Elite Plus
Individual Health and Accident Insurance Policy
(Merely Translation Only)

In reliance upon statements contained in the insurance application, which is an integral part of this Policy, and in consideration of the premiums payable by the Insured, and subject to the definitions, general conditions, insuring agreements, general exclusions, and attachments to this Policy, the Company agrees with the Insured as follows.

Section 1: Definitions

Unless specified otherwise in this Policy, words or expressions to which specific meanings have been assigned in any part of this Policy will have the same meaning wherever they appear.

1 Company	means	LMG Insurance Public Company Limited
2 Policy	means	Insurance Policy Schedule, Benefit Schedule, General Provisions, General Exclusions, Insuring Agreement, Appendices, Special Notes, Representations, Application, Endorsements, Certificate of Renewal, and Summary of Conditions of Coverage Agreement and Exclusions under this Insurance Policy which constitute an integral part of Insurance Agreement.
3 The Insured	means	the Person who applies for the insurance coverage and whose name is indicated as the Insured in this Insurance Policy, Application, Renewal Certificate or endorsement (if any).
4 Accident	means	any incident suddenly occurring due to external factors and leads to unintentional or unexpected results for the Covered Persons.
5 Injury	means	any physical injury occurring to the body which is directly caused by Accident occurring individually and independently from other factors.
6 Illness	means	any physical abnormalities caused by disease.
7 Physician	means	a person obtaining a medical degree and having medical practitioner's license pursuant to the law in the area in which the service is provided.
8 Specialist Physician	means	a Physician obtaining a diploma or certificate of specialization in such field issued by the Medical Council of Thailand or equivalent institution in accordance with the law of the area in which the service is provided. However, Medical Specialist shall not be the primary Physician but the consulting Physician who jointly takes care of or provides treatment to the patient together with the primary Physician.
9 Dentist	means	a person obtaining a degree in dentistry and having the dental professional license pursuant to the law in the area in which the service is provided.
10 Nurse	means	a person obtaining nursing professional license pursuant to the law in the area in which the service is provided.
11 Health Facility	means	a place arranged for medical license or medical and public health professional practice pursuant to the law in the area in which the service is provided.

12 Hospital	means	any Health Facility which arranged for providing medical services which can accommodate overnight patients or treat Diseases or Injuries for 24 hours as well as obtaining a permit or being registered as a "hospital" pursuant to the law in the area in which the service is provided.
13 Clinic	means	any Health Facility providing medical services but unable to accommodate overnight patients and permitted or registered to operate as a "Clinic" pursuant to the law in the area in which the service is provided.
14 Inpatient	means	a patient who has medical necessity to be admitted to the Hospital or Health Facility to receive treatment for Injury or Illness continuously for not less than 6 hours and registered as an Inpatient which shall include the case of admission as an Inpatient but the person dies prior to the completion of 6 hours.
15 Outpatient	means	a patient receiving the treatment for Injury or Illness in Outpatient Department or Emergency Department of the Hospital or Health Facility without medical necessity to be admitted as an Inpatient.
16 Treatment	means	Provision of medical and public health services for examination and diagnosis, treatment, relief, care and rehabilitation necessary for health and living.
17 Medical Standards	means	rules or practices for treating the Injury or Illness in accordance with academic principles in compliance with the standards of the area in which the service is provided, which consist of (1) Professional standards and related professional requirements (2) Health Facility standards (3) Medicine and Medical Tools Standards (4) Non-discriminatory patient care
18 Medical Necessity	means	the necessity to use medical services or other services of the Health Facility for examination or treatment of Injury or Illness which shall be subject to the following conditions: (1) the services must be consistent with the diagnosis and treatment according to the symptoms of the Injury or Illness in a treated person (2) there is a clear medical indication in accordance with the standards of modern medical practice (3) the services are not solely for the convenience of the Covered Person or the Covered Person's family or the medical service provider.
19 Customary and Reasonable Medical Charges	means	any medical expenses and/or reasonable costs comparing to those charged to general patients for provided by a Hospital or medical center or clinic where a Covered Person is treated.
20 Alternative Medicine	means	any treatment of Injury or Illness performed by the practitioner holding the practitioner's license in the area in which the service is provided in the field of Thai traditional medicine or Chinese traditional medicine or Chiropractic or other fields which are not conventional medicine.
21 Deductible	means	the first amount of the loss that a Covered Person must be liable to pay before benefits under the Policy are payable by the

		Company according to the terms of the insurance agreement. The Deductible is an amount per Covered Person per Policy Year.
22 Terrorist Act	means	the use of force or violence and/or threat thereof, by any person or group of persons, whether alone or on alone or on behalf of or in connection with any organization or government, that is done for political, religious, ideological or similar purposes, including the intention to put any government and/or the public, or any section of the public, in fear.
23 Policy Year	means	A period of one year from the date the insurance Policy first come into effect or from the anniversary date of the following year and Health Insurance will renew as condition of Renewal of the Policy
24 Insurance Fraud	means	fraudulent claims of benefits under the Insurance Policy or presentation of false evidence in claims including the intention of causing injuries or illnesses with the aims of demanding compensations.

Section 2: General conditions

1. Insurance agreement

This insurance agreement is established based upon the Company's reliance on the Insured 's statements in the insurance application, health declaration, and any other additional declarations that the Insured has signed in evidence of the acceptance of the insurance agreement. The Company therefore issues this Policy.

If the coverage has been provided based on the Insured knowingly misrepresenting the facts in the declarations under the first paragraph, or knew of any facts but failed to disclose them to the Company, whereby if the Company had known those facts, it might have been convinced to charge a higher premium or refuse to enter into the insurance agreement, this insurance agreement will become void in accordance with section 865 of the Civil and Commercial Code and the Company will be entitled to nullify this agreement.

The Company shall not disclaim liability based on any statements except those declared by the Insured in the document under the first paragraph.

2. Incontestability

The Company shall not dispute or object to the incompleteness of this Insurance Policy when this Insurance Policy has been effective while the Insured is alive for two years (2 years) and above from the first effective date hereof or when the Insured has made this Insurance Policy with the Company for at least two (2) consecutive years or the date of the Company's approval of additional benefits under this Insurance Agreement, or date of reinstatement whichever happens later. However, upon the approval of additional benefits, the Company may dispute or object to the incompleteness of this Insurance Policy regarding such additional benefits only.

If the Company is aware of any reason to terminate the Insurance Policy under the first paragraph but does not exercise its rights to terminate it within a period of one month (1 month) from the date of such awareness, then the Company will no longer be able to terminate the Insurance Policy in such cases.

The Company shall rely on other facts apart from those declared in the application for insurance as the reason to dispute or object to the incompleteness of this Insurance Policy under the first and the second paragraph.

In the event, that the Insured is injured due to an Accident, the Company shall not dispute or object to the completeness of this Insurance Agreement but will pay the benefits under this Insurance Policy up to the sum insured of the selected plan. When the Company approves the benefit payment for such Accident, this Insurance Policy shall expire after the date of claim for compensation. The Company shall refund the premium to the Insured by proportionately deducting the premium for the period of coverage.

3. Amendment to the Policy

Any amendment to this Policy will be valid only if it is agreed to by the Company, and will become effective only after the Company, through its authorized person, records it on the Policy or issues an endorsement.

4. Premium payment and commencement of coverage

4.1 Annual premium payment

4.1.1 In the first year of this Policy, the Insured must pay the annual premium before or on the inception date. The coverage will commence from the inception date as stated in the Policy Schedule and/or Renewal Certificate in the case of renewal.

4.1.2 In subsequent renewal years, the premium must be paid within 31 days from the expiry date stated in the Policy Schedule and as agreed upon by the Company, the Company will continue the coverage and the Company will not re-apply the conditions of Waiting Period and Pre-existing Conditions to the Policy.

4.1.3 If the Insured does not pay the premium within the specified period, it shall be deemed that the Insured does not wish to renew the Insurance Policy and the coverage hereunder shall expire as indicated in the Insurance Policy Schedule.

4.2 Premium payment by installment as specified in the Policy Schedule

4.2.1 In the first month, the insured must pay the premium immediately before or on the inception date. The coverage will commence from the inception date as stated in the Policy Schedule and/or renewal certificate.

4.2.2 In subsequent renewal years, the premium must be paid within 31 days from the due date. If the premium is paid, the coverage on this policy is deemed to have been continuously in force from the previous insurance period and the Company will not re-apply the conditions of Incontestability or objection of the completeness of the insurance contract, Waiting Period and Pre-existing Conditions to the Policy.

4.3 Premium payment by monthly as specified in the Policy Schedule

4.3.1 In the first month, the insured must pay the premium immediately before or on the inception date. The coverage will commence from the inception date as stated in the Policy Schedule and/or renewal certificate.

4.3.2 In subsequent renewal years, the premium must be paid within 31 days from the due date. If the premium is paid, the coverage on this policy is deemed to have been continuously in force from the previous insurance period and the Company will not re-apply the conditions of Incontestability or objection of the completeness of the insurance contract, Waiting Period and Pre-existing Conditions to the Policy.

If the Company is unable to collect the insurance premium after this time, the Policy will be terminated on the last date the premium that has been paid can purchase the coverage.

