Individual Health and Accident Insurance Policy

SwitchCare

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Remark: The English version is a translation of the original in Thai for information purpose only. In case of a discrepancy, the Thai original shall prevail.

SwitchCare
Individual Health and Accident Insurance Policy

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	AXA 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.	Dependents	means	the following persons: 1. the legitimate spouse who is aged at least 18 years old and not older than 71 years old 2. the legitimate children of the Insured, or of the Insured's spouse, who are unmarried and unemployed, and are between the age of 15 days and 18 years, or 23 years if a student.
5.	Covered Persons	means	the Insured and/or the Insured's Dependents named in this Insurance Policy or endorsement (if any).
6.	Accident	means	any incident suddenly occurring due to external factors and leads to unintentional or unexpected results for the Covered Persons.
7.	Injury	means	any physical injury occurring to the body which is directly caused by Accident occurring individually and independently from other factors.
8.	Illness	means	any physical abnormalities caused by disease.
9.	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.
10.	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.
11.	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.
12.	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.
13.	Nurse	means	a person obtaining nursing professional license pursuant to the law in the area in which the service is provided.
14.	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.
15.	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.

16.	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.
17.	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.
18.	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.
19.	Treatment	means	Provision of medical and public health services for examination and diagnosis, treatment, relief, care and rehabilitation necessary for health and living.
20.	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.
21.	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.
22.	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
23.	Medical Necessary	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.
24.	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.
25.	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.
26.	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.

27.	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).
28.	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.
29.	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
30.	Benefits Schedule	means	the table listing the maximum benefit amounts for the respective Covered Persons.
31.	Area of Cover	means	**1**. **Asia excluding China, Hong-Kong, Singapore, Macau and Taiwan** means Bangladesh, Bhutan, Brunei, Cambodia, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, the Philippines, South Korea, Sri Lanka, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan and Vietnam **2**. **Asia** means Bangladesh, Bhutan, Brunei, Cambodia, China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, the Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan and Vietnam. **3**. **Worldwide excluding USA,** which means all countries around the world except the USA and its surrounding islands.
32.	Outside Area of Cover	means	the coverage that is provided only for Emergency Inpatient Treatment not arising during travel undertaken directly for securing Medical Treatment, or that is prepared while a Covered Person travels out of the Area of Cover, or for any aspect of pregnancy or childbirth.
33.	Main Country of Residence	means	the country where the Covered Person resides for most of the year, being one hundred eighty-five (185) days or more and which will be shown as the Covered Person's address and place of residence in our records. It is deemed to be in Thailand.
34.	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.
35.	Emergency	means	a sudden, serious, and unforeseen acute Medical Condition or injury requiring immediate medical treatment, that without treatment commencing within 24 hours of the Emergency event could result in death or serious impairment of bodily function.
36.	Medical Condition	means	any disease, Injury, Illness, including mental Illness, that has been diagnosed and concluded by a Physician.
37.	Associated Medical Condition(s)	means	a symptom, disease, injury or illness that has one or more of the following characteristics: - Medical Condition(s) caused by or related directly or indirectly to a Pre-existing Condition; or - Medical Condition(s) in which the underlying condition (disease, injury or illness) is generally known to be the same with the underlying disease that caused a Pre-existing Condition; or - Risk factor (s) that is generally or directly known to be a Medical Condition that is the cause of or arising from the Pre-existing Condition.

38.	Chronic Condition	means	any Medical Condition that has one or more of the following characteristics: - it needs ongoing or long-term monitoring through consultations, examinations, check- ups and/or tests - it needs ongoing or long-term control or relief of symptoms - it requires your rehabilitation or for you to be specially trained to cope with it - it continues indefinitely - it has no known cure - it comes back or is likely to come back
39.	Congenital Conditions	means	all kinds of congenital abnormalities, including physical anomalies happening during six months from birth, that are categorized as congenital malformations by the World Health Organization, and deformations or genetic abnormalities, including all kinds of hernia or epilepsy, except epilepsy caused by an Injury after the Covered Person has obtained the insurance.
40.	Organ transplantation	means	the transplantation of bone marrow, heart, lung, liver, pancreas or kidney.
41.	Terminal Medical Condition	means	the conclusive diagnosis of an illness that is expected to result in the death of the Covered Person within twelve (12) months.
42.	Active Cancer Treatment	means	a treatment which is intended to shrink a cancer, stabilize it or slow down the spread of the disease. This excludes treatment given solely to relieve symptoms.
43.	Invasive Cancer	means	The developed stage of tumor or cell diagnosed and confirmed by a pathologist as cancer and has spread beyond the layer of tissue (Basement Membrane) or spread to surrounding tissue or other parts of the body including Leukemia, Lymphoma, Multiple Myeloma, and Choriocarcinoma, but this does not include: (1) Prostate Cancer, Thyroid Cancer or Urinary Bladder Cancer stage T1N0M0 as per TNM Classification. (2) Chronic Lymphocytic Leukemia less than RAI stage 3. (3) Non-invasive cancer, Carcinoma in Situ. (4) Any Skin Cancers, except Melanoma (Malignant Melanoma), stage 2 and above, as per Severity of Melanoma one by American Joint Committee on Cancer Classification. (5) Borderline malignant potential or low malignant potential. (6) Tumor which is diagnosed as pre-malignant lesion, such as CIN I CIN II CIN III. (7) Cancer in HIV patients. (8) Cancer which is recurring or spreading from other parts of the body and this cancer is developed for the first time before the commencement of the Policy or within 90 (ninety) days after the inception date of the Policy.
44.	Non-invasive cancer /Carcinoma in Situ	means	The first developing stage of tumor or cell diagnosed and confirmed by a pathologist as cancer and has not spread beyond the layer of tissue (Basement Membrane) or not spread to surrounding tissue or other parts of the body including cancer or tumor, as follows: (1) Prostate Cancer, Thyroid Cancer or Urinary Bladder Cancer stage T1 N0 M0 as per TNM Classification. (2) Chronic Lymphocytic Leukemia less than RAI stage 3. (3) Melanoma (Malignant Melanoma), a serious type of Melanoma less than stage 2 as per Severity of Melanoma done by American Joint Committee on Cancer Classification. (4) Borderline malignant potential or low malignant potential, stage of dread disease or relevant definitions.

