Emergency Medical Insurance

Terms and Conditions

BDO Insure

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BDO Insure is a registered trademark of BDO Insurance Brokers, Inc., an insurance broker licensed and supervised by the Insurance Commission of the Philippines.

Insurance provided by:

DEFINITION OF TERMS

1. ACCIDENT. A visible, external, sudden and violent event occasioned by a physical cause and occurring entirely beyond the Insured Person's control causing damage to the health of the Insured Person.

2. ACCREDITED NETWORK. A group of Physicians, Dentists, including Specialists like Surgeons and Cardiologists, Hospitals and Clinics with an agreement with the Company or Company's subsidiary (Pacific Cross Health Care, Inc.) to provide services to the Insured Persons of the Company. The Company pays directly to the accredited network for valid benefit availment of the Insured Person.

3. ANESTHESIOLOGIST. A medical specialist duly licensed and registered to administer anesthetic agents and conduct other anesthesia procedures during necessary for surgical procedures.

4. ATTENDING PHYSICIAN. The chief Physician in charge of the medical treatment of an Insured Person.

5. CHRONIC CONDITION. Any condition or diagnosis that has been in existence for a minimum of six (6) months from the first date of diagnosis or when symptom(s) first occurred regardless of nature, severity or location.

6. CONFINEMENT. A continuous stay for a period of not less than 18 hours as a registered bed patient in a Hospital required by a Physician for treatment of a covered Illness or Injury.

7. CONTACT SPORT. A sport (e.g., football, rugby, karate, boxing, martial arts and wrestling, among others) that necessarily involves physical contact between and among players and engaged in by an Insured Person solely for leisure, recreation, entertainment, fitness or physical education.

8. CORRECTIVE DEVICE. A device, such as but not limited to stents and devices, prescribed by a Physician to prevent or correct body malfunctions or to improve body function.

9. COSMETIC SURGERY AND RECONSTRUCTIVE SURGERY. Surgery uniquely undertaken to improve or enhance an Insured Person's appearance through surgical and medical techniques. This includes any surgery arranged for any kind of psychological reason, adaptation or personal satisfaction.

10. COUNTRY OF RESIDENCE. Shall be each Insured Person's place of residence or place of employment for not less than 6 months within the Period of Insurance. It is deemed to be the Philippines unless otherwise declared and covered by an Endorsement to the Policy, with coverage governed by additional terms and conditions as specified in the Endorsement attached to the Policy.

11. DEVELOPMENTAL, CONGENITAL CONDITION, BIRTH DEFECT. A medical abnormality existing at the time of birth as well as neonatal physical or mental abnormalities developing thereafter because of causal factors or conditions present at the time of birth.

12. DISABILITY. An Illness or Injury, and any symptom, sequelae, or complication thereof requiring treatment. All injuries arising from the same event or series of continuous events are considered as one (1) Disability.

13. DURABLE MEDICAL EQUIPMENT. As determined by the Company, medically prescribed items of medical equipment for repeated use, owned or rented, such as but not limited to crutches or wheelchairs which are placed in the home of an Insured Person to facilitate treatment and/or rehabilitation of Illness or Injury.

14. ELIGIBLE EXPENSES. Expenses incurred in the treatment of a covered Illness or Injury which are medically necessary and not exceeding the limits indicated on the Policy.

15. EMERGENCY: A condition wherein the Insured Person is in severe pain or suffers serious Illness or Injury that requires immediate medical or surgical attention which, if not rendered, may result in loss of a vital function of the body such as the loss of limb or eyesight, or the loss of life.

Definition of Terms
Accident
Accredited Network
Anesthesiologist
Attending Physician
Chronic Condition
Confinement
Contact Sport
Corrective Device
Cosmetic Surgery and Reconstructive Surgery
Country of Residence
Developmental, Congenital Condition, Birth Defect
Disability
Durable Medical Equipment
Eligible Expenses
Emergency
Hospital
Illness
Implant
Injury
Insured Persons
Medically Necessary
Medicine and Drugs
Mental Nervous Disorder
Miscellaneous Hospital Services
Normal, Usual and Customary Fees
Physician, Surgeon, Specialist, or Doctor
Policyholder
Professional Fees
Recreational Scuba Diving
Supplements
Surgeon's Fees
Surgery
Terrorism
Eligibility
Period of Insurance
Policy Benefits
In-Patient / Hospitalization Benefit
Emergency Out-Patient Benefit
General Exclusions
Claims and Payment Provision
Claims Submissions
Benefit Payment
Terms and Conditions
Important Notes

16. HOSPITAL. An institution which is legally licensed as a medical or surgical Hospital in the country where it is located and whose main activities are not those of a spa, hydroclinic, sanitarium, nursing home, home for the aged, a place for alcoholics or drug rehabilitation. It must be under the constant supervision of a resident Physician.