4.4 In the event that there are claims to be paid during the 31 days from the payment due date and the Company is still unable to collect the premium, the Company will deduct the outstanding premium from the payable claim amount under this insurance policy and reimburse the remaining balance to the Insured or the beneficiary (in case of loss of life).

5. Misstatement of sex or age

If any Covered Person's sex or age is misstated, thereby causing the Company to receive a premium less than the prescribed rate, the amounts of benefits payable under this Policy will be adjusted to the amounts of protection that the premium received would have purchased at the Covered Person's actual sex or age. If the Covered Person is not eligible for the coverage under this Policy based on his or her actual sex or age, the Company will not pay any benefits but will return the premium paid hereunder in full.

If the Company finds that there was a claim record under the prevailing Policy, the Company will return the premium based on the remaining period from the date the Company is aware of that cause.

6. Renewal of the Policy

This policy shall have continuous renewal until the Policy year when the Insured is 99 years of age. However, if the Company agrees to renew policy, the Company shall retain the right to

1) adjust the premium rate to suit a risk and grow older of the insured
2) change the terms and conditions of the insurance policy as necessary
3) the company reserve the right to refuse a renewal of health insurance contract for following cases

6.3.1 In case there's evidence that the Insured Person doesn't make a true statement as revealed in Proposal Form of Insurance, Renewal Form, Health Condition Declaration Form, that will be essential cause for the company to charge higher insurance premium, and to refuse to make a contract or conditional insurance.

6.3.2 The Insured Person requests for benefit from injury treatment or sickness that causes no medication.

The Company may refuse renewal of this Policy upon the above reason by giving prior written notice at least 30 days before the date this Policy comes to an end, provided that the Company gives the reason for its refusal.

However, this Renewal of the Policy under clause 6 will not apply with the Insuring Agreement for Health Insurance (Inpatient).

7. Premium adjustment

The Company may adjust the premium for a Policy Year, to reflect the age ranges and claim records of the respective Covered Persons, according to the rates approved by the registrar. The Company will give prior written notice thereof to the Covered Persons

8. Changes of benefits and coverage

If the benefits provided to the Insured under the terms and condition of this Insurance Policy are increased after the effective or renewal date of this Insurance Policy, this change in the Insurance Policy shall be effective as of the first date of the month after the Company has been notified of the Insured's amendment provided that:

8.1 If the Insured has Injury or Illness prior to the time of adjustment of the benefits, the maximum benefit limit to be received for treatment of the Injury or Illness which has occurred prior to the adjustment of benefits shall not exceed the original maximum benefit limit provided prior to such adjustment.

8.2 If the Insured who is covered for any pre-existing Injury or Illness under the original benefits before the adjustment of benefits, the maximum benefit limit shall not exceed the original maximum benefit limit provided prior to such adjustment.

In this case, the Insured shall notify the Company of the amendment of benefits in writing and the Company shall accept the change in the insurance benefits.

9. Termination of coverage

The coverage of the Insured under this Insurance Policy shall expire upon the occurrence of any of the following events, whichever happens first:

1. When the Insured fails to pay the insurance premium within the period specified in Clause 4 Payment of Insurance Premium and Commencement of Coverage.

2. On the date of expiration of the Period of Insurance indicated in the Insurance Policy Schedule in the Policy Year when the Insured is 99 years of age.

3. When the Insured is dead or confined to a prison or penitentiary, the Company shall refund the insurance premium to the beneficiary after proportionate deduction of the insurance premium for the period of prior enforcement of this Insurance Policy unless the Company has fully paid all benefits at the Maximum Benefits per Policy Year as indicated in the Benefit Schedule.

4. When the Insured or the Company terminates the Insurance Policy under Clause 15 Termination of the Insurance Policy

5. When the Company refuses to renew the Insurance Policy under Clause 6 Renewal of the Policy on the date of completion of the Policy Year whereby the Company shall notify the Insured in writing by registered mail or electronic means in accordance with the law on electronic transactions at least 30 days prior to the date of expiration of this Insurance Policy indicated in the Insurance Policy Schedule or the endorsement (if any).

6. The insurance coverage of each section under this Insurance Policy will end when the Company has paid the maximum benefit amount specified in the Policy Schedule of that section. The Company will continue to provide cover until the policy has expired only where benefits remain.

7. At midnight, Thailand time, on the expiration date of the coverage as specified in the schedule.

Expiration of this Insurance Policy shall not prejudice any right to claim which has existed prior to the expiration of this Insurance Policy. The Company's receipt of the insurance premium payment after the expiration hereof shall not cause any liability to the Company but the Company shall refund the insurance premium to the Insured.

10. Reinstatement

Upon the Policy expiration due to the Insured's failure to pay the insurance premium within the specified period under Clause 4, the Insured may request reinstatement of this Insurance Policy within 90 days from the due date of the insurance premium payment subject to the Company's approval. When the Company allows the reinstatement upon the Insured's request, this Insurance Policy shall begin covering the Injury or Illness which occurs from the date of the Company's approval of the reinstatement provided that the Company shall not recount the Pre-existing Condition and the Waiting Period.

In the event that the Company approves the reinstatement, the Insured shall pay the insurance premium of this Insurance Policy from date of lapsation (one full year) so that there is no break in coverage.

11. Medical Assessments

The Company has the right to conduct medical examinations or investigation of the medical records of all Covered Persons as necessary for this Insurance Policy. The Company has the right to request a postmortem examination on any deceased if it is necessary and not in conflict with the law. The Company will bear this cost.

In case that the Covered Person declines the Company for medical investigations for claim adjudication, the Company can deny to pay the coverage to the Covered Person.

12. Notification of Claim

The Insured Person or their representative must notify the Company as soon as possible of the Injury or Illness that might be the cause of a claim subject to the benefit coverage under this Insurance Policy.

In case the Covered Person dies, the notification of death must be informed to the Company immediately unless there is evidence or proof that the cause of the delay as mentioned above was beyond their control.

13. Submission of the Proofs of Claim

To claim for the benefits under this Policy, the Covered Person or his or her representative, as the case may be, must submit the evidence to the Company at his or her own expense within 30 days from the date of discharge from a Hospital or Health Facility, or the date of treatment at a clinic.

Failure to submit the above proofs shall not deprive of the right to claim if it can be proven that there is an acceptable reason for failing to submit the proofs within the specified period despite an attempt to do so.

14. Payment of benefits and/or claims

The Company will pay the benefits and/or claims which are Customary and Reasonable Medical Charges within 15 days from the date on which correct and complete evidence of damage is received by the Company. If the Covered Person dies, the Company will pay them to his or her beneficiaries.

If there are reasonable grounds for suspecting that a claim for benefits under the Policy is not made in accordance with the insuring agreements hereunder, the Company may extend the payment period as necessary, but to no more than 90 days from the date of its receipt of complete evidence of damage.

In the event that the Insured receives treatment outside Thailand in accordance with the coverage agreement hereof, the Company shall pay the sum insured based on the exchange rate on the date indicated in the medical expenses receipt.

If the Company is unable to completely pay the benefits within the stipulated time, the Company is liable to pay interest at 15 percent per annum on an amount payable by it, as from the due date of payment thereof.

15. Cancellation of the Insurance Policy

15.1 **Annual premium payment**

15.1.1 The Company will inform the Insured of the cancellation of the Insurance Policy by giving advance notice in writing not less than 30 days by registered mail to the Covered Person based on the last address that the Company is given. If there is clear evidence that the Insured has committed Insurance Fraud to make him/herself or other to obtain the sum insured hereunder. The Company shall not be liable for any indemnity claim arising out of the above action.

The Company will refund the insurance premium to the Insured after the premium was deducted for the period that the insurance policy has been in force.

However, in the case that the Insured terminates the Insurance Policy under 15.1.2 and the Company has completely paid the Maximum Benefits per Policy Year (If any) as indicated in the Benefit Schedule, the Company shall not refund the insurance premium.

15.1.2 The Insured has the right to cancel this Insurance Policy by informing the Company in writing. The Company will refund the insurance premium to the Insured after the premium was deducted for the period that the insurance policy has been in force in accordance with the short-rate premium specified in the table below :

Table of short rate premium

Coverage period (not exceeding/month(s)	% of the full-year premium
1	15

2	25
3	35
4	45
5	55
6	65
7	75
8	80
9	85
10	90
11	95
12	100

15.2 Premium payment by installment or monthly premium as specified in the Policy Schedule

15.2.1 The Company may terminate this Insurance Policy by sending the Insured a written notice at least 30 days in advance by registered mail or other methods that the Insured has accepted if there is clear evidence that the Insured has committed Insurance Fraud to make him/herself or other to obtain the sum insured hereunder. The Company shall not be liable for any indemnity claim arising out of the above action.

In this case, the Company shall refund the insurance premium to the Insured after proportionate deduction of the insurance premium for the period in which the Insurance Policy has partially been in effect. This Insurance Policy will automatically be terminated if the installment or monthly premium is not received on the date that the paid premium is due and received and the coverage was provided according to the monthly installment premium payment type which is chosen by the Insured. The Company will not refund the premium received to the Insured.

However, in the case that the Insured terminates the Insurance Policy under 15.2.2 and the Company has completely paid the Maximum Benefits per Policy Year (If any) as indicated in the Benefit Schedule, the Company shall not refund the insurance premium.

