**. Cover will still be governed by the **benefits**, terms and conditions of **your plan** with **us** except for **benefit** exclusion BE1.

**Hazardous pursuit** – any activity or sport that places **you** at an increased risk of suffering a **medical condition** or making an existing **medical condition** worse.

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**Home country** – the country you are from as given to us on your application.

**Hospital** – a legally licensed facility providing treatment under the laws of the country in which it is located.

**Inherited** – a medical condition which is hereditary.

**In-house doctor** – a doctor who is employed by the hospital, is considered a permanent member of staff and charges in line with hospital tariffs.

**In-patient treatment** – treatment at a hospital where you need to stay in a bed for one or more nights.

**Main member** – the person who is named first on a valid Certificate of insurance.

**Material fact** – information, as follows, which is likely to influence us in the assessment, acceptance or renewal of a plan, or in making any changes to it:

- about you, your lifestyle, health or medical conditions, that we have asked you questions about;
- about the planholder and any members, including dependants, where we have asked the planholder questions; or
- that you or the planholder have chosen to give to us.

If there is any doubt about whether a fact is material, for your own protection, you must tell us.

**Medical condition** – signs or symptoms, injury, illness, sickness or disease.

**Medical necessity, medical necessary** – treatment prescribed by your medical practitioner attending specialist which is appropriate for your medical condition and is in line with accepted medical standards.

**Medical practitioner** – a person who is registered and licensed to practise medicine in the country where treatment is provided and has obtained the primary degrees in medicine and surgery following attendance at a recognised medical school listed within the World Directory of Medical Schools published by the World Health Organisation.

**Member** – see you, your, yourself.

**MHD, Medical History Disregarded** - we will cover pre-existing medical conditions suffered by you, subject to the benefits, terms and conditions of your plan. Benefit condition BC5 and benefit exclusions BE1 and BE2 will not apply.

**Moratorium** – a period of 24 months from your date of joining, or the date shown on the special terms section of your Certificate of insurance, that must have passed before claims for pre-existing medical conditions or related medical conditions may be eligible under the UltraCare plan. See benefit exclusion BE1 for more information. The moratorium also applies to the Maternity add-on plan.

**Natural teeth** – any teeth that are original and organic, not artificial implants or replacements.

**Necessary and reasonable expenses** – the average cost of treatment, expertise or services given by similar types of provider:

- within the same country or geographical region; and
- based on our experience and knowledge.

**Nurse** – a person who is qualified in nursing, currently practicing and on the professional register of nursing in the country where treatment is provided.

**Our, us, we** – the insurer as shown on the Certificate of Insurance.

**Out-patient treatment** – treatment in a hospital, consulting room or clinic when you do not need a bed.

**Palliative treatment** – any surgical or medical services aimed to relieve the symptoms rather than to cure, stop, reverse or delay progression of the medical condition causing them.

**Physiotherapist** – a person who is qualified to practise physiotherapy and is licensed in the country where treatment is provided.

**Plan** – the contract between the planholder, you and us.

**Plan administrator** – the person who acts as co-ordinator with us for your group plan, as chosen by the planholder.

**Planholder** – the person or organisation we have issued the plan to as named on a valid Certificate of insurance.

**Plan start date** – the date the plan begins each year.

**Plan year** – a period of 12 months, from the, plan start date, as shown on a valid Certificate of insurance.

**Pre-authorisation** – the process you must follow to obtain approval from us before receiving treatment or services, or incurring costs.

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**Pre-existing** – any **medical condition** or **related medical condition** which has one or more of the following characteristics:

- clearly showed itself;
- **you** had signs or symptoms of;
- **you** asked for advice about;
- **you** received **treatment** for;
- to the best of **your** knowledge, **you** were aware **you** had.

**You** must also read General Condition GC2, **Benefit** Condition BC5 and **Benefit** Exclusion BE1.

**Preventative services** – medical services where no **medical condition** or symptoms are present.

**Psychiatric** – that which affects **your** mind, mental function or emotions, whether the cause is organic, traumatic or reactive.

**Related medical condition** – a **medical condition** that in the opinion of both your **medical practitioner** or **specialist**, and us is:

- a direct or indirect result of another **medical condition**;
- associated with another **medical condition**; or
- an associated risk factor of another **medical condition**.

**Renewal date** – the anniversary of the **plan start date** as shown on a valid Certificate of insurance.

**Routine health check** – **diagnostic tests and procedures** where no **medical condition** or symptoms are present.

**Specialist** – a **medical practitioner** who is practising and has a recognised:

- certificate of higher specialist training;
- consultant appointment or equivalent;

in the relevant field of medicine in the country where **treatment** is provided.

**Start date** – the date **you** join the **plan** or any future **renewal date** as shown on a valid Certificate of insurance.

**Terminal** – the end stages of a **medical condition** where life expectancy is considered to be days or weeks and only **palliative treatment** is given.

**Therapist** – an osteopath, chiropractor, homeopath, podiatrist, acupuncturist or Chinese herbalist who is qualified and licensed in the country where **treatment** is provided.

**Treatment** – any surgical or medical services, including **diagnostic tests and procedures**, that are needed to diagnose, relieve or cure a **medical condition**.