17. ILLNESS. Poor health or poor physical condition marked by a pathological deviation from a normal healthy state caused by disease or sickness.

18. IMPLANT. A substance or object (such as but not limited to silicone, lens, pacemaker, cochlear, metals or pins) that is placed within the body as a replacement of a diseased part to improve function.

19. INJURY. Physical damage or trauma arising wholly and exclusively from an Accident or other events of violent or external and visible nature.

20. INSURED PERSONS. Are those persons specifically listed and named in Schedule 2 of the Policy.

21. MEDICALLY NECESSARY. A treatment or supply which is necessary and appropriate for the diagnosis or treatment of an Illness or Injury based on generally accepted standards of current medical practice subject to the approval of the Company. In the context of a coverable Injury or Illness, such medical treatment is necessary and appropriate for the diagnosis and treatment of an Insured Person's particular symptoms. It is not provided or obtained merely for the convenience of the Insured Person or his Physician without any evident (manifest) and vital (urgent) need for it nor should such treatment exceed the level of care needed to ensure safe, adequate and suitable diagnosis or treatment.

22. MEDICINE AND DRUGS. Those for which a licensed medical practitioner has prescribed for dispensing, which are specifically required for the treatment of a covered Illness or Injury within the Period of Insurance.

23. MENTAL NERVOUS DISORDER. A disorder that includes neurosis, psychosis, psychoneurosis or any form of psychopathy as well as degenerative brain disorder and personality disorder. This also encompasses mental nervous disorders without demonstrable organic origin.

24. MISCELLANEOUS HOSPITAL SERVICES AND SUPPLIES. Includes eligible expenses for required diagnostic laboratory test, x-rays, prescribed medicines, blood and components, anesthesia, surgical appliances, physical or physiotherapy and other therapy services as approved by the Company.

25. NORMAL, USUAL AND CUSTOMARY FEES OR CHARGES. Fees or charges for medical or health services are deemed to be Normal, Usual and Customary if the fees or charges do not exceed the usual level of charges for similar treatment, supplies or medical services provided in the geographical area where the expenses were incurred.

26. PHYSICIAN, SURGEON, SPECIALIST, OR DOCTOR. A person qualified by degree and duly licensed or registered to practice medicine in the geographical area in which he serves. This person must not be a relative of any covered person by consanguinity or affinity.

27. POLICYHOLDER. An entity or person to whom the Policy has been issued to in respect of the coverage for persons specifically named in Schedule 2 of the Policy.

28. PROFESSIONAL FEES. As distinct from Surgeon and Anesthesiologist's Fees, fees paid to licensed medical professionals including but not limited to an Occupational Therapist, Physiotherapist, Attending Physician's visits or Pathologists.

29. RECREATIONAL SCUBA DIVING. Diving with a scuba equipment using only compressed air as the breathing mixture (not requiring a decompression stop), for the purpose of leisure and enjoyment of either a certified diver or a non-certified diver who should be with the supervision of a recognized scuba diving certification agency approved dive master or instructor to a depth of no greater than 40 meters.

Definition of Terms
- Accident
- Accredited Network
- Anesthesiologist
- Attending Physician
- Chronic Condition
- Confinement
- Contact Sport
- Corrective Device
- Cosmetic Surgery and Reconstructive Surgery
- Country of Residence
- Developmental, Congenital Condition, Birth Defect
- Disability
- Durable Medical Equipment
- Eligible Expenses
- Emergency
- Hospital
- Illness
- Implant
- Injury
- Insured Persons
- Medically Necessary
- Medicine and Drugs
- Mental Nervous Disorder
- Miscellaneous Hospital Services
- Normal, Usual and Customary Fees
- Physician, Surgeon, Specialist, or Doctor
- Policyholder
- Professional Fees
- Recreational Scuba Diving
- Supplements
- Surgeon's Fees
- Surgery
- Terrorism

Eligibility
Period of Insurance
Policy Benefits
- In-Patient / Hospitalization Benefit
- Emergency Out-Patient Benefit

General Exclusions
Claims and Payment Provision
- Claims Submissions
- Benefit Payment

Terms and Conditions
Important Notes

30. SUPPLEMENTS. Items prescribed by the Attending Physician other than the conventional Medicine and Drugs meant to relieve the signs and symptoms of Illness or Injury which the Insured Person is suffering from during the time of consultation for a covered condition.
31. SURGEON'S FEES. All of the fees payable to a Surgeon(s) for providing surgery to treat a covered Illness or Injury. The Surgeon's Fees include pre-surgical assessment and post-surgical care and in total is limited to the Normal, Usual and Customary Charges while the Insured Person is confined in the treatment area where the surgery is provided.
32. SURGERY: The branch of medicine dealing with manual or operative procedures for the correction of deformities and defects, repair of injuries, diagnosis and cure of certain diseases. This includes surgery performed in an out-patient setting for a covered Illness or Injury.
33. TERRORISM. An act, or threat thereof, or both, including but not limited to the use of force or violence committed by any person or group(s) of persons, whether acting alone or on behalf of, or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

Words in the singular form include the plural and vice versa and words importing the masculine or neuter gender shall each include the feminine, masculine and neuter gender.