15.2.2 The Insured has the right to cancel this Insurance Policy by informing the Company in writing. The Insurance Policy will automatically be terminated on the last date that the paid premium was received and the coverage was provided. The Company will not return the premium to the Insured.

16. Dispute settlement by arbitration

If there is any dispute, conflict, or claim under this Policy, between a person who is entitled to exercise a claim hereunder and the Company, and if that person wishes and deems it appropriate to settle the dispute by arbitration, the Company agrees to have the dispute settled by arbitrators in accordance with the rules of arbitration of the Office of the Insurance Commission (the "OIC").

17. Precedent Condition

The Company shall not be liable to compensate under this Insurance Policy unless the Insured, the beneficiary or the representative has complied with all the General Terms and Conditions of the insurance agreement.

18. Free Look Period

If the Insured wishes to terminate this Insurance Policy for whatever reason, the Insured can return the Insurance Policy to the Company within 15 days from the date of receipt of the Insurance Policy and the Company shall refund the insurance premium after deduction of the Company's expenses amounting to

500 Baht per policy within 15 days from the date of the Company's being notified of the intention to terminate the Insurance Policy. In the event that the Insured has exercised the right to claim indemnity, the Insured shall not be entitled to terminate the Insurance Policy under this free-look period, but it shall not prejudice the Insured's right to terminate the Insurance Policy under Clause 15 Termination of the Policy.

Section 3: General Exclusions

This insurance does not cover any expenses arising from Medical Treatment, or damage arising from an Injury or Illness (including any complication), symptom, or irregularity, caused by:

1. Any Injury occurring while the Covered Person is committing a felony or being arrested, under arrest or escaping the arrest.

2. Any Injury or Illness arising from the Covered Person playing or participating in or competing in sports or all kinds of dangerous activities, professional sports, racing of all types, riding horses, skiing including jet skiing, skateboarding, skating, boxing, and sports requiring body contact, weight lifting, parachuting (except for parachuting to save a life) ballooning or skydiving, gliders, bungee jumping, diving that requires an air tank or underwater breathing apparatus and driving a car or motorcycle without a valid driver's license.

3. War, invasion, acts of foreign enemies or any act like war (whether declared or not), civil war, insurrection, uprising, civil commotion, riot and strike, revolutionary coup, martial law declaration or any event which will cause the announcement or maintaining of martial law.

4. Terrorism

5. Radiation or radioactivity from any nuclear fuel or nuclear refuse arising from the combustion of nuclear fuel or any process of self-sustaining nuclear fission or fusion including. Radioactive explosion, or any nuclear component or harmful substance that may cause an explosion in a nuclear process.

6. Any Injury occurring whilst

1)) the Covered Person is under the influence of narcotic drugs or intoxicating substances resulting in the Covered Person losing of control his / her mind or senses

2) the Covered Person is under the influence of alcohol resulting in the Covered Person losing of control his / her mind or senses. The term "under the influence of alcohol" refers to blood alcohol level of 150 mg per ML of blood or over when undertaking a blood test.

3) the Covered Person is under the influence of alcohol resulting in the Covered Person losing of control his / her mind or senses and in the event that the alcohol level cannot be measured.

Section 4: Insuring Agreement

Under the regulation, general conditions, general exclusions, insuring agreements and endorsements to this Policy, and in consideration of the premium paid by the Insured, the Company agrees to indemnify the Insured as specified in the Policy Schedule, Benefit Schedule and/or renewal certificate.

Section of Personal Health Insurance
Additional Definitions

1. Per Confinement	means	Hospitalization as an Inpatient or treatment by day surgery at the Hospital (or "Health Facility") each time and shall include hospitalization as an Inpatient or day surgery at the Hospital or Health Facility any times due to the same Injury or Illness which is not fully recovered including related or consequential complications within 90 days from the date of the latest discharge from the Hospital or Health Facility which shall be deemed as the same hospitalization.
2. Maximum Benefits per Policy Year	means	The Maximum Benefits per Policy Year can be divided into 2 cases: (1) In case of Inpatient, the medical fee shall be calculated from the first date of hospitalization which occurs in that Policy Year regardless of whether the hospitalization completes in the same Policy Year or not; (2) In case of Outpatient, the medical fee shall be calculated according to the visit/per day or a lump sum limit which occurs in that Policy Year.
3. Major Surgery	means	An operation through body wall or hole in which general anesthesia or regional anesthesia is required.
4. Minor Surgery	means	An operation at a skin level or under skin level or epithelial level in which local/topical anesthesia is used.
5. Day Surgery	means	a Major Surgery or procedure in lieu of Major Surgery or use of special treatment tool which can replace Major Surgery without the need of hospitalization as an Inpatient at the Hospital (or "Health Facility").
6. Co-Payment	means	Liabilities between the Insurance Company and the Insured who shall co-pay the medical fee payable according to the sum insured after Deductible (if any).
7. Simple diseases	means	The simple diseases are categorized according to the ICD-10 system into 5 groups as follows: (1) Upper Respiratory Tract Infection (2) Influenza (3) Acute Diarrhea (4) Vertigo and (5) other diseases that do not show symptoms or complications or diseases developed into severe illnesses or transformed into any other diseases as announced by the company. The Company will attach the list of mentioned above in the insurance policy for the insured. If the list is changed, the company will revise and update to the insured.
8. Renewal Premium	means	Renewal or reinstatement as OIC has been approved. The co-payment and discount premiums in the renewal conditions will not apply to the renewal premium calculation.

Additional General Conditions (apply with Section of Personal Health Insurance)

1. Pre-Existing Conditions

The Company will not pay benefits under this Policy for any Pre-existing condition or Chronic Conditions, including any complications that are not yet fully cured before the date this Policy first comes into effect, unless:

1. the Covered Person has declared that condition to the Company, and the Company agrees in writing to accept
that condition when the Company accepts the insurance application without excluding the condition.

2. this Policy has been in effect for a continuous period of at least three (3) years, and the Chronic Conditions, Injury, or Illness (including any complication) has not appeared, or has not been treated, or diagnosed by a Physician, or no consultation or advice has been sought from a Physician during five (5) years before the date this Policy first comes into effect, which would have been sufficiently crucial for an ordinary person to seek diagnosis, care, or Medical Treatment by a Physician, or for a Physician to provide diagnosis, care, or Medical Treatment.

2. Waiting Period

1) The Company will not pay any benefit for any Illness occurring during the 30 days from the first day of the commencement date of the Insurance Policy. The benefit for any Injury is starting on the first effective date state on the Policy Schedule of the Insurance Policy.

2) The Company will not pay any benefit for the following Illnesses which occurred in the period of 120 days from the first effective date of the Insurance Policy;

2.1 Tumors, cysts or all types of cancer
2.2 Hemorrhoids
2.3 All types of Hernia
2.4 Pterygium or Cataracts
2.5 Tonsillectomy or adenoidectomy
2.6 All types of Calculus
2.7 Varicose Veins
2.8 Endometriosis

However, in the case that the Company approves additional benefits under Clause 8, the Company shall not cover the above illnesses for the additional benefits only.

The above non-coverage conditions shall not apply in the case that the Insured gets injured or is in need of Emergency operation which is not a consequence of any disease existing prior to the insurance.

<u>Additional exclusions</u> (apply with Section of Personal Health Insurance)

This insurance does not cover any expenses arising from Medical Treatment, or damage arising from an Injury or Illness (including any complication), symptom, or irregularity, caused by:

1. Chronic disease, injury or illness that has not been cured before the date of the insurance contract (including complications that may occur later) or can be clinically proven or certified that such disease or disorders has occurred before the Insurance contract date, Birth Defect or Congenital Anomalies and Abnormalities, chronic disease, injury or illness which occurred prior to the effective date of the policy (including complications or recurrence that may occur later), abnormal growth, developmental problems, genetic disorders, hernias in a child age under 16 years old, circumcision, surgical treatment for Scoliosis, surgical treatment for Deviate Nasal Septum.

2. Cosmetic related treatment, surgery for reconstruction, skin treatment, acne, blemish, freckles, dandruff, scaring, hair loss, underweight or overweight, surgery to fix or adjust body defects, elective surgery, cosmetic surgery, unless the surgery on the organ is to fix and return it to normal function(s) which were damaged by the accident that was covered by this Insurance Policy. Such surgery must not be performed on genitals or breast.

3. Normal pregnancy, prenatal postnatal complications, childbirth delivery or termination of pregnancy or any consequence of it, except as specified otherwise in the Covered Person's plan in this Policy.

4. Acquired Immune Deficiency Syndrome caused by the Human Immuno-deficiency Virus (HIV) infection including opportunistic pathogenic infection, Malignant Neoplasm or infection or any illness that reveals an HIV (Human Immunodeficiency Virus) positive blood test. Opportunistic pathogenic infection is also including but not limited to Pneumocystis Carinii Pneumonia, Organism or Chronic Enteritis, Disseminated Viral/Fungi Infection, Malignant Neoplasm including but not limited to Kaposi's Sarcoma, Central Nervous System Lymphoma and/or any severe diseases known that are caused by AIDS or sudden death, illness or disability. AIDS includes HIV, Encephalopathy (Dementia) , viral epidemics, Venereal disease and sexually transmitted diseases.