**UltraCare plan** – the healthcare **plan**.

**Visiting doctor** – a **medical practitioner** who is not employed by the **hospital**, but has a contract to use the **hospital** facilities and may have different charges to the **hospital** tariffs.

**You, your, yourself** – a person who has met the eligibility criteria of the **plan** and is named on a valid Certificate of insurance.

## Group Eligibility

Eligibility depends on us accepting the Group application, Group **member** applications if the underwriting terms are **moratorium** or **CPME**, previous certificates of insurance if the underwriting terms are **CPME**, Group **member** applications including the medical questionnaire if **your** underwriting terms are **FMU**, Group declaration of health (if this applies) and a complete Group membership census.

**Plans** must be made up of a group of employees of the same company or **members** of an existing affinity group. The size of a group **UltraCare plan** at the **start date** must be at least three **main members** (employees or affinity **members**). If there are less than three **main members** at the **start date** or at a **renewal date**, the group cannot continue and **we** will offer individual **plans** to the remaining **members**.

The **UltraCare plans** and add-on **plans** are available to people of all nationalities, including **dependants**, except citizens of the USA who live in the USA and people who are governed by exchange controls or local licensing regulations. If **your area of cover** is Area 3 and **you** are a citizen of the USA, **you** will no longer be eligible for cover if **you** have spent more than 180 continuous days in the USA in any one **plan year**.

**Plans** may not meet specific visa requirements. Cover may also be illegal under local laws. It is the **planholder's**

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responsibility to ensure that any **plans** chosen meet **your** needs.

All **dependant** children on a **plan** must be unmarried. **Dependant** children aged 18 to 24 must be in continuous full-time education at their **start date**.

**You** cannot be older than 74 at **your start date**.

**Main members** and their **dependants** must have the same **area of cover**.

Add-on **plans** are only valid when the **UltraCare plan** is in force.

The maximum age at entry for the Personal accident add-on **plan** is 74. This **plan** can cover:

- the **main member** only; or
- the **main member** and all of their **dependants** who are included on the **UltraCare plan**. All **dependants** aged 18 to 74 must have the same level of cover as the **main member**. All **dependants** aged 0 to 17 can only have one unit of cover.

The Personal accident add-on **plan** provides cover for managerial, clerical and administrative occupations only. See **benefit** condition BCPA1 for more information.

Additional eligibility criteria apply to some **plan** types. These are shown in the Group **member** application and Table of **benefits** where applicable.

**We** can refuse cover on any of **our plans** for any reason. **We** may provide cover under **our plans** with any special terms that **we** may set. Any special terms will be shown on the Certificate of insurance.

### Group Plan start date

With **our** agreement cover under the **UltraCare plan** will begin immediately or on a future date the **planholder** has given and **we** have agreed, as long as **we** accept the application, and as soon as **we** have received the:

- Group application;
- Group **member** applications if the underwriting terms are **moratorium** or **CPME**;
- Group **member** applications including the medical questionnaires if the underwriting terms are **FMU**;
- previous certificates of insurance if the underwriting terms are **CPME**;
- acceptance of all special terms offered in the quotation if the underwriting terms are **CPME** or **FMU**;
- Group declaration of health if this applies; and
- Group membership census.

**We** will tell the **planholder** the **start date** in writing.

Cover under any add-on **plans** will begin on the same day as the **UltraCare plan** or any future **UltraCare plan renewal date**. **We** cannot backdate cover under any circumstances. All **plans** will continue for 12 months until the next **renewal date** or until they are cancelled or extended for any reason.

### Group Premiums

Each **plan** is a yearly contract.

The premiums in the quotation accepted by the **planholder** will apply for the **plan year**.

The **planholder** must choose how often the **UltraCare plan** premiums are paid from the payment options available for that **plan** type. They must choose this at application or renewal and it will apply throughout the entire **plan year**.

Personal accident add-on **plan** premiums can only be paid yearly.

The **planholder** is responsible for paying all premiums. Premiums must be paid in Thai Baht. The premium will be returned if payment is received in a different currency to the currency of **your plans**.

The **planholder** will be responsible for:

- any shortfall as a result of exchange rate differences; and
- any associated bank charges.

**We** must receive all premiums, including any taxes that apply, on or before the premium due dates.

Premiums may change as a result of adding or removing **members**. The **planholder** must pay any extra premiums when the next reconciliation statement is sent, in accordance with the credit terms. Any refund due to the **planholder** will be carried forward to the next reconciliation statement.



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### Ways to pay group premiums

Premiums must be paid in Thai Baht.

Premiums can be paid by:

- bank transfer; or
- cheque.

See the Group application or invoice for payment details. When making a payment, the **planholder** must give the group name and the quotation number or **UltraCare plan** number as the reference.

### Unpaid or late group premiums payments

The **planholder** must make sure premiums are paid on or before the due date. **We** will tell the **planholder**, in writing, if payments are not made on time.

**We** will not approve or pay any **claims** until the payments are up to date.

**We** will cancel a **plan** if payment is not received within 30 days of the premium due date.

If **we** cancel a **plan**, the **planholder** will have to apply for a new **plan**. The premiums may change and the cover may have new terms.