ELIGIBILITY AND PERIOD OF INSURANCE

ELIGIBILITY.
Principal Insured Person
A person who has attained the age of 15 days and not more than 65 years old is eligible.

PERIOD OF INSURANCE:
The Policy shall commence on the Effective Date shown on your Policy upon payment in full of the due premium and successful registration of the pre-paid card. The Philippine standard time of 12:00 AM shall be deemed to be the effective time and ceases on whenever any of the following occurs first:

a) the Policy End Date as specified in Schedule 1 of the Policy; or
b) after claims approval when benefits are availed of in the manner described and not exceeding the limits as specified in your Policy.

POLICY BENEFITS

IN-PATIENT/ HOSPITALIZATION BENEFITS. The Insured Person under the Policy may avail of a medically necessary treatment in respect of a covered condition and the Company will reimburse eligible medical expenses based on the Claims Settlement of the Policy

EMERGENCY OUT-PATIENT BENEFIT. The Company will pay the eligible expenses up to the limit of the applicable benefits for a coverable emergency treatment not leading to Confinement provided by the Out-Patient department of a Hospital for a covered Illness or Injury.

GENERAL EXCLUSIONS

The following conditions and all expenses related to them are not covered under the Policy:

1. Confinement required wholly for executive check-ups, routine medical examinations or check-ups or Confinement purely for diagnostic purposes, hearing test or any service and treatment that are deemed unnecessary by the Company to the physical and mental conditions involved;

Definition of Terms
- Accident
- Accredited Network
- Anesthesiologist
- Attending Physician
- Chronic Condition
- Confinement
- Contact Sport
- Corrective Device
- Cosmetic Surgery and Reconstructive Surgery
- Country of Residence
- Developmental, Congenital Condition, Birth Defect
- Disability
- Durable Medical Equipment
- Eligible Expenses
- Emergency
- Hospital
- Illness
- Implant
- Injury
- Insured Persons
- Medically Necessary
- Medicine and Drugs
- Mental Nervous Disorder
- Miscellaneous Hospital Services
- Normal, Usual and Customary Fees
- Physician, Surgeon, Specialist, or Doctor
- Policyholder
- Professional Fees
- Recreational Scuba Diving
- Supplements
- Surgeon's Fees
- Surgery
- Terrorism

Eligibility
Period of Insurance
Policy Benefits
- In-Patient / Hospitalization Benefit
- Emergency Out-Patient Benefit

General Exclusions
Claims and Payment Provision
- Claims Submissions
- Benefit Payment

Terms and Conditions
Important Notes

2. Expenses due to vaccination except the first dose of anti-rabies, anti-venom and anti-tetanus;

3. Expenses for marriage, family and dietary counseling except if the dietary counseling by a dietician is incidental during confinement;

4. Screening and treatment of congenital, heredo-familial, developmental abnormalities, birth defect and complications arising therefrom;

5. Screening and treatments for Sexually Transmitted Diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), AIDS-Related Complex (ARC), Erectile Dysfunction Syndrome and all complications arising therefrom;

6. Expenses for chronic dermatologic condition, weight treatment, management and its sequelae;

7. Screening and treatment for error of refraction, laser or eye surgery to correct refractive error;

8. Cosmetic Surgery or procedure, or any cosmetic related complication, eye glasses/contact lenses, hearing aids and prescriptions thereof except as may be required for reconstructive Surgery necessitated by Illness or Injury or Accident wholly occurring during the Period of Insurance;

9. Dental care and treatment, braces, dental appliances, dental implant and other dental-related expenses except as provided in the benefits in Schedule 3 or as necessitated by Injuries wholly occurring during the Period of Insurance;

10. Durable medical equipment, graft, prosthetic devices, corrective devices other than artificial limb and any form of artificial implant permanent or otherwise unless specified as covered in the Schedule of Benefits;

11. Expenses incurred for surgery pertaining to perineal repair, sex transformation and enhancement, circumcision and any condition arising therefrom;

12. Expenses incurred for surgical, mechanical or chemical contraceptive methods of birth control or screening and/or treatment pertaining to infertility such as but not limited to sterilization, hormone treatment, artificial insemination, in vitro fertilization or embryo transfer and any procedures and conditions arising therefrom including expenses related to pregnancy and screening;