5. Treatment or usage of drugs or substances for anti-ageing or giving of replacement hormone during climacteric or menopause, or for any bodily change arising from any physiological or natural cause, corporal imbecility in a female or male, treatment of sexual disorder, gender confirmation or transgender surgery.

6. General Health Check-up, request to be admitted at a Hospital or Medical Center, request for a surgical treatment, rehabilitation or rest for recuperation or treatment by only resting methods, any investigations that are not relating directly to an admission to a Hospital, Medical Center or Clinic, investigations for any injury or illness, treatments or laboratory tests which are considered as non-medical necessity or non-medical standard.

7. Investigation and treatment for abnormal eyesight, corrective eye muscle surgery, LASIK, expenses for vision devices, treatment, investigation or surgery for all types of strabismus.

8. Dental treatments, surgery or prevention of periodontal disease (gum disease), dental or Jaw disease, bruxism, prosthetic dentistry, dentures, crowns, root canal therapy, filling, orthodontic treatment, scaling, tooth extraction, root implants with the exception of accidental injury to teeth whilst the insurance policy is in force but also excluding dentures, crowning, orthodontics, dental bridge, root canal treatment or root implants.

9. Treatments for alcoholism and complications, treatment of narcotic drug addiction, cigarettes, alcohol or psychoactive substances.

10. Diagnostic, investigations or treatments symptoms or disease relating to mental illnesses, psychiatric, stress, anxiety, psychotic state, abnormal behavior or characteristics, attention deficit disorder, autism, stress, including eating disorders or anxiety.

11. Any experimental treatment, examination or treatment for Obstructive Sleep Apnea, sleeping disorders or snoring.

12. Any inoculations and vaccinations excluding rabies vaccination after animal bite and tetanus vaccination after injury.

13. Any treatment that is not considered as modern medical treatment including alternative medical treatments.

14. Any medical treatment given by a medical practitioner who is the parent, spouse, child or family member of the Covered Person. The Covered Person who is a registered medical practitioner may not be reimbursed for any self-administered treatment.

15. Suicide, suicide attempt, self-inflicted or self-inflicted attempt either by the Covered Person or any other person allowed to do so whether they are insane or not, this also include accidents arising from whatever the Covered Person eats, drinks, consumes, intakes or injects any drug or toxic substance into the body or drug overdoses taken.

Insuring Agreement - Insuring Agreement -Hospitalization and Surgery
Insuring Agreement:

If this insurance Policy is terminated for any reason, the Insured or the Covered Person must return the membership card issued by the Company within 30 days from the termination date. If it is found that after the termination of this Insurance Policy, the membership card is used for any medical treatment and expenses are incurred, the Insured or the Covered Person shall be responsible for those expenses.

Benefit Schedule

Benefit	**Sum Insured (Baht)**	**Maximum (Days or Times)**	**Maximum Sum Insured (Baht)**
1. Inpatient Benefits			
Article 1: Room charge, meal fee and hospital service fee (Inpatient) for each policy year In the case that the Insured is treated in the Intensive Care Unit Inpatient Room, room charge, meal fee and hospital service fee shall be paid based on the actual cost incurred up to the Maximum Benefits per Policy Year as stated.			
Article 2 : Medical fee for examination or treatment, blood and blood component service fee, nurse service fee, medicine fee, parenteral nutrition fee, and medical supplies fee for each policy year			
Sub-article 2.1 Medical fee for examination			
Sub-article 2.2 Medical fee for treatment, blood and blood component service fee, and nurse service fee			
Sub-article 2.3 Medicine fee, parenteral nutrition fee and medical supplies fee			
Sub-article 2.4 Medicine fee and disposable supplies fee (Medical Supplies 1) for take away			
Article 3: Physician's examination fee (Physician) for each policy year			
Article 4: Operation (surgery) and procedure fee for each policy year			
Sub-article 4.1 Operating room fee and procedure room fee			
Sub-article 4.2 Medicine fee, parenteral nutrition fee, medical supplies fee, and surgery and procedure fee			
Sub-article 4.3 Physician's fee for Physicians performing surgery and procedure (including assistant) (Physician fee)			
Sub-article 4.4 Physician's fee for anesthetist (Physician fee)			
Sub-article 4.5 Medical fee for organ transplantation			
Article 5: Day surgery			

Benefit	Sum Insured (Baht)	Maximum (Days or Times)	Maximum Sum Insured (Baht)
2. Non-Inpatient Benefits			
Article 6: Medical fee for related direct examination before and after hospitalization as an Inpatient or Outpatient treatment fee which is in consequence of or in connection with hospitalization as an Inpatient for each policy year			
Sub-article 6.1 Medical fee for related direct examination which occurs within 90 days before and after hospitalization as an Inpatient			
Sub-article 6.2 Outpatient Treatment fee after hospitalization as an Inpatient for each consequential treatment within 90 days after such discharge from the hospital (excluding medical fee for examination)			
Article 7: Medical fee for Treatment of injury in Outpatient case within 24 hours after each accident			
Article 8: Rehabilitation medicine fee after each hospitalization as an Inpatient per policy year			
Article 9: Medical fee for Treatment of chronic kidney failure by hemodialysis through vascular access for each policy period			
Article 10: Medical fee for Treatment of tumor or cancer by radiotherapy, interventional radiology, and nuclear medicine for each policy period			
Article 11: Medical fee for Treatment of cancer by chemotherapy for each policy period			
Article 12: Ambulance fee			
Article 13: Medical fee for Minor Surgery			
Deductible / Co-Payment			
Deductible			
Co-Payment			

Maximum Benefits per Policy Year as specified in the Policy documents

1. Inpatient Benefits

In the case that the Insured needs to get admitted as an Inpatient, the Company shall pay the medical fee as follows:

Article 1: Room charge, meal fee and hospital service fee (inpatient) for one hospitalization as an inpatient

- The Company shall pay the room charge, meal fee and Hospital service fee for Inpatient
- In the case that the Insured is treated in the Intensive Care Unit Inpatient Room, the room charge , meal fee and Hospital service fee shall be paid in the amount of actual cost with the maximum as specified in the Policy Schedule

Article 2: Medical fee for examination or treatment, blood and blood component service fee, nurse service fee, medicine fee, parenteral nutrition fee, and medical supplies fee

The Company shall pay the medical fee for examination or treatment, blood and blood component service fee, nurse service fee, medicine fee, parenteral nutrition fee, and medical supplies fee for each hospitalization as an Inpatient as follows:

Sub-article 2.1 Medical fee for examination

The Company shall pay the laboratory fee, pathological examination fee, radiotherapy fee, interventional radiotherapy fee, and nuclear medicine fee, electrocardiogram fee, interpretation fee for the above results (if any), and other medical examination fees.

Sub-article 2.2 Medical fee for treatment, blood and blood component service fee, and nurse service fee

The Company shall pay the medical fee in the case that the Insured is treated by interventional radiotherapy, radiotherapy, nuclear medicine (including brachytherapy), physical therapy and occupational therapy, blood service, medical equipment, Orthosis and Prosthesis service (excluding equipment fee), lump-sum treatment fee and nursing fee, excluding special nursing care service.

Sub-article 2.3 Medicine fee, parenteral nutrition fee and medical supplies fee

The Company shall pay medicine fee, parenteral nutrition fee and medical supplies fee, excluding the following medical supplies and equipment:

(a) Automated External Defibrillator (AED), Defibrillator or Pacemaker outside the body

(b) Prosthesis outside the body, Orthosis and Prosthesis equipment, Prosthetic device

(c) Durable medical equipment used outside the body (Medical Supplies 2) e.g. medical tools and hearing aids, glasses, contact lenses, glass lenses, ventilator, oxygen device, vital sign measuring machine (vital signs, blood pressure, temperature), crutches, wheelchair

(d) Prosthesis e.g. prosthetic arm, prosthetic leg, prosthetic eye

Sub-article 2.4 Medicine fee and disposable supplies fee (Medical Supplies 1) for take away

The Company shall pay medicine fee and disposable supplies fee (Medical Supplies 1) for take away for use after discharge from the hospital as an Inpatient.

Article 3: Physician's examination fee

The Company shall pay the Physician's examination fee, for examination of the Insured or the Covered Person during hospitalization as an Inpatient of the Hospital or Health Facility.

Article 4: Medical Operation (surgery) and procedure in the operating room

The Company shall pay the medical fee arising out of operation (surgery) and procedure during hospitalization as an Inpatient of the Hospital or Health Facility.

Sub-article 4.1 Operating room fee and procedure room fee

The Company shall pay operating room fee and procedure room fee as well as the medical equipment service see in the operating room and procedure room.

Sub-article 4.2 Medicine fee, parenteral nutrition fee, medical supplies fee, and surgery and procedure fee

The Company shall pay the medicine fee, parenteral nutrition fee, medical supplies fee, and surgery and procedure fee.

Sub-article 4.3 Physician's fee for Physicians performing surgery and procedure (including assistant) (Physician fee)

The Company shall pay the Physician's fee for Physicians performing surgery and procedure (including

assistant) on the actual basis with the maximum limit as specified in the Policy Schedule.

Sub-article 4.4 Physician's fee for anesthetist (Physician fee)

The Company shall pay the Physician's fee for anesthetist who administers anesthetics or anesthesia during surgery or procedure of the Physician as indicated in the medical fee manual of the Medical Council of Thailand which is effective at the time of operation.