**We** reserve the right to charge commercial interest on any overdue premium at the Bank of England base rate, plus 5%. Interest will accrue on a daily basis from the premium due date until full payment is made for the overdue premium.

### Adding group members

With our agreement the **plan administrator** may add **members** to the **UltraCare plan** after the **plan start date**. The **plan administrator** must make the request as follows, depending on the underwriting terms.

**MHD** – the **plan administrator** must make the request in writing by letter, fax or email.

**Moratorium** – if a new **dependant** is being added the **plan administrator** must make the request in writing by letter, fax or email. If a new **main member** is being added the **plan administrator** must send a group application for the **main member**, and any **dependants** to be included.

**CPME** – see the 'Group member transfers' section.

**FMU** – the **plan administrator** must send a Group **member** application, including the medical questionnaire.

With our agreement the **plan administrator** may also add **members** to any add-on **plans** at the same time they are added to the **UltraCare plan**. The **plan administrator** must request this in writing by letter, fax or email.

When making a request to add **members**, the **plan administrator** must also tell us all **material facts**. If there is any doubt about whether a fact is material, the **plan administrator** should tell us. See general condition GC2 for more information.

With our agreement cover will begin as follows, depending on the underwriting terms.

**MHD** – as soon as **we** receive the written request or on a future date given to **us** by the **plan administrator**.

**Moratorium** – as soon as **we** receive the written request or on a future date given to **us** by the **plan administrator**.

**CPME** – as soon as **we** receive acceptance of the special terms offered in the quotation or on a future date the **plan administrator** has given and **we** have agreed, as long as there is no break in cover.

**FMU** – as soon as **we** receive acceptance of the special terms offered in the quotation.

Cover under any add-on **plans** will begin on the same day as the **UltraCare plan**. **We** will not backdate cover under any circumstances.

With our agreement the **plan administrator** may add newborn children as **dependants** during the **plan year**. When making a request the **plan administrator** must tell us all **material facts**.

If the **plan administrator** applies in writing before the newborn child is 30 days old **we** will not apply any underwriting terms to the newborn child's cover on the **UltraCare plan** and their **date of joining** will be their date of birth. **Benefit** condition BC5 and **benefit** exclusions BE1 and BE2 will not apply.

If the **plan administrator** applies in writing after the newborn child is 30 days old, underwriting terms will apply. If the underwriting terms on the **UltraCare plan** are:

**MHD** – cover will begin as soon as **we** receive the written request or on a future date given to **us** by the **plan**

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administrator.

**Moratorium** – cover will begin as soon as we receive the written request or on a future date given to us by the plan administrator.

**FMU** – the plan administrator must send a Group member application, including the medical questionnaire. Cover will begin as soon as we receive acceptance of the special terms offered in the quotation.

We will not backdate cover for any requests received by us after the newborn child is 30 days old.

Premiums may change in line with any agreed requests. The Stamp duty or any specific taxes will not be refunded in any situation.

When adding any dependants, we will send the plan administrator a revised Certificate of insurance and a new membership card, if this applies, showing the changes and any special terms that may apply.

When adding any new main members we will send the plan administrator a Certificate of insurance for the main member and any dependants included, showing any special terms that may apply. We will also send membership cards for the main member and their dependants.

### Removing group members

With our agreement the administrator may remove a member from a plan after the plan start date. The plan administrator must make the request in writing by letter, fax or email. The last day of cover will be the date that we receive the request, or a future date the administrator has given. If a main member is removed from a plan, all of their dependants will also be removed.

When members are removed, the plan administrator is responsible for collecting and destroying their Certificates of insurance and membership cards on or by the end date. If the plan administrator does not collect and destroy the Certificates of insurance and membership cards and a removed member uses these to obtain treatment at a direct billing facility, the planholder will be responsible for paying any costs to the treatment provider. We will not be responsible for any costs after cover has ended.

If a member is removed from an UltraCare plan they will also be removed from any add-on plans. The last day of cover on any add-on plans will be the same as their last day of cover on the UltraCare plan.

Premiums may change in line with any agreed requests. The Stamp duty or any specific taxes will not be refunded in any situation.

When removing any dependants, we will send the plan administrator a revised Certificate of insurance showing the changes and any special terms that may apply.

### Group member transfers

If a new person wants to transfer cover from another insurer to apply for CPME underwriting terms with us, a Group member application for CPME must be completed, and we will need an original certificate of insurance from their previous insurer, which shows:

- their original start date with that insurer;
- their underwriting terms; and
- any special terms that may have applied.

If there is a break in cover between the end date of the previous insurance plan and the application to us, we will not offer a transfer of previous underwriting terms.

If we accept the application we may charge an increased premium. Cover will begin as soon as we receive acceptance of any special terms offered in the quotation or on a future date the plan administrator has given and we have agreed, as long as there is no break in cover.

Our plan terms, conditions and benefits may be different to those of the previous insurer.

### Continuing cover when leaving a group plan

If your cover is coming to an end, with our agreement you can be transferred to an individual UltraCare plan, as long as there is no break in your cover with us and you meet our individual eligibility criteria.