13. Pregnancy related expenses and screening, childbirth, surgical delivery, miscarriage, abortion including its complications, pre-natal or post-natal care as well as nursing care for a newborn child unless provided for in your Policy;

14. Expenses for Out-Patient Medicines, take home Medicines, Professional Fees, procedures and supplies for the continuing phase of treatment after discharge from Hospital confinement unless specifically provided for in the Out-Patient Benefit of Schedule 3 of the Policy;

15. Food supplement; care or treatment by herbalist, bonesetter, hypnotherapist, Chiropractor, Acupuncturist, or any experimental medical procedure or treatment not yet acceptable as a standard of practice unless specifically provided for in Schedule 3 of the Policy;

16. Organ transplantation including follow-up treatment and sequelae whether it is part of an organ or the whole organ itself for donor or recipient;

17. Medical expenses or surgical procedures that are not accepted as standard expenses/procedures by the medical profession or treatments subsequent to refusal or failure by an Insured Person to follow recommended therapeutic procedures;

- Definition of Terms
  - Accident
  - Accredited Network
  - Anesthesiologist
  - Attending Physician
  - Chronic Condition
  - Confinement
  - Contact Sport
  - Corrective Device
  - Cosmetic Surgery and Reconstructive Surgery
  - Country of Residence
  - Developmental, Congenital Condition, Birth Defect
  - Disability
  - Durable Medical Equipment
  - Eligible Expenses
  - Emergency
  - Hospital
  - Illness
  - Implant
  - Injury
  - Insured Persons
  - Medically Necessary
  - Medicine and Drugs
  - Mental Nervous Disorder
  - Miscellaneous Hospital Services
  - Normal, Usual and Customary Fees
  - Physician, Surgeon, Specialist, or Doctor
  - Policyholder
  - Professional Fees
  - Recreational Scuba Diving
  - Supplements
  - Surgeon's Fees
  - Surgery
  - Terrorism
- Eligibility
- Period of Insurance
- Policy Benefits
  - In-Patient / Hospitalization Benefit
  - Emergency Out-Patient Benefit
- General Exclusions
- Claims and Payment Provision
  - Claims Submissions
  - Benefit Payment
- Terms and Conditions
- Important Notes

18. Psychotic, mental or nervous/anxiety disorders, degenerative brain disorder including any neuroses and their physiological or psychosomatic manifestations;

19. Auto-immune conditions and their complications arising thereof and the use of immunotherapy, unless specified as covered in the Schedule of Benefits;

20. Experimental medical procedures, chelation and laser treatment or non-established medication for various medical conditions except those that are approved by the Company;

21. Care or treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity covering the Insured Person;

22. Expenses which are in excess of Normal, Usual and Customary Charges for the geographical area as determined by the Company in consultation with reputable medical practitioners and institutions located in the geographical area;

23. Expenses incurred in rest cures, convalescent, intermediate, domiciliary, and custodial or palliative and hospice care;

24. Injury or Illness arising directly or indirectly out of excessive consumption of alcohol, misuse or irrational use of drugs/medications, solvent/substance or any addicting and habit-forming drugs which cause complications that will require treatment or medical intervention. Excessive consumption of alcohol is characterized by the Insured Person's alcohol level being above the normal range of such alcohol test;

25. Treatments or services arising from suicide, attempted suicide or intentionally self-inflicted Injury;

26. Active duty in the military, naval or air forces of any Country or International Authority;

27. Natural Catastrophes; Injuries or Illness arising out of epidemics including military/paramilitary epidemics which are declared by any local, regional or international agency or organization authorized to address health issues in the local and national geographical area or country;

28. Charges incurred for provision of all certificates, documentation, information and other pieces of evidence required by the Company including the translation cost of such evidence if other than English in support of an application or claim for benefits;

29. Communication and transportation expenses other than medically necessary telecommunications and local ambulance or transportation services;

30. Injury or disease arising out of duties of employment or professions with physical hazard;

31. Assault or fighting provoked by the Insured Person; injury or illness arising directly or indirectly out of any law violation, participation in an illegal and unlawful activity or deliberate exposure to exceptional danger except in an effort to save human life;

32. Ionizing radiations or contamination by radioactivity from any sources like nuclear plant leaks, nuclear waste from process of nuclear fission, or from any nuclear weapon material;

33. Participating in, but not limited to, the following activities including the practice and actual competition: Auto racing, professional sports, Contact Sports, winter sports except recreational skiing within authorized tracks, racing other than foot racing, motorcycling (except daily use for transportation on a paved road), dressage, skydiving, parasailing, hang gliding, flying (other than as a fare paying passenger on a duly licensed commercial aircraft), caving, rock or mountain climbing (with or without the use of ropes or other equipment), bungee jumping, polo, steeple chasing, hitchhiking, sport diving, non-Recreational Scuba Diving as defined in the Policy, or any hazardous activity, unless declared to and accepted by the Company.