Sub-article 4.5 Medical fee for organ transplantation

The Company shall pay the medical fee arising out of organ transplantation e.g. liver, pancreas, kidney, heart, lung, due to the last stage of malfunction and bone marrow transplantation by using Haematopoietic Stem Cells after Bone Marrow Ablation on the actual cost with the maximum limit as specified in the Policy Schedule.

Article 5: Day surgery

In case of day surgery, the Company shall pay the benefits equivalent to hospitalization as an Inpatient at a Hospital or Health Facility.

2. Non-Inpatient Benefits

Article 6: Medical fee for related direct examination before and after hospitalization as an Inpatient or Outpatient Treatment fee which is in consequence of or in connection with hospitalization as an Inpatient for each hospitalization as an Inpatient

The Company shall pay the medical fee for related direct examination before and after hospitalization as an Inpatient or Outpatient treatment fee which is in consequence of or in connection with hospitalization as an Inpatient for each hospitalization as an Inpatient as follows:

Sub-article 6.1: Medical fee for related direct examination which occurs within 30 days before and 60 days after hospitalization as an Inpatient

The Company shall pay the laboratory fee, pathological examination fee, radiotherapy fee, interventional
radiotherapy fee, and nuclear medicine fee, electrocardiogram fee, interpretation fee for the above results (if any), and other medical examination fees for direct examination which occurs within 30 days before and 60 days after hospitalization as an Inpatient

Sub-article 6.2 Outpatient treatment fee after hospitalization as an Inpatient for each consequential
treatment within 30 days after such discharge from the hospital

The Company shall pay the medical fee arising out of consequential treatment at the Outpatient Department of the Hospital Health Facility within 30 days after such discharge from the hospital as an Inpatient.

However, medical fee for examination shall be excluded.

Article 7: Medical fee for Emergency Outpatient Treatment of injury within 24 hours after each accident

The Company shall pay the medical fee arising out of the Injury caused by Accident in the case that the Insured is required to receive treatment at the Outpatient Department of the Hospital or Health Facility for the Injury caused directly by Accident within 24 hours after each Accident.

Article 8: Rehabilitation medicine fee after each hospitalization as an Inpatient for each policy period

The Company shall pay rehabilitation medicine fee, physical therapy fee, and occupational therapy, rehabilitation practitioners or physical therapist fee, medical tools and supplies fee for consequential treatment at the Outpatient Department of the Hospital or Health Facility after each hospitalization as an Inpatient.

However, nursing service fee and psychological clinic fee shall be excluded.

Article 9: Medical fee for treatment of chronic kidney failure by hemodialysis through vascular access

The Company shall pay the medical fee for treatment of chronic kidney failure by hemodialysis through vascular access.

Article 10: Medical fee for treatment of tumor or cancer by radiotherapy, interventional radiology, and nuclear medicine for each policy period

The Company shall pay for medical fee for treatment of tumor or cancer by radiotherapy, interventional radiology, and nuclear medicine (including brachytherapy) and including Physicians' fee for the radiologist performing the treatment.

Article 11: Medical fee for treatment of cancer by chemotherapy for each policy period

The Company shall pay medical fee for treatment of cancer by chemotherapy including targeted therapy.

However, Physicians fee for the physician performing the treatment shall be included.

Article 12: Local Road Ambulance transportation fee

The Company shall pay the ambulance fee for transferring the Insured to the Hospital or Health Facility according to Medical Necessity in using the ambulance, including medicine, medical supplies and Physician's fee arising while being on the ambulance which shall be directly related to and conforming to the Injury or Illness which is the cause of hospitalization as an Inpatient of the Hospital or Health Facility.

Article 13: Medical fee for minor surgery

The Company shall pay the medical fee for treatment of the Injury or Illness due to minor surgery.

Additional conditions (apply with Section of Personal Health Insurance)

1. Renewal of the Policy

This Insurance Policy shall be renewed upon the completion of the Policy Year until the Policy Year when the Insured is 99 years of age without the need of evidence. However, the Company remains entitled to adjust the insurance premium as specified in Clause 7 Premium Adjustment upon an approval of the Registrar except for any of the following cases that the Company reserves the right not to renew the Insurance Policy:

1) If there is evidence indicating that the Insured has not declared factual statements in accordance with the insurance application, health declaration form, and any other additional declarations related to the issuance of the health insurance policy, which is the subject matter entitling the Company to demand higher insurance premium or reject the application or accept the application for insurance with conditions.

2) The Insured claims the benefits from his/her treatment of injury or illness without medical necessity.

3) The Insured claims the benefits for compensation of Hospital or Health facility admission from all companies in the higher amount than the actual income.

Non-renewal due to the above reasons shall be informed to the Insured in writing by registered mail or other
methods that the Insured has accepted, at least 30 days prior to the date of expiration of this Insurance Policy indicated
in the Insurance Policy Schedule or the endorsement (if any).

Upon renewal hereof, the Company reserves the right to amend the terms and conditions of coverage by
increasing the co-payment condition of the Insured as follows:

(1) not exceed 30 percent of the covered expenses and reducing the renewal premium not exceed 30 percent or

(2) not exceed 30 percent of the covered expenses and reducing the renewal premium as the Company's guidelines

for policies where claims for simple diseases is more than 3 times and the loss ratio of each Covered person is more than 200 percent or

(3) not exceed 30 percent of the covered expenses and reducing the renewal premium as the Company's guidelines

for policies where the loss ratio of each Covered person is more than 400 percent.

If the Company add co-payment due to (1), (2) or (3), the Company will specify the conditions for co-payment by not exceeding 50 percent of the covered expenses and reducing the renewal premium by no more than 50 percent of the renewal premium. If the loss ratio has decreased from above, the Company will consider reducing the co-payment

If the Company add co-payment, the Company will issue an endorsement and notified to the Insured at least 15

days in advance.

2. Premium adjustment

The Company may adjust the insurance premium upon completion of the Policy Year as a result of the following factors:

1) Age, Occupation and Sex of each person including Main Country of Residence

2) Increasing medical expenses or experience in disbursement of total indemnities of the portfolio of this Insurance Policy or experience for payments of compensation per person provided that the Insured shall be notified in writing at least 30 days in advance by registered mail or others methods that the Insured has accepted. However, the Insurance Policy to be adjusted shall remain at the rate which has been approved by the Registrar.

3. Submission of the Proofs of Claim

To claim for the benefits under this Policy, the Covered Person or his or her representative, as the case may be, must submit the following evidence to the Company at his or her own expense:

1. a form of claim for Medical Treatment or other benefits as prescribed by the Company

2. an original medical certificate or medical report that specifies the significant symptoms, the diagnosis results, and the treatments and

3. the original receipt listing expenses or summary of the balance together with the receipt

The above proofs must be submitted within 30 days from the date of discharge from a Hospital or Health Facility, or the date of treatment at a clinic. The receipt must be an original. The Company will return the original receipt, bearing the certification of the amount paid, to the Covered Person for use in a claim for a shortfall amount from another insurer. If the Covered Person is already compensated by government welfare or any other welfare, or 9 other insurance, the Covered Person may submit a copy of the receipt bearing the certification of any amount paid by the government welfare or other agency in order to claim the shortfall amount from the Company.

Failure to submit the above proofs shall not deprive of the right to claim if it can be proven that there is an acceptable reason for failing to submit the proofs within the specified period despite an attempt to do so.

4. Area of coverage

The area of coverage that specific in the Benefit Schedule.

The Company will pay for the costs of Medically Necessary services up to the maximum limit specific in the Benefit Schedule less any Deductible (if any). All Premium and claims payments under this Policy will be paid in Thai currency. The Company will pay benefits based on the exchange rate announced by the Bank of Thailand on the date specified in the receipt.

The Company will cover charges for medical Emergencies which occur outside the Covered Person's Area of Cover. The benefit coverage as provided under the specific plan in the Benefit Schedule pays up to a maximum period of forty five (45) days per trip and within the Maximum Benefits per Policy Year which includes Treatment required in the event of an Emergency Accident only.

Insuring Agreement
Outpatient Care
(apply with Section of Personal Health Insurance)

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

1. Outpatient Care

The amount paid will not be more than the actual eligible amount of charges incurred or the applicable amount specified in the Schedule, whichever is smaller.

The covered person is able to receive medical treatment as outpatient. According to the amount specified in the policy table, maximum to 30 times per policy year.

2. Medicine for Outpatient

Medicine must be prescribed by the physician as necessary and must not exceed amount specified in the policy table from the date of treatment.

EXTENDED CLAUSE - Hospice and Palliative Care
(apply with Section of Personal Health Insurance)

Definition

hospice or palliative treatment	means	A program of medical, psychological, social, and spiritual care provided to persons who have been diagnosed as suffering from a *terminal illness*. Treatment must be prescribed by a *physician* and provided by a *hospital* or institution licensed by the competent medical authorities of the country in which care is provided and which, in providing care, is practicing within the scope of its license. *Hospice* or *palliative treatment* costs may only be claimed under the *hospice* or *palliative treatment* section of the *benefits schedule*, and no other type of benefit under this policy provides coverage in connection with *hospice* or *palliative treatment*.