You must send us your application before you leave the group plan. If we accept your application to continue cover, we may charge an increased premium and your underwriting terms may change. The application will be governed by the definitions, benefits, general conditions, benefit conditions and benefit exclusions in force at your new plan start date.

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The start date of your new individual plan will be the first day after you leave the group plan.

### Changing the cover and add-on plans for groups

When making any request for changes to a plan, including add-on plans, the plan administrator must also tell us all material facts. If there is any doubt about whether a fact is material, for your own protection, the plan administrator should tell us. See general condition GC2 for more information.

If you change your address the plan administrator must tell us in writing by letter, fax or email. If your new address is in a different country, we will consider this to be the country where you live unless the plan administrator tells us otherwise.

If a main member needs to change their area of cover on the UltraCare plan, the plan administrator must tell us in writing by letter, fax or email giving the reason for the change in circumstances. With our agreement this change can be made at any time during the plan year. We will make this change from the date the plan administrator tells us or any future date they have given. Their dependants will also change to the new area of cover on the same day.

If there is a change to the country where a member lives or their area of cover changes, we will send the plan administrator a revised Certificate of insurance. If the area of cover changes, we will also send new membership card for the main member and any dependants. The Certificate of insurance and membership card will show the changes and any special terms that may apply. Premiums, taxes and benefit limits may change in line with any agreed requests. The Stamp duty or any specific taxes will not be refunded in any situation.

The planholder cannot make changes to:

- the UltraCare plan type;
- the UltraCare plan benefits;
- deductibles or how often the premiums are paid on the UltraCare plan; or
- the number of units on a Personal accident add-on plan;

during the plan year. With our agreement these changes can be made at the next plan renewal date. The planholder must tell us about the changes in writing by letter, fax or email before the plan renewal date. Premiums, taxes and benefit limits may change in line with any agreed requests.

Add-on plans cannot be added during the plan year. With our agreement these can be included from the next plan renewal date. The planholder must apply in writing by letter, fax or email before the plan renewal date. When making the application the planholder must also tell us all material facts. If there is any doubt about whether a fact is material, for your own protection, the planholder should tell us.

### Renewing the group plan

With our agreement the planholder may renew the UltraCare plan and any add-on plans each year.

If the planholder wants to renew, they must tell us in writing by letter, fax or email before the renewal date.

The planholder must tell us all material facts about all members before the renewal date. If there is any doubt about whether a fact is material, for your own protection, the planholder should tell us. See general condition GC2 for more information.

We may change the definitions, benefits, general conditions, benefit conditions and benefit exclusions that apply to the UltraCare plan and any add-on plans. Any changes will be sent to the planholder together with the renewal quotation at least six weeks before the renewal date. Renewal premiums must be paid on or before the renewal date.

With our agreement the planholder can make changes to the plan at renewal.

All cover is subject to our eligibility criteria.

A child will no longer be eligible as a dependant under any plan at the next renewal date if any one or more of the following apply:

- they marry;
- they are not in continuous full-time education and they are 18 to 24; or
- they reach the age of 25.

With our agreement they can apply to have their own UltraCare plan and add-on plans by completing an Individual application. As long as there is no break in their cover with us, their date of joining will stay the same. Their application will be governed by the definitions, benefits, general conditions, benefit conditions and benefit exclusions in force at their new plan start date.

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We will not renew the group plan automatically.

If the planholder does not want to renew the plan they must tell us in writing by letter, fax or email before the renewal date.

### Cancellation the group plan

If the planholder wants to cancel a plan, they must confirm in writing by letter, fax or email. The last day of cover will be the date that we receive the written confirmation, or on a future date given to us.

If the UltraCare plan is cancelled, any add-on plans will also be cancelled. The last day of cover on any add-on plans will be the same as the last day of cover on the UltraCare plan.

As each plan is a yearly contract the planholder must pay any premium owed for the rest of the plan year. No refunds will be issued and the planholder may have to pay a cancellation charge.

The plan administrator must destroy all Certificates of insurance when they cancel a plan.

The plan administrator must also destroy all membership cards if the UltraCare plan is cancelled. If a membership card is used to obtain treatment at a direct billing facility after the plan has been cancelled, the planholder will be responsible for paying any costs to the treatment provider. We will not be responsible for any costs after cover has been cancelled.

### General conditions, benefit conditions and benefit exclusions

The UltraCare plan and all add-on plans, are governed by the general conditions shown below. The UltraCare plan is governed by the benefit conditions shown on the next page. Some of these benefit conditions also apply to the Personal accident add-on plan. See the 'Extra benefit conditions and benefit exclusions for add-on plans' section for more information. Claims will only be paid under a plan if you meet these general conditions and benefit conditions.

Extra benefit conditions also apply to the Personal accident add-on plans. See the 'Extra benefit conditions and benefit exclusions for add-on plans' section for more information.

### General conditions

**GC1** The planholder or plan administrator must tell us immediately in writing by letter, fax or email about any important change that affects information given in connection with the application for cover under a plan, for example:

- you change your name or occupation;
- there is a change to planholder details;
- you plan to engage in any hazardous pursuits; or
- you change your address.

If your new address is in a different country, we will consider this to be the country where you live unless the planholder or plan administrator tells us otherwise.