- Definition of Terms
  - Accident
  - Accredited Network
  - Anesthesiologist
  - Attending Physician
  - Chronic Condition
  - Confinement
  - Contact Sport
  - Corrective Device
  - Cosmetic Surgery and Reconstructive Surgery
  - Country of Residence
  - Developmental, Congenital Condition, Birth Defect
  - Disability
  - Durable Medical Equipment
  - Eligible Expenses
  - Emergency
  - Hospital
  - Illness
  - Implant
  - Injury
  - Insured Persons
  - Medically Necessary
  - Medicine and Drugs
  - Mental Nervous Disorder
  - Miscellaneous Hospital Services
  - Normal, Usual and Customary Fees
  - Physician, Surgeon, Specialist, or Doctor
  - Policyholder
  - Professional Fees
  - Recreational Scuba Diving
  - Supplements
  - Surgeon's Fees
  - Surgery
  - Terrorism
- Eligibility
- Period of Insurance
- Policy Benefits
  - In-Patient / Hospitalization Benefit
  - Emergency Out-Patient Benefit
- General Exclusions
- Claims and Payment Provision
  - Claims Submissions
  - Benefit Payment
- Terms and Conditions
- Important Notes

CLAIMS AND PAYMENT PROVISIONS

CLAIMS SUBMISSION

CERTIFICATION, INFORMATION AND EVIDENCE: All certificates, accounts, receipts, information and evidence required by the Company shall be furnished in such form as the Company may require.

SUFFICIENCY OF NOTICE
Written notice of any claim given by or on behalf of the Insured Person or Beneficiary to the Company or to any authorized representative of the Company, with information sufficient to identify the Insured Person, shall be deemed notice to the Company.

NOTICE OF CLAIM
The Company shall provide the Insured Person with its usual form for filing Proof of Claim. Upon receipt of notice of claim, the Company shall provide any additional form as needed. All claims must be submitted to the Company within 30 days after completion of the events for which the claim is being made.

PROOF OF CLAIM
All claims shall be filed together with reasonable proof obtained, at the Insured Person's expense, of the death, Illness, Disability, Injury, or loss for which the claim is made as well as any and all supporting information. All proof of claim must be submitted in the English language and if in another language the translation shall be at the expense of the Insured Person. The list of reasonable proof of claim is as stated in the Company's Notification Claim (NOC) Form.

Completed claim forms and written proof of loss must be furnished to the Head Office of the Company within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce the claim if it was not reasonably possible to give proof within such time.

Claims are not deemed to be complete and benefits are not payable unless all bills under such claims have been submitted and agreed upon by the Company.

PAYMENT OF CLAIMS
Indemnity under this policy is payable to the insured person himself or to the person other than the insured person himself, who has legal right to insure the subject of the policy of insurance, as the case may be. However, in case of death of the insured person during the period of insurance, indemnity for loss of life of the Insured Person is payable to the Beneficiary specified in the Application for insurance, if surviving the Insured Person. If no beneficiary is designated, the benefit due, if still unpaid, shall be paid to the heirs or estate of the insured person under the law on succession.

The amount of any damage or loss for which the Company may be liable under the Policy shall be paid within 30 days after proof of loss is received by the Company and ascertainment of loss or damage is made either by agreement between the Insured Person and the Company or by arbitration; but if the ascertainment of the loss is not had or made within 60 days after such receipt by the Company of proof of loss, then the loss or damage shall be paid within 90 days after such receipt. Refusal or failure to pay the losses within the time prescribed herein will entitle the Insured Person to collect interest or the proceeds of the Policy for the duration of the delay at the rate of twice the ceiling prescribed by the Monetary Board, unless such refusal or failure to pay is based on the ground that the claim is fraudulent.

CONDITIONS PRECEDENT TO ANY LIABILITY
Any Liability of the Company to the Insured Person shall be wholly dependent upon:

a.) The Company being furnished with all required statements and declarations to be provided by the Insured Person (parent or duly appointed guardian if the Insured Person is minor) or an Application or enrollment form provided by the Company and the complete truth of all such statements and declaration.