45.	Conventional Treatment	means	treatment that: - is established as best medical practice and is practised widely; and - is clinically appropriate in terms of necessity, type, frequency, extent, duration and the facility or location where the treatment is provided; and has either: - been shown to be effective for the insured's Medical Condition through substantive peer reviewed clinical evidence in published authoritative medical journals; or - been approved by NICE (The National Institute for Health and Care Excellence) or the relevant government authorities and/or recognized medical association of the country where the treatment is sought and as a treatment which may be used in routine practice. If the treatment is a drug, the drug must be: - licensed for use by the Medicines and Healthcare products Regulatory Agency or Authority in the locality where treatment is provided or the Food and Drug Administration (FDA) - used according to that license and dosage for which it is approved for Conventional treatment will also apply to the use of related medical equipment or consumables.
46.	Prescribed Medication	means	medicines or dressings prescribed by a Physician for treating a Medical Condition covered under the Policy.
47.	Lifetime Limit	means	the maximum aggregate amount (in money or visits) of all benefits paid and payable for the whole period of the Covered Person's membership under the Plan/policy for the covered Medical Conditions.
48.	Surgery	means	an operation requiring the incision of tissue or other invasive surgical intervention payable under the terms of this Policy.
49.	Major Surgery	means	an operation through body wall or hole in which general anesthesia or regional anesthesia is required.
50.	Minor Surgery	means	an operation at a skin level or under skin level or epithelial level in which local/topical anesthesia is used.
51.	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").
52.	Day Care Treatment	means	eligible Treatment at a hospital or day-care unit where the Covered Person needs a medically supervised recovery but does not occupy a bed overnight.
53.	Fees for Nursing Services	means	expenses regularly charged by a Hospital or medical center for services provided by professional Nurses to a Covered Person when the Covered Person is an Inpatient.
54.	Chinese Traditional Medical Approach	means	a diagnosis, Medical Treatment, or prevention of disease by any means provided by a Chinese traditional physician in the locality in which the services are provided.
55.	Physiotherapist	means	a person who is capable of practicing, and is licensed to practice, physical therapy.
56.	Experimental	means	treatment modality or medication in the Company's reasonable opinion whose efficacy and safety are yet to be established and lack the authoritative evidence-based clinical studies. These are also treatment modalities or medicines which are not generally accepted by the medical community as proven to be effective or recognized by the professional medical organizations as conforming to accepted medical practice. This definition also includes equipment used for purposes other than those defined under their license or which is undergoing study, research or testing.
57.	Care card	means	the Covered Person's health member ID card issued by the Company. The Covered Person is responsible for returning the Membership Card to the Company if the termination of coverage is requested before the date of insurance Policy becomes invalid as described in the Policy Schedule.

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. Breach of the insurance agreement

If a Covered Person breaches any condition of the Policy, or dishonestly claims or attempts to claim compensation, the Company will:

2.1 refuse to pay the compensation and

2.2 refuse to renew the Policy or

2.3 specify the conditions of the Policy that are different from the original ones or

2.4 immediately revoke the Policy and the entire coverage.

The Policy will be canceled entirely and the premium refunded to the Insured,the Covered Person, the Beneficiary, as the case may be, by deducting a ratable proportion of the premium for the time the Policy has been in force.

3. 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.

4. Governing law

This Policy is governed by, and interpreted in accordance with, the laws of Thailand. The Insured and/or the Covered Persons agree that Thai law is the exclusive law for settling all disputes arising from or in connection with this Policy.

5. 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.

6. Premium payment and commencement of coverage

6.1 Annual premium payment

6.1.1 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.

6.1.2 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.

6.1.3 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.

6.2 Premium