After we have been told about a change, we have the right to reassess your cover. We can change any of the terms or cancel the plan. Any claim related to a change in risk that the planholder or plan administrator has not told us about may be reduced or rejected, or the plan may be cancelled.

**GC2** The planholder or plan administrator must tell us all material facts before we accept an application, make changes to a plan or renew a plan. The planholder and plan administrator must check that any material facts are correct. You must check that any material facts about you are correct.

If there is any doubt about whether a fact is material, for your own protection, the planholder or plan administrator should tell us. Where applicable the 24-month moratorium will still apply even if the planholder or plan administrator tells us about any pre-existing medical conditions you may have.

If we find out that the planholder has not told us about all material facts we can cancel the plan or apply different terms to the plan.

**GC3** If you make a claim that you know is false or fraudulent, we will refuse the claim. If any payment has already been made, we will recover any costs from the planholder. We will cancel cover from a date given by us.

**GC4** We will send all correspondence about a plan to the planholder.

**GC5** When handling your claim we will always:

- communicate directly with you if you are aged 18 or over;
- communicate directly with the main member if you are under 18;

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unless you or your personal representative give us explicit consent to contact any other individual about your claim in accordance with our data protection policy.

**GC6** If you need to make a claim, you must follow your Claims procedures and send the following information as soon as possible.

- the original itemised bill;
- the original receipt;
- the fully completed Claim form;
- a copy of the prescription; and
- a copy of the investigative tests results where relevant (e.g. blood tests, x-rays, ultrasound, etc).

This information is required to support your claim. If this information is not sufficient, we may ask for more information to support your claim. You must provide this additional information or your claim may not be paid.

**GC7** We have the right to instruct a specialist of our choice to examine you as we see necessary to support a claim.

**GC8** If we reject a claim under a plan, for any reason, you will have to prove that the claim is covered under the plan.

**GC9** If you attend a hospital, clinic or any other facility where direct billing or cashless arrangements are in place, and the claim for this is subsequently found to be ineligible, we have the right to recover the full amount of the claim from you or the planholder. Payment of a claim is not an indication of our acceptance of liability for the claim or confirmation that further costs for the same medical condition or any related medical condition will be met.

**GC10** If there are other insurance plans or policies that cover a claim, including any reciprocal health insurance arrangements, and they have any of the same, or equivalent benefits, only our share of the claim will be paid under your plan with us, after:

- you have paid any deductibles that apply on any of the other plans or policies; and
- you have paid any deductible on your plan with us.

**GC11** We can make an administration charge to replace or reissue plan documents or membership cards.

**GC12** The planholder or plan administrator must tell us immediately in writing by letter, fax or email about any proceedings or right of action against any other party, due to any circumstances which led to a claim under a plan. The planholder or plan administrator must continue to keep us informed in writing and take all steps we reasonably need, for us to take proceedings against the other party.

**GC13** The planholder or plan administrator must tell us about any negotiations or settlement discussions that you enter into with any other party about any action which leads to a claim under a plan. You must not agree to a settlement with any party before we give our written agreement.

**GC14** If you want to take legal action against us in respect of a plan, you must do so within the relevant time bar according to Thai law.

**GC15** The UltraCare plan and add-on plans are governed by and shall be construed in accordance with the laws of Thailand and shall be subject to the exclusive jurisdiction of the courts of Thailand.

**GC16** Any translated versions of our documents that we issue are for your information only. In the case of any dispute or discrepancy of wording or interpretation, the English version will apply.

## Benefit Conditions

**BC1** All treatment must be given by medical practitioners, specialists, nurses or therapists with the aim to cure or substantially relieve medical conditions.

**BC2** You or your personal representative must request pre-authorisation for any in-patient treatment, daycare treatment, medical evacuation, compassionate emergency visit, or preparation or transportation of your body or mortal remains, before it takes place. Once you or your personal representative have received our approval, we will settle all covered costs directly with the providers. If you or your personal representative do not receive our approval before it takes place, we will only approve the costs we would have negotiated if we had been involved and given our approval.

**BC3** Hospital accommodation will be paid up to the cost of a standard single room with a private bathroom. This will include your hospital meals.

**BC4** If a local situation makes it impossible, dangerous or not practical to enter a specific location or country, we may be unable to arrange a medical evacuation.

**BC5** If we have not been given details of your medical practitioner on your application and a claim is made that we

believe is for a **pre-existing medical condition**:

- we will reject the claim if **your** underwriting terms are **moratorium** or **CPME previously moratorium**;
- we will reject the claim if your underwriting terms are **FMU** or **CPME previously FMU** and you did not tell us about the **medical condition** when we asked about it on the application, or we have not accepted it.

This **benefit** condition does not apply if your underwriting terms are **MHD**.

**BC6** Only necessary and **reasonable** expenses will be paid for claims. Any costs above the relevant limits shown in your Table of **benefits** will not be paid. If the costs are not necessary and **reasonable** expenses, or are above the limits shown in your Table of **benefits**, you will have to pay the difference.

**BC7** If you choose to use a **visiting doctor** instead of an **in-house doctor**, in a **hospital**, clinic or any other facility where direct billing or cashless arrangements are in place, only necessary and **reasonable** expenses will be paid. If the **visiting doctor's** costs are not necessary and **reasonable** expenses and not in line with the **in-house doctor's** costs, you will have to pay the difference.