Definition of Terms
- Accident
- Accredited Network
- Anesthesiologist
- Attending Physician
- Chronic Condition
- Confinement
- Contact Sport
- Corrective Device
- Cosmetic Surgery and Reconstructive Surgery
- Country of Residence
- Developmental, Congenital Condition, Birth Defect
- Disability
- Durable Medical Equipment
- Eligible Expenses
- Emergency
- Hospital
- Illness
- Implant
- Injury
- Insured Persons
- Medically Necessary
- Medicine and Drugs
- Mental Nervous Disorder
- Miscellaneous Hospital Services
- Normal, Usual and Customary Fees
- Physician, Surgeon, Specialist, or Doctor
- Policyholder
- Professional Fees
- Recreational Scuba Diving
- Supplements
- Surgeon's Fees
- Surgery
- Terrorism

Eligibility
Period of Insurance
Policy Benefits
- In-Patient / Hospitalization Benefit
- Emergency Out-Patient Benefit

General Exclusions
Claims and Payment Provision
- Claims Submissions
- Benefit Payment

Terms and Conditions
Important Notes

b.) The complete truth of all statements and declarations made in respect to any claim made against the Company by the Insured Person under the provisions of the Policy.
c.) The due observance and fulfillment of the terms, conditions, and provisions of the Policy and Endorsements to it insofar as they relate to anything to be done or complied with by the Insured Person.

FRAUDULENT CLAIMS
If any claim under the Policy is in any respect fraudulent, all benefits payable and/or paid in relation to that claim shall be forfeited and if deemed appropriate, recoverable respectively.

PHYSICAL EXAMINATION AND AUTOPSY
The Company shall have the right and opportunity to examine the Insured Person when and as often as it may reasonably require during the pendency of claim hereunder, and the right and opportunity to make an autopsy in case of death, where it is not forbidden by law.

BENEFIT PAYMENT

Currency
All benefits payment shall be in Philippine Peso.

Payment of Benefits
If an Insured Person incurs eligible expenses during the effectivity of the Policy, the Company will pay benefits in accordance with the Schedule of Benefits in your Policy. The Company will pay the eligible expenses after application of any deductions that may apply.

Coordination of Benefits
Benefits will not exceed the total medical expenses when combined with other insurance in force or organizations or which are provided free of charge in government or private facilities.

TERMS AND CONDITIONS

ENTIRE CONTRACT/CHANGES IN THE POLICY
The Policy, the submitted Application form and all Schedules, Endorsements, rider clauses or warranties attached thereto are the whole contract. Any change to the Policy must be approved by an authorized officer of the Company and such approval must be endorsed or attached to the Policy in accordance with Section 50 of the Insurance Code. Unless applied for by the Insured Person, no such alteration or Endorsement shall affect any Policy issued prior to the alteration or Endorsement without the written consent of the Insured Person. If applied for by the Insured Person, the written request or consent must be received by the Company and shall be taken as his agreement to the contents of such alteration or Endorsement. If a special meaning is attached to any word or expression in the Policy, or its Schedules, Applications or Endorsements, it will continue to bear such meaning throughout the Policy.

OBSERVANCE OF TERMS AND CONDITIONS
The due observance and fulfillment by the Insured Person(s) of the Terms and Conditions, as printed on the Policy and any Endorsement, rider clause or warranty attached to the Policy insofar as they relate to anything to be done or complied with by them, and the truth of the statements and particulars in every Application or proposal for insurance or submission of a claim shall be conditions precedent to any liability of the Company.

CHANGE OF COUNTRY OF RESIDENCE, OCCUPATION, HABITS, OR PURSUANT
The Insured Person shall give or cause to give immediate notice to the Company of any change in address, Country of Residence, occupation, habits or pursuits of any person covered under the Policy. For change in Country of Residence, the Company shall not be liable for losses arising from such a change until and unless such notice is duly given within 90 days from such occurrence of change and approved by the Company. The change must be endorsed to the Policy.

Definition of Terms
Accident
Accredited Network
Anesthesiologist
Attending Physician
Chronic Condition
Confinement
Contact Sport
Corrective Device
Cosmetic Surgery and Reconstructive Surgery
Country of Residence
Developmental, Congenital Condition, Birth Defect
Disability
Durable Medical Equipment
Eligible Expenses
Emergency
Hospital
Illness
Implant
Injury
Insured Persons
Medically Necessary
Medicine and Drugs
Mental Nervous Disorder
Miscellaneous Hospital Services
Normal, Usual and Customary Fees
Physician, Surgeon, Specialist, or Doctor
Policyholder
Professional Fees
Recreational Scuba Diving
Supplements
Surgeon's Fees
Surgery
Terrorism
Eligibility
Period of Insurance
Policy Benefits
In-Patient / Hospitalization Benefit
Emergency Out-Patient Benefit
General Exclusions
Claims and Payment Provision
Claims Submissions
Benefit Payment
Terms and Conditions
Important Notes

SUITS AGAINST THE COMPANY

If a claim is made and rejected, and an action or suit is not commenced either in the Insurance Commission or any court of competent jurisdiction within 12 months from receipt of written notice of such rejection, or in case of arbitration taking place as provided herein, within 12 months after written notice of the award made by the arbitrator or the arbitrators or umpire, then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

ALTERNATIVE MODES OF DISPUTE RESOLUTION

In the event of any controversy or claim arising out of or relating to this contract, or breach thereof, the parties hereto agree first to try and settle the dispute by mediation, administered by the Insurance Commission or any recognized mediation institution under its Mediation Rules, before resorting to arbitration, litigation or some other dispute resolution procedure.