Insuring Agreement

While this Policy is in effect and after the expiration of a waiting period of 1 2 months, and subject to the condition that the Insured has paid a renewal premium, the Company will pay benefits for hospice and palliative care in a care center or facility where the Covered Person is admitted to, with a Physician's opinion, and the Company's written acknowledgment, that his or her Injury or Illness reaches its terminal stage. To receive benefit payment, the Covered Person must continue to renew this Policy every year, without decrease in the benefits. If the Covered Person fails to do so, the benefits will come to an end upon the expiration of the last Policy Year renewed by the Covered Person or when the amount of benefits paid by the Company reaches the maximum limit specified in the schedule.

If there is any change to the insurance plan which results in an increased premium, the benefits and coverages will not be varied until the Policy continues to be in effect for at least 12 months a er the change.

EXTENDED CLAUSE - Psychiatric Treatment (Apply with Silver & Gold Plan only)

Insuring Agreement

While this Policy is in effect and after the expiration of a waiting period of 12 months, and subject to the condition that the Insured has paid a renewal premium, if a Covered Person is a psychiatric Illness, the Company will pay Reasonable and Customary Charges for psychiatric treatment according to the actual amount, but not exceeding the maximum limit of benefits specified in the schedule.
The Covered Person must Procees pre-authorization with the Company before obtaining the coverage, and the total period of this Medical Treatment must not exceed 100 days in a Covered Person's Lifetime.

EXTENDED CLAUSE - DENTAL CARE

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

Definition

Teeth	Means	Organs in the oral cavity where is a root attached to the jaw and a tooth. Which has the function of biting, tearing, chewing food and helping to speak clearly.
Gum	Means	Part of the oral mucosa. It is the soft tissue covering the protrusion of the tooth socket (Alveolar process), extending from the gingival margin to the oral mucosa junction. It is the tissue that covers part of the tooth and parts of the jawbone acts to resist food friction during chewing and swallowing.
Limestone	Means	Plaque that hardened due to the calcium content from saliva to precipitate. Which is stuck on the teeth which cannot be spit out.
Tooth decay	Means	Symptoms of teeth with dental tissues include enamel, dentin, and root canal, destroying the minerals that are important building blocks of those tissues until causing a hole or cavity in the tooth.
Wisdom tooth	Means	Teeth that cannot come up in the oral cavity normally because they don't have enough room to emerge or develop normally or something that prevents the rise of the tooth.
Dental examination	Means	Oral and dental examination Including the surrounding organs body teeth by a dentist.
X-ray of teeth	Means	Irradiation of radiation into the oral cavity to display information about teeth, bone and supportive tissues to guide the diagnosis Treatment plan and treatment follow-up.

Fluoride coating	Means	Using fluoride to coat the teeth to prevent cavities. This coverage is for children up to 12 years old only.
Scaling	Means	Removal of tartar from teeth using a dental instrument.
Tooth filling	Means	A tooth restoration or repair method used by dentists to treat tooth decay. The dentist will remove the decayed or infected dentin and fill the teeth with filling materials
Tooth extraction	Means	Process to removes the tooth and root canal due to the severe tooth decay, the tooth cavity can not be restored, it could be a severe gum disease, a broken tooth that cannot be repaired or have problems with the position and rise of the teeth.
Wisdom tooth extraction	Means	Surgery or extraction of teeth that cannot go up normally or the last molar Which is usually in the age range of 18 - 20 years.
Root canal treatment (Not including crowns)	Means	Tooth cavity resection or a small tissue in the center of the tooth which the damaged, inflamed or dead tooth cavity is cut off the rest of the area will be cleaned, shaped and caulked.
Wearing a removable denture with a base type.	Means	Dentures made for those whose natural teeth remain. It is only part of the tooth. Which can be removed and washed

The Company agrees to pay for dental care given to the covered person by a dentist. The amount of benefit paid with respect to each disability shall not be more than the actual eligible amount of charges incurred or the maximum amount specified in the schedule, whichever is smaller.

Dental Care expenses are:

1. Scaling and cleaning
2. Dental filling or restoration
3. Examinations
4. X-Rays
5. Extraction of teeth
6. Root Treatment (not including crowns and bridges)
7. Wisdom teeth operation
8. Fluoride Coating (only for the covered person who is less than 12 years old).
9. Removable dentures

Limitation

1. The insured person can use the dental treatment rights that the company specified. In which each item is covered the covered person can receive treatment for a maximum of 2 times per year.
2. Fluoride coating will provide coverage only for the insured person who is not over 12 years old.

Specific conditions for coverage (Only applicable to the attachment of dental treatment coverage)

1. Under dental benefits, the company will pay the actual amount that has to be paid. However, all items will be paid in total, not exceeding the sum insured as specified in the insurance policy schedule.
2. At the policy renewal year, the insured will be covered without applying the waiting period under this coverage.

Supporting documents needed for claiming the dental care benefit are:

1. Original receipt

2. Dentist's Report
3. Completed Claims Form
4. Other documents as deemed necessary for claims consideration

Exclusions:

The Company does not cover:

1. Treatment or surgery not recommended by a dentist including dental care which is deemed unnecessary.
2. Artificial device or organ.
3. Dental treatment aiming for beauty or cosmetic purpose i.e. whitening, gap filling, teeth coloring.
4. Dental treatment to stop symptoms of teeth grinding or other abnormalities while sleeping.
5. Orthodontic services including for disorders of the jaw and mal occlusion.
6. Dental treatment for non-pathological conditions.

EXTENDED CLAUSE – VISION

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

The Company agrees to pay for vision care if the eye sight of the Insured change from the last record. The Company will pay 80% of customary and reasonable charges but not exceeding the maximum limit specified in the policy Schedule for eyes examination, sight examination, including eye glasses, correction lens, contact lens.

Coverage for eye examinations Eye measurement and the ability to see, including

1. Eye examination expenses And eye measurements - limit coverage up to 2 times a year and
2. Any expenses for 1 eyeglasses or contact lens not more than 12 pairs per insurance policy year. The insured can choose only one option.
3. In the event that the insured chooses to use the contact lens option, the company will cover the total cost up to 12 pairs for the contact lens that has a monthly lifetime or expenses for one pair of yearly contact lenses (the insured can choose only 1 option) at the first time the company has received a claim for the treatment of abnormalities related to eyes.

Specific conditions for vision coverage (Applicable only to the attached document to expand eye examination coverage Eye measurement and the ability to see)

Eye conditions specified at the Insured's first ophthalmologist visit after the policy date becomes effective. It is to be and is considered a condition that is preceded by the insurance. But for the purpose of this attachment, the company will pay for the eye examination.

The Company agrees to pay benefits for any expenses necessary and reasonable in the eye examination or eye examination at the first sighting of an ophthalmologist. The covered person must submit a complete ophthalmologist report along with the claim of compensation in accordance with this vision examination benefit.

The covered person must submit full eyes sight report from ophthalmologist with a claim form.

Documents required are:

1. Original Receipt
2. Medical Certificate from ophthalmologist
3. Claim Form
4. Other document

EXTENDED CLAUSE – ALTERNATIVE TREATMENT FOR OUTPATIENT

(Silver & Gold Plan only)

It is agreed that within the period this insurance policy becomes effective. This insurance policy extends the coverage for alternative treatment if treatment as outpatient.

However, the company agrees to pay for alternative treatment if the treatment and doctor fees based on the actual amount payable but not more than the maximum amount specified in the policy schedule. And Treatment must certified and recommended by a LMG network hospital only.

Coverage for alternative treatment for outpatient as follows:-

1. Expenses for treatment with Thai traditional medicine.
2. Expenses for treatment with traditional Thai medicine.
3. Expenses for traditional Chinese medicine therapy, acupuncture
4. Expenses for chiropractic treatment

The Company agree to pay actual cost for physician fee but not exceeding the maximum amount specified in the policy Schedule. Furthermore, this treatment must be certified and recommended by a LMG network hospital only.

In case of claim procedure related to alternative treatment for outpatient, the Covered Person or their representative must submit the following evidence to the Company at their own expense;

1. Original receipt with itemized charges or statement and receipt.
2. Physician Report that states signs and symptoms, diagnosis and treatment.
3. Notification of Claim Form as specified by the Company.
4. Any other support document the Company requests.

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

If anything specified in this clause is contrary to the policy, this clause shall prevail.

All other term and conditions of this Policy remain unaltered.

EXTENDED CLAUSE – SPECIAL NURSING CARE

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

The Company agrees to pay for the special nursing care given to the covered person, which is deemed necessary and recommended by the attending physician during the stay in the hospital as an in-patient, or staying at home directly after being discharged from the hospital. The amount of benefit paid with respect to each disability shall not be more than the actual amount of eligible charges incurred or the maximum amount specified in the Schedule, whichever is smaller.

If any words in this extended clause conflict with the Policy, this extended clause will hold precedence over the words stated in the Policy.

EXTENDED CLAUSE - MATERNITY (Apply with Silver & Gold Plan only)

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

The Company agrees to pay benefits for hospital and physician's expenses in connection with each pregnancy and childbirth provided that the person covered has been continuously insured for at least of 280 days in the case of childbirth and 90 days in the case of miscarriage.