**BC8** If you move to a **plan** where a lifetime limit applies to a **benefit**, any amount previously paid under the same, or equivalent **benefit**:

- on any one or more **plans**;
- regardless of any previous **benefit** limit; and
- whether or not there has been a break in **your** cover;

will be deducted from the current lifetime limit on the **benefit**.

**BC9** Physiotherapy must be referred by a **medical practitioner** or **specialist**. If more than six physiotherapy sessions are needed for any **medical condition**, **your** therapist must provide the reasons in the **Claim** form so we can consider cover.

**BC10** Complementary **treatment** must be referred by a **medical practitioner** or **specialist**. If more than four osteopathic, chiropractic, homeopathic, podiatry, Chinese traditional medicine or acupuncture sessions are needed for any **medical condition**, **your** therapist must provide the reasons in the **Claim** form so we can consider cover.

**BC11** All psychiatric **treatment** and psychotherapy must be given by **medical practitioners**, psychiatrists or qualified and registered psychotherapists or psychoanalysts.

**BC12** The normal pregnancy and childbirth **benefit** covers no more than one routine antenatal 2D ultrasound scan in each trimester of a normal uncomplicated pregnancy. If any more ultrasound scans are needed, **your medical practitioner** must confirm the reasons in the **Claim** form so we can consider cover. The **benefit** also covers 12 routine antenatal visits during a normal uncomplicated pregnancy. If any more antenatal visits are needed your **medical practitioner** must provide the reasons in the **Claim** form so we can consider cover.

The **benefit** covers the following for the newborn child:

- one physical examination;
- vitamin K, hepatitis B and BCG vaccinations;
- routine blood tests for PKU, congenital hypothyroidism and G6PD;
- one hearing examination; and
- necessary and **reasonable** expenses of accommodation costs for no more than four nights, if the mother is admitted and not suffering any complications.

**BC13** If we receive new information that shows a **claim** we have already approved is not eligible, no costs will be paid. If any costs have already been paid, we will recover these from **you** or the **planholder** and no further costs will be paid. Any approval we have given during the **pre-authorisation** process may also be withdrawn.

### Benefit exclusions

The **UltraCare plan** does not cover **claims** for, arising from or connected with the following **benefit** exclusions unless shown on your Table of **benefits**, or agreed by us in writing.

Some of these **benefit** exclusions also apply to the Personal accident add-on **plan**. See the 'Extra **benefit** conditions and **benefit** exclusions for add-on **plans**' section for more information.

Extra **benefit** exclusions also apply to the Personal accident add-on **plan**. See the 'Extra **benefit** conditions and **benefit** exclusions for add-on **plans**' section for more information.

**BE1** (This **benefit** exclusion applies if **your** underwriting terms are **moratorium** or **CPME previously moratorium**, as shown on **your** Certificate of insurance. See **benefit** exclusion BE2 if **your** underwriting terms are **FMU** or **CPME**

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previously FMU, as benefit exclusion BE1 does not apply to these underwriting terms. Benefit exclusions BE1 and BE2 do not apply if your underwriting terms are MHD.)

A medical condition or related medical condition that is pre-existing within the 24-month period before the date of joining or the date shown on the special terms section of your Certificate of insurance.

Pre-existing medical conditions or related medical conditions may be covered after you have had 24 months' continuous cover under the plan and within that time you have not:

- experienced symptoms;
- asked for advice; or
- needed or received treatment, medication, or a special diet.

If you have;

- experienced symptoms;
- asked for advice; or
- needed or received treatment, medication, 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. Pre-existing medical conditions or related medical conditions may then be covered. This is the rolling part of the moratorium.

**BE2** (This benefit exclusion applies if your underwriting terms are FMU or CPME previously FMU, as shown on your Certificate of insurance. See benefit exclusion BE1 if your underwriting terms are moratorium or CPME previously moratorium, as benefit exclusion BE2 does not apply to these underwriting terms. Benefit exclusions BE1 and BE2 do not apply if your underwriting terms are MHD.)

A medical condition or symptom that you were aware of before your start date unless we were given all the information we asked for in the application and we have not specifically excluded the medical condition or symptom as shown on your Certificate of insurance.

**BE3** Costs that exceed a limit shown on your Table of benefits.

**BE4** A benefit not included on your plan.

**BE5** A benefit not included on your plan at the time the costs are incurred, even if the benefit was included in any previous plan year.

**BE6** A benefit included on your plan, if you have not completed the period shown on your Table of benefits.

**BE7** Pregnancy, childbirth or postnatal costs, whether complicated or not.

**BE8** Any journey made specifically for the purpose of receiving medical treatment, unless you have requested pre-authorisation and we have given our approval.

**BE9** Non-emergency transportation.

**BE10** Burial, cremation, or the costs of moving your body or mortal remains, if you die in your home country.

**BE11** Any journey, activity, action or pursuit carried out against the advice of a medical practitioner, specialist/ nurse or therapist.

**BE12** Treatment given, or referrals made by, a medical practitioner, specialist, nurse or therapist who is in any way related to you, and self-prescribed treatment or self-referral if you are a medical practitioner, specialist or therapist.