ABSOLUTE OWNERSHIP

The Company shall, unless otherwise expressly provided by endorsement on the Policy, be entitled to treat the Insured Person as the absolute owner of the Policy and shall not be bound to recognize any equitable or other claim to or interest in the Policy. The receipt of the Insured Person or of the Insured Person's personal representative alone shall be an effectual discharge.

CANCELLATION

Cancellation by the Company. Without prejudice to any claim made or in respect of a Disability incurred or that begins or manifests itself prior to the date of cancellation and further without prejudice to any right of the Company to avoid the Policy or any cover under the Policy, the Policy may only be cancelled by the Company at any time by written notice to the Policyholder at his last known address in any of the following circumstances or events:

a.) Non-payment of premium by the end of the grace period;
b.) Conviction of a crime leading to an increase in the hazard insured against;
c.) Discovery of fraud or material misrepresentation;
d.) Discovery of willful or reckless acts or omissions increasing the hazard insured against; or
e.) A determination by the Insurance Commissioner that the continuation of the Policy would violate or would place the Company in violation of the Insurance Code.

All notices of cancellation shall be in writing - mailed, or delivered to the Insured Person at the address shown in the Policy, and shall state: (a) which of the grounds set forth in this provision is relied upon and (b) that, upon written request of the Insured, the Company will furnish the facts in which the cancellation is based. In the event of such cancellation, the Company shall refund to the Insured Person the paid premium less the applicable cancellation fee for the remaining coverage of the Policy provided no claim is paid during the Period of Insurance. Once the refund of the unearned premium is paid to the Insured Person, all pending claims will no longer be processed and any subsequent claim filed will not be payable.

Cancellation by the Policyholder. If the Policyholder surrenders the Policy for cancellation, notice of which must be in writing, the Company shall retain the earned premium for the time the Policy has been in force, computed in accordance with the Short Period Rate Scale indicated as follows:

SHORT PERIOD RATE SCALE

If the Policy has been in force for	Percentage of Annual Premium Retained by the Company
a period not exceeding 1 month	20% of annual premium
a period not exceeding 2 months	30% of annual premium
a period not exceeding 3 months	40% of annual premium
a period not exceeding 4 months	50% of annual premium
a period not exceeding 5 months	60% of annual premium
a period not exceeding 6 months	70% of annual premium
a period not exceeding 7 months	75% of annual premium
a period not exceeding 8 months	80% of annual premium
a period not exceeding 9 months	85% of annual premium
a period not exceeding 10 months	90% of annual premium
a period exceeding 10 months	FULL Annual Premium

Definition of Terms
Accident
Accredited Network
Anesthesiologist
Attending Physician
Chronic Condition
Confinement
Contact Sport
Corrective Device
Cosmetic Surgery and Reconstructive Surgery
Country of Residence
Developmental, Congenital Condition, Birth Defect
Disability
Durable Medical Equipment
Eligible Expenses
Emergency
Hospital
Illness
Implant
Injury
Insured Persons
Medically Necessary
Medicine and Drugs
Mental Nervous Disorder
Miscellaneous Hospital Services
Normal, Usual and Customary Fees
Physician, Surgeon, Specialist, or Doctor
Policyholder
Professional Fees
Recreational Scuba Diving
Supplements
Surgeon's Fees
Surgery
Terrorism
Eligibility
Period of Insurance
Policy Benefits
In-Patient / Hospitalization Benefit
Emergency Out-Patient Benefit
General Exclusions
Claims and Payment Provision
Claims Submissions
Benefit Payment
Terms and Conditions
Important Notes

The Company shall refund the unearned premium provided no claim is paid during the Period of Insurance. The refund of premium is exclusive of the non-refundable relevant government charges. Once the refund of the unearned premium is paid to the Insured Person, all pending claims will no longer be processed and any subsequent claim filed will not be payable.

Free-Look Period. If the Insured Person is not completely satisfied with this Policy, he may return it, together with a letter, signed by the Insured Person, requesting for cancellation. This Policy will then be cancelled and the Company shall refund the paid premium to the Insured Person. This Free-Look Period has the following conditions: a.) The request to cancel must be sent directly to and received at the Company's Office within 15 days from the issue date of the Policy. b.) No refund can be made when a claim has been incurred and submitted to the Company. The Free-Look Period will commence on the date that the Policy was received by the Insured Person or by any of the Insured Person's authorized representative.