1. **ROOM AND BOARD**
   The Company will pay the cost of room and board, including nursing care not more than the amount paid by the covered person up to a maximum limit per day or the amount stated in the Schedule, whichever is smaller.
2. **HOSPITAL GENERAL EXPENSES**
   2.1 Use of the operating room or delivery room, laboratory tests, diagnostic tests, medicine, and blood administration
   2.2 Physician's fee, anaesthesia and its administration
   1) Obstretrician's fee
   2) Ante natal care and post natal follow up consultations
   3) Ambulance not exceeding the benefit amount as stated in the Schedule
3. **Surgical fee**
   Surgeon's fee in the event of caesarian or miscarriage

Maximum Benefit for Each Pregnancy

The Company will pay the actual expenses incurred but shall not exceed the maximum limit shown in the policy Schedule per pregnancy:

1. Actual cost but not more than 100% of the maximum shown in the schedule in the case of normal delivery, planned caesarian and forceps delivery
2. Actual cost but not more than 50% of the maximum shown in the schedule in case of miscarriage
3. Actual cost but not more than 200% of the maximum shown in the schedule in the case of emergency caesarian section and ectopic pregnancy

Limitation:

1. The Company will not pay the covered person for any expenses for any complications of pregnancy arising during the first 280 days from the policy commencement date.
2. Services and treatment not related to child delivery are excluded unless such services and treatment are necessary to save the life of the mother or new born child.

EXTENDED CLAUSE – FREE NEW-BORN CHILD of Insured and spouse (For Gold Plan only)

Hereby agreed that if Insured and spouse have same insurance policy with company, the new born child of an Insured Person is eligible for free medical benefits under the same plan as the Insured Person, If the parents are insured for different levels of benefits, then the level of benefits for the child shall be the lower of such levels of benefit.

Coverage for the child shall be subject to medical underwriting and will continue on renewal of the Policy provided the additional premium required by the Company at that time is duly paid, and a statement of health is provided to the Company in respect of such child.

Additional condition:

1. **How to apply and policy effective date**
   If the insured wish the child to be cover. Insured must fill in application form with enclosed birth certificate. Policy will effective after 15 days after the date of birth
2. **Continuous cover**
   After policy expired if insured wish to extend the child cover. Insured must inform company and pay premium company will continue cover and not apply waiting period.

Exclusion:

This insurance will not cover

1. Vaccination and well care costs,
2. Any outpatient visits and costs

If anything specified in this clause is contrary to the policy, this clause shall prevail.
All other term and conditions of this Policy remain unaltered.

EXTENDED CLAUSE – Health check-up and vaccinations (Apply with Silver & Gold Plan only)

Insuring Agreement

While this Policy is in effect, when the Covered Person has been insured for at least 12 consecutive months and has renewed the Policy under the former plan, the Company will pay a health check-up and vaccination benefit according to the actual amount, but not exceeding the maximum limit of benefits specified in the schedule and no more than once a year.

If anything specified in this clause is contrary to the policy, this clause shall prevail.

All other term and conditions of this Policy remain unaltered.

EXTENDED CLAUSE – FUNERAL EXPENSE (Apply with Silver & Gold Plan only)

Definition

Funeral expenses or expenses in the funeral arrangement	Means	Costs associated with funeral arrangements. This includes the cost of a coffin, cremation or burial, and other expenses where necessary for that purpose, which the company pays to the beneficiary in the event that the insured or the insured death from injury or illness.

Coverage

It is agreed that within the effective period specified in this attachment. Insurance policy as mentioned above has extended the cover for funeral expenses or funeral management expenses. In the event that the insured dies from injury from an accident or sickness that occurs during this attachment to come into force.

The company agrees to pay funeral expenses or funeral expenses to the beneficiary according to the sum insured as specified in this attachment. But not more than the amount stated on the benefit table page. This is considered a reasonable real cost for the management of the corpse. According to the current situation.

General terms and conditions

1. This funeral benefit has a waiting period of 180 days from the first effective date. If the insured dies from illness within 180 days from the effective date the insured will not be entitled to receive funeral money or funeral expenses according to this attachment. But the company will return the premiums in all attachments without deducting expenses to the beneficiary.
2. The insured who renew this insurance policy within 30 days from the end of the coverage will be covered for compensation for ongoing funeral management expenses. But if the insured renews this policy after 30 days from the end of coverage will have to start counting the waiting period again for coverage of funeral expenses in the event of sick death.

Death Claim, dismemberment, disability from accident

The covered person, beneficiary (for death claim), or representative must submit the following evidence to the Company at their own expense within 30 days of the death or physician diagnosed for total disability or loss of organ;

1. Notification of Claim Form as specified by the Company, and
2. Death Certificate, and
3. Post Mortem Examination certified by attending police officer or issued department (copy), and
4. Daily Police Report certified by attending police officer (copy), and
5. Identification Card and Census Registration ("Died" stamped) of the Insured Person (copy), and
6. Medical certificate that states disability or organ loss and photo (if any)
7. Any other document and evident support that company may request if necessary.

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

If anything specified in this clause is contrary to the policy, this clause shall prevail.

All other term and conditions of this Policy remain unaltered.

Section for Personal Accident Insurance

Additional Definitions (apply for Section for Personal Accident Insurance)

Any loss of or damage	means	Bodily Injury suffered by the Insured as a result of an accident and which cause loss of life, dismemberment, loss of sight or permanent disability or Injured

Additional Conditions (apply for Section for Personal Accident Insurance)

1. Change of occupation

If the Insured Person has been injured while at work and receives compensation in a career that is more dangerous than the career notified to the Company. The company will pay the benefit equal to the benefit that received premium payment. The Insured Person could buy the new coverage for the new career.

If the Insured person changed the career that the Company specified as less dangerous than the career notified to the Company, the Company will refund the insurance premium on pro-rata basis to the Covered Person since the day that the Company received the evidence of occupation changed.

2. Notice of Accident

The Insured, the Beneficiary or the Insured's representative, as the case maybe, shall notify the Company of the Injury which may be the cause of claim without delay. In case of death, the Company shall be notified immediately unless it can be proven that there is an acceptable reason for not informing the Company despite the attempt to notify.

3. Murder by beneficiary

If the insured is intentionally murdered by the beneficiary, the Company will not pay any benefits under the coverage specified under this insurance policy. In the event that there is only one beneficiary, the Company shall return the premium paid by deducting the premium for the period the insurance policy has been in force, in proportion to the inheritance or legal heir of the Insured.

However, if there is more than one beneficiary, neither of the beneficiaries participates in the intentional killing of the insured. The Company will pay benefits to the beneficiaries who do not participate in the killing of the Insured in proportion to the stated proportion. In this case, the company will not return the insurance premium.

4. Beneficiary of policy

The Insured can specify his/her beneficiary in the policy. Upon the Insured's death, the benefit will be paid to such named beneficiary. However, if no beneficiary is named on the policy, the benefit will go to the Insured's estate. In case the Insured named only one beneficiary and that person dies before the Insured, the Insured must notify the change of the beneficiary to the Company in writing. If this is not done or the Insured dies in the same accident as the beneficiary, the benefit will go to the Insured's estate.

In case the Insured named more than one person as beneficiary, and any of them dies before the Insured, the Insured must notify the change of the beneficiary to the Company in writing. If this is not done or the Insured dies in the same accident , the benefit will go to the rest of the persons named as beneficiary by dividing the portion of the deceased beneficiary to the rest proportionately.

Additional Exclusions (apply for Section for Personal Accident Insurance)

This insurance does not cover Any Loss or Injury arising from/ or in consequence of the following causes

1. Suicide, suicide attempt, attempting to commit suicide or self-inflicted attempt by the Covered Person.

2. Infections except pyogenic infections, tetanus, or rabies from a wound or suffered as a result of an Accident.

3. Medical treatment or surgical treatment except the necessary treatment for the injury which is covered under this Insurance Policy and occurring within the period of this Insurance Policy.

4. Miscarriage.

5. Dental treatment or root canal treatment except the treatment which is required within 7 days from the date of the Accident.

6. Replacement of or new set of dentures, Dental Crowns, Artificial dentures.

7. Food Poisoning

8. Backache as a result of Disc herniation, Spondylolisthesis, Degenerative disc disease, Spondylosis, Defect or Pars interarticularis (Spondylolysis) except if there is a fracture or dislocation of spinal cord as a result of an accident.

9. War, invasion or execution by foreign enemy or any acts similar to wars (whether it is declared or not), civil war, militancy, rebellions, riots, work strike, disturbance, revolution, coup, martial law declaration or any situations that causes or maintains as martial law.

10. Any loss or damage in the following circumstances (unless the coverage is extended by endorsement)

10.1 While riding or being a passenger on a motorcycle

10.2 While the Insured is boarding or traveling in an aircraft which has no license for carrying passengers or does not operate as a commercial aircraft.

10.3 While the Insured pilots or works as a crew in any aircraft.

10.4 While the Insured is taking part in a brawl or taking part in inciting a brawl

10.5 While the Insured is performing duties as a soldier, a police representative or a volunteer and engaged in war or crime suppression. If the Insured has to be in charge of such duties longer than 30 days, the Company shall refund the premium since the date that the performing duties have started and remains until such performance is ended. After such time, the Policy shall become effective again until the expiry date as specified on the Policy Schedule.