**BE13** Alcohol, drug or any other intoxicating substance abuse, any addictive condition of any kind and any medical condition arising directly or indirectly from any such abuse or addictive condition.

**BE14** You being under the influence of alcohol, drugs or any other intoxicating substance.

**BE15** Male to female or female to male gender reassignment.

**BE16** Tests or treatment for, or because of, sexually transmitted infections.

**BE17** Experimental or unproven treatment, unless you have requested pre-authorisation and we have given our approval.

**BE18** Bone marrow transplants, the costs of finding and obtaining an organ, costs as a result of removing an organ from a donor, any costs related to the transplant of an organ that is not obtained in accordance with the World Health Organisation's guidelines, costs of removing an organ from you to transplant it into another person, and any resulting complications.

**BE19** Cryopreservation, implantation or re-implantation of living cells or living tissue, whether taken from **your** own body or provided by a donor. Costs of removing living cells or living tissue from **you** to implant or re-implant into another person, and any resulting complications.

**BE20** Foetal **treatment**.

**BE21** Terminating a pregnancy.

**BE22** Congenital abnormalities or birth defects.

**BE23** Suicide, attempted suicide or any deliberate, self-inflicted **medical condition**.

**BE24** Putting yourself in needless danger, except in an attempt to save human life.

**BE25** Any **medical condition** suffered by military, naval or air force personnel engaging in any military, naval or air force operation or exercise.

**BE26** Any **medical condition** **you** suffer as a result of taking part in, or engaging in, any one or more of the following:

- an illegal or criminal act;
- military activity, war, riot, revolution, strike, lock-out or civil commotion;
- terrorism, usurped power; or
- any similar event.

**BE27** Contamination from biological, chemical or nuclear materials, including waste products from the combustion of nuclear fuel. Any biological, chemical or nuclear weapon of mass destruction, whether or not as the result of an explosion.

**BE28** **Treatment** received and costs incurred outside your **Area of cover**.

**BE29** **You** using a weapon or firearm for any purpose, or engaging in any professional sports when **you** receive payment for that sport as the main source of **your** income.

**BE30** Sleep apnoea, sleep-related breathing disorders, snoring or insomnia.

**BE31** Developmental disorders of the brain, learning disorders, learning difficulties, speech problems and voice problems.

**BE32** The costs of:

- cosmetic, reconstructive or remedial **treatment**; or
- replacing any implant;

including any related complications, whether or not the **treatment**, replacement or complications are for psychological reasons.

We will pay these costs if an in-patient or daycare surgical operation is needed as the result of an eligible **medical condition** that first occurred after your **date of joining**.

**BE33** Removing fat from any part of the body, breast reduction or breast enlargement.

**BE34** **Treatment** in a quarantine, isolation ward or unit, nursing home, hydro spa, spa, health farm or similar facility.

**BE35** Charges incurred for overdue payment of invoices.

**BE36** Myopia, hypermetropia, astigmatism, natural or non-medical degenerative sight or hearing disorders, aids to help with **your** sight or hearing, contact lens solutions, eye drops, sunglasses or prescription sunglasses. Preventative services and examinations for sight or hearing.

**BE37** **Treatment** needed as a result of tattooing or piercing any part of the body.

**BE38** Costs of:

- precious crowns;
- **dental** implants;
- removable bridges;
- dentures; or
- false teeth,

preventative dental services, including but not limited to:

- sealants;
- fluoride **treatment**; or
- scraping, cleaning and polishing, or

**BE39** Orthodontic **treatment** to affect the structure, function, development or appearance of the teeth, upper or lower jaw or the oral cavity.



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**BE40** Compulsive or addictive eating disorders or homesickness.

**BE41** Obesity, special diet or weight control.

**BE42** Costs of:

- vitamin, mineral or organic supplements;
- children's food or baby supplies; or
- products that can be obtained without a prescription, including, but not limited to, mouthwash, toothpaste, antiseptic lozenges or sprays, shampoo and sunscreen.

**BE43** Supplying, fitting or maintaining any external prostheses, appliance or device. The cost of renting or, buying wheelchairs or other equipment, medical or otherwise. **We** will pay for a spinal support, knee brace or air cast boot if it is part of a surgical operation or part of the **treatment** of an eligible **medical condition**. **We** will also pay for crutches if medically necessary for the **treatment** of an eligible **medical condition**.

**BE44** Costs of:

- completing **Claim** forms; or
- completing or obtaining any other documents.

If **you** receive **treatment** outside Thailand, **we** will not pay any registration fees or service administration fees, including concierge and interpreter services.

**BE45** Any consequential loss, including but not limited to:

- loss of earnings while unable to work due to illness or injury
- additional childcare costs incurred while **you** are admitted to **hospital**
- additional local travel costs incurred due to illness or injury
- parking fees at the **hospital** or clinic

**BE46** Costs incurred before **your start date** or after **your end date**.

**BE47** Any costs relating to **in-patient, daycare or out-patient treatment** in a **hospital**:

- received at the time of **your start date**; or
- that **you** were aware of at **your start date**;

whether the **treatment** was planned or not, unless **you** have told **us** about it and **we** have accepted it.