SUCCESSOR INSURED

If the Policyholder dies during the Period of Insurance and the remaining Insured Person is a minor, the legal guardian shall become the Policyholder.

DOCTOR'S AND HEALTH SERVICES PROVIDER'S REFERRAL

The Company shall not be held legally liable and responsible for acts of any doctor and health service provider causing damages to an Insured Person as a result of omissions, negligence, incompetence, and unsatisfactory services rendered by said doctor or service provider referred by the Company to the Insured Person upon the latter's request.

POLICY NOT ASSIGNABLE

The Policy is not assignable and the Company shall not be affected by notice of any trust change in lieu of assignment or other dealing with the Policy.

VENUE IN CASE OF LITIGATION

In the event of any legal action which may arise out of the provisions of the Policy, the case shall be filed within the various courts of Makati or in the court having jurisdiction in the address of the Policyholder or Insured as appearing in your Policy or Change of Address Endorsement provided it is within the Philippines and to the exclusion of any other courts outside the Philippines.

RIGHT OF RECOVERY

In the event that authorization of payment and/or payment is made by the Company for a claim which is not covered under the Policy or when the limit of liability of this insurance is exceeded, the Company reserves the right to recover the said sum or excess from the Policyholder/Insured Person.

CIVIL CODE ARTICLE 1250

The provisions of Article 1250 of the Civil Code of the Philippines (Republic Act No. 386) which reads, *"In case an extraordinary inflation or deflation of the currency stipulated should supervene, the value of the currency at the time of establishment of the obligation shall be the basis of payment*", shall not apply in determining the extent of liability under the provisions of the Policy.

LOSS AND DAMAGE AS A RESULT OF WAR, TERRORISM AND RELATED ACTS

The Company shall not pay any charge of:

a.) Loss or damage directly occasioned by, happening through or in consequence of: (i) War or any act of war, invasion, act of a foreign enemy, hostilities or warlike operations (whether war be declared or not), civil war, mutiny, civil commotion assuming the proportions or amounting to a popular rising, riot, strike, lock-out, military rising, insurrection, rebellion, revolution, military or usurped power, martial law or loot, sack or pillage in connection therewith, confiscation or nationalization or requisition or destruction of or damage to property by or under the order of any government or public or local authority or any act or condition incident to any of the above; (ii) nuclear and chemical contamination caused by any criminal of any country or international authority.

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- Recreational Scuba Diving
- Supplements
- Surgeon's Fees
- Surgery
- Terrorism

Eligibility

Period of Insurance

Policy Benefits
- In-Patient / Hospitalization Benefit
- Emergency Out-Patient Benefit

General Exclusions

Claims and Payment Provision
- Claims Submissions
- Benefit Payment

Terms and Conditions

b.) Loss, damage, cost or expenses of whatsoever nature directly or indirectly caused by, resulting from or in connection with: (i) any act of Terrorism regardless of any cause or event contributing concurrently or in any other sequence to the loss; (ii) any action taken in controlling, preventing, suppressing or in any way relating to any act of Terrorism; (iii) any act of any person(s) acting on behalf or in connection with any organization whose objective(s) include(s) the overthrowing or influencing of any de jure or de facto government by Terrorism or any violent means.

An act or event is an act of terrorism when an official written declaration has been made by any of the following Government Entities:

a.) President or Office of the President;
b.) Department of National Defense;
c.) Department of Justice;
d.) National Bureau of Investigation;
e.) Armed Forces of the Philippines;
f.) Anti-Terrorism Council;
g.) Philippine National Police;
h.) the concerned Local Government unit where the event happened;
i.) any entity duly authorized by law to declare an act or event as an Act of Terrorism; or
j.) Court declaration.

IMPORTANT NOTES

1. Pre-Existing Conditions are covered, with 7 calendar days waiting period upon successful registration.
2. For Out-patient availment, it is required that the client is accommodated for treatment in the Emergency Room Department of a hospital.
3. Use of Emergency Medical Cash is subject to one-time availment for one (1) emergency case/condition at a time.
4. Coverage will be exhausted after one (1) year of non-usage or immediately upon approval of eligible claims, whichever occurs first.
5. This benefit can be used on top of your Philhealth and/or any other HMO/Medical Plans.
6. Multiple purchases are allowed but can register the succeeding coverage after two (2) months or 60 days interval period from prior availment.

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- Supplements
- Surgeon's Fees
- Surgery
- Terrorism

Eligibility
Period of Insurance
Policy Benefits
- In-Patient / Hospitalization Benefit
- Emergency Out-Patient Benefit

General Exclusions
Claims and Payment Provision
- Claims Submissions
- Benefit Payment

Terms and Conditions
Important Notes