Insuring Agreement
Loss Of Life, Dismemberment, Loss Of Sight Or Permanent Disability (PA1)

Additional Definitions (apply for Section for Personal Accident Insurance)

Dismemberment	means	Amputation of limb from the wrist or ankle, including the total loss of function of that part which according to a clear medical indication, will be incapable of functioning again.
Loss of Sight	means	Complete, permanently incurable, blindness.
Total Permanent Disability	means	Disability to the extent of being unable to perform the normal duty in the Insured's regular occupation or any other occupation totally and permanently and such permanent disability prevent the Covered Person to perform 3 or more activities of daily living by himself/ herself. Activities of Daily Living (ADL) means the ability to perform 6 types of daily self-care activities which is a term used in healthcare to assess the patient. The Activities of Daily Living consist of (1) The ability to move from chair to bed and vice versa without the help another person or equipment. (2) The ability to move from one room to another without the help of another person or equipment.

		(3) The ability to put on and take off clothes without the help of another person or equipment. (4) The ability to wash body in a bath or shower including the ability to get to and from the bathroom without the help of another person or equipment. (5) The ability to feed oneself without the help of another person or equipment. (6) The ability to get to and from the toilet, using it appropriately, and cleaning oneself without the help of another person or equipment.

Insuring Agreement:

While this Policy is in effect, if a Covered Person sustains an Injury from an Accident, causing him or her to die, or to suffer Dismemberment, Loss of Sight, loss of hearing, loss of speech, or Total Permanent Disability within one hundred eighty (180) days from the date of the Accident, or if the Injury sustained by the Covered Person necessitates his or her continuous Treatment as an Inpatient in a Hospital and the Covered Person dies as a result of that Injury at any time, the Company will pay compensation as follows:

1.	100% of the sum insured	For loss of life
2.	100% of the sum insured	For Total Permanent Disability that continues for not less than 12 months a-er the Accident, or with a medical indication that the Covered Person will become a totally and permanently disabled person.
3.	100% of the sum insured	For the loss of both hands at or above the wrists, or the loss of both feet at or above the ankles, or the Loss of Sight of both eyes.
4.	100% of the sum insured	For the loss of one hand at or above the wrist and the loss of one foot at or above the ankle.
5.	100% of the sum insured	For the loss of one hand at or above the wrist and the Loss of Sight of one eye.
6.	100% of the sum insured	For the loss of one foot at or above the ankle and the Loss of Sight of one eye.
7.	60% of the sum insured	For the loss of one hand at or above the wrist.
8.	60% of the sum insured	For the loss of one foot at or above the ankle.
9.	60% of the sum insured	For the loss of Sight of one eye.

The Company shall compensate only one item of loss which has the highest amount. In the aggregate, the total compensation for this insuring agreement cannot exceed the maximum sum insured stated on the policy Schedule. If the Company has not paid up to such maximum amount of sum insured, the remaining benefit is still valid until the expiry of the policy period.

Claim for benefits for loss of lifes

The beneficiary, at his or her own expense, must submit the following evidence to the Company within thirty (30) days from the death of the Covered Person:

1. a claim form as prescribed by the Company s
2. a death certificate
3. a copy of the post-mortem report certified by the police officer in charge of the case or the agency issuing the report

4. a copy of the daily case report certified by the police officer in charge of the case
5. copies of the Insured's citizen identification card and house registration indicating the "deceased" status of the Insured and
6. copies of the beneficiary's citizen identification card and house registration.

Claim for Benefits for Total Permanent Disability, Dismemberment, Loss of Sight, loss of hearing, or loss of speech

The Insured, at his or her own expense, must submit the following evidence to the Company within thirty (30) days after the date of a Physician's diagnosis that the Covered Person has suffered a Total Permanent Disability or Dismemberment:

1. a claim form as prescribed by the Company and
2. a medical report that confirms the Total Permanent Disability, Dismemberment, Loss of Sight, loss of hearing, or loss of speech.

Failure to submit the evidence within the prescribed time will be without prejudice to the right of claim, if it can be proven that the failure is justified, and the evidence is submitted as soon as practical.

Summary of Terms and Conditions Elite Plus
Individual Health and Accident Insurance Policy

The benefits under this Personal Health Insurance Policy shall be disbursed in case of the Insured's injury or illness after the waiting period to the extent that medical treatment at a hospital or health facility is required. The Company shall pay the expenses incurred as a result of medical treatment in accordance with the medical necessity and standard at the general service rate. The payment shall be made for the items listed in the Schedule of Benefits below on actual basis but not exceeding the sum insured indicated in the Schedule of this Insurance Policy or the Appendix (if any). The benefits are as follows:

Benefit Schedule

Benefit	**Sum Insured (Baht)**	**Maximum (Days or Times)**	**Maximum Sum Insured (Baht)**
1. Inpatient Benefits			
Article 1: Room charge, meal fee and hospital service fee (Inpatient) for each policy year In the case that the Insured is treated in the Intensive Care Unit Inpatient Room, room charge, meal fee and hospital service fee shall be paid based on the actual cost incurred up to the Maximum Benefits per Policy Year as stated.			
Article 2 : Medical fee for examination or treatment, blood and blood component service fee, nurse service fee, medicine fee, parenteral nutrition fee, and medical supplies fee for each policy year			
Sub-article 2.1 Medical fee for examination			
Sub-article 2.2 Medical fee for treatment, blood and blood component service fee, and nurse service fee			
Sub-article 2.3 Medicine fee, parenteral nutrition fee and medical supplies fee			
Sub-article 2.4 Medicine fee and disposable supplies fee (Medical Supplies 1) for take away			
Article 3: Physician's examination fee (Physician) for each policy year			
Article 4: Operation (surgery) and procedure fee for each policy year			
Sub-article 4.1 Operating room fee and procedure room fee			
Sub-article 4.2 Medicine fee, parenteral nutrition fee, medical supplies fee, and surgery and procedure fee			
Sub-article 4.3 Physician's fee for Physicians performing surgery and procedure (including assistant) (Physician fee)			
Sub-article 4.4 Physician's fee for anesthetist (Physician fee)			
Sub-article 4.5 Medical fee for organ transplantation			
Article 5: Day surgery			
2. Non-Inpatient Benefits			
Article 6: Medical fee for related direct examination before and after hospitalization as an Inpatient or Outpatient treatment fee which is in consequence of or in connection with hospitalization as an Inpatient for each policy year			

Benefit	Sum Insured (Baht)	Maximum (Days or Times)	Maximum Sum Insured (Baht)
Sub-article 6.1 Medical fee for related direct examination which occurs within 90 days before and after hospitalization as an Inpatient			
Sub-article 6.2 Outpatient Treatment fee after hospitalization as an Inpatient for each consequential treatment within 90 days after such discharge from the hospital (excluding medical fee for examination)			
Article 7: Medical fee for Treatment of injury in Outpatient case within 24 hours after each accident			
Article 8: Rehabilitation medicine fee after each hospitalization as an Inpatient per policy year			
Article 9: Medical fee for Treatment of chronic kidney failure by hemodialysis through vascular access for each policy period			
Article 10: Medical fee for Treatment of tumor or cancer by radiotherapy, interventional radiology, and nuclear medicine for each policy period			
Article 11: Medical fee for Treatment of cancer by chemotherapy for each policy period			
Article 12: Ambulance fee			
Article 13: Medical fee for Minor Surgery			
Deductible / Co-Payment			
Deductible			
Co-Payment			

Maximum Benefits per Policy Year as specified in the Policy documents

Summary of Important Conditions

1. This Insurance Policy is the insurance agreement with one-year insurance period.
2. This Insurance Policy shall be renewed upon the completion of the insurance period, except for the cases below, that the Company reserves the right not to renew the Insurance Policy:

1) If there is evidence indicating that the Insured has not declared factual statements in accordance with the insurance application or reinstatement, health declaration form, and any other additional declarations related to execution of health insurance policy, which is the subject matter entitling the Company to demand higher insurance premium or reject the application or accept the application for insurance with conditions.

2) The Insured claims the benefits from his/her treatment of injury or illness without medical necessity. 3) The Insured claims the benefits for compensation of hospital or health facility admission from all companies in the higher amount than the actual income.

3. The period of insurance premium payment is within 31 days as stated in the Insurance Policy.
4. The cases excluded from the coverage are

4.1 The Insured commits insurance fraud.

4.2 The illnesses occurring during the – day (Not applicable) waiting period from the first effective date of the Insurance Policy indicated in the Insurance Policy Schedule or the date in which the Company approves additional benefits of this Insurance Policy, whichever happens later, or

4.3 Pre-existing Condition, except

1) when the Insured has declared to the Company and the Company unconditionally accepts the risk without any exception of such coverage or

2) Chronic diseases, injury or illnesses (including complications) are inapparent, untreated or unexamined by the doctor or the Insured has not met or consulted with the doctor during the period of 5 years prior to the first effective date of this Insurance Policy and during the period of 3 years from the first effective date of this Insurance Policy.

4.4 General exclusions described in this Insurance Policy such as congenital disorders, treatment under trial, fertility and infertility treatment(including investigation and treatment), convalescence or rest for rehabilitation or rest cure, and so on.

4.5 Any exclusions or non-coverage as indicated in each coverage agreement.

This document is a summary of essences and some parts of coverage conditions and exclusions only.
Please carefully read and understand all details in this Insurance Policy.