**BE48** Drugs or dressings that:

- are not recognised by the pharmaceutical regulator in the country where **treatment** is provided;
- are available without prescription; or
- are prescribed for a **medical condition** that is different to the one that **you** are claiming for.

**BE49** Costs as a result of proven medical negligence or malpractice.

**BE50** Any deductible that applies to your **plan**.

**BE51** Costs of:

- contraception or sterilisation;
- **treatment** for sexual problems, including impotence, whatever the cause;
- fertility or infertility tests or **treatment**;
- assisted reproduction; or
- surrogacy.

**BE52** Any **treatment** needed for a newborn child if the pregnancy was the result of assisted conception.

**BE53** Invoices, **Claim** forms, medical reports or any other documents that have been altered or amended.

**BE54** Travelling in, or on, a motorised vehicle as a driver or passenger:

- if the driver does not have a valid licence as required by local law; or
- **you** are not wearing the necessary safety equipment.

**BE55** Antenatal 3D or 4D ultrasound scans.

**BE56** Health education programmes or services including, but not limited to, family planning, antenatal classes and parenting classes.

**BE57** **Treatment** of birthmarks.

## Benefit conditions for the Personal accident add-on plan

Claims will only be paid under the **plan** if you meet **benefit** condition BC13 in the 'Benefit conditions' section and the extra **benefit** conditions listed below.

**BCPA1** We provide cover for managerial, clerical and administrative occupations only. If you engage in any manual or dangerous occupation or **hazardous pursuit** which puts you at greater risk of a **bodily injury** caused by an **accident**, the **planholder** must tell us. We will tell the **planholder** if we agree to cover you and let them know any extra premium that applies.

**BCPA2** No amount above the maximum accumulation limit shown on the Table of **benefits** will be paid for **claims** arising from any one event in any one location or **vehicle**, if they are made by multiple **members** on the same Personal accident add-on **plan**. If the total value of claims exceeds the maximum accumulation limit, the amount paid for each claim will be reduced proportionately to the amount each **member** is due, up to the maximum accumulation limit.

**BCPA3** You will not be paid more than the overall maximum limit for each unit shown in the Table of **benefits** for any one or more **accidents**.

**BCPA4** If you suffer one or more permanent total or permanent disablements within 12 months of an **accident**, you will only be paid up to the **benefit** limits shown on your Table of **benefits** that applied in the **plan year** when you had the **accident**. You will not be paid any more than the overall limit shown on your Table of **benefits**.

**BCPA5** If you die within 12 months of an **accident**, payment will only be made up to the **benefit** limit shown on your Table of **benefits** that applied in the **plan year** when you had the **accident**, in line with the instructions received from your personal representative. If you die before any **disablement benefit** is paid, only the accidental death **benefit** will be paid.

If any **disablement benefit** has already been paid under this **plan** for any **accident** that happened in the same **plan year**, the accidental death **benefit** amount paid will be reduced by the value of any **claims** already paid.

No payment will be made for any more than the overall limit shown on your Table of **benefits**.

**BCPA6** We must be told as soon as possible about any **accident** that causes or may cause a **claim**.

**BCPA7** Cover is not provided for sickness or disease.

**BCPA8** You must make all medical records, notes and correspondence we need available to us, and any medical advisor we have appointed.

**BCPA9** For any **claim** to be considered for loss of sight of both eyes, you must be diagnosed as blind on the authority of a fully qualified ophthalmic **specialist**.

**BCPA10** For any **claim** to be considered for loss of sight of one eye, the degree of sight after correction must be 3/60 or less on the Snellen Scale, seeing at 3 feet what you should see at 60 feet, or an equivalent scale.

**BCPA11** If you have an existing **medical condition** and suffer a **bodily injury** because of an **accident**, we will ask an independent **specialist** to assess if your existing **medical condition** has contributed to your disability after the accident, or if your disability after the **accident** has made your existing **medical condition** worse. We will decide the difference between your existing **medical condition** and the disability suffered after the **accident** and pay any **claim** based on this difference. This will be expressed as a percentage and applied to the appropriate **benefit**.

An example of this is:

You are partially deaf in your right ear. You have an **accident** that causes total permanent loss of hearing in your right ear.

We will ask an independent ENT **specialist** to assess the difference between the level of deafness you had before and after the **accident**. If the independent ENT **specialist** advises that the deafness in your right ear before the **accident** was at 25%, you will be paid 75% of your **benefit** limit for total deafness of one ear.

## Benefit exclusions for the Personal accident add-on plan

The Personal accident add-on **plan** does not cover **claims** for, arising from or connected with the **benefit** exclusions, BE3 to BE4, BE11 to BE14, BE23 to BE27, BE29, BE43, BE44, BE47, BE52 and BE53 listed in the 'Benefit exclusions' section and the extra **benefit** exclusions listed below.

**BEPA1** Aviation other than as a fare-paying passenger in a fully-certified passenger carrying aircraft, flown in the course of licensed operation for transporting passengers by licensed crew.

**BEPA2** Engaging in manual or dangerous occupations or **hazardous pursuits**.

**BEPA3** Any **accident** that happens before your **start date** or after your **end date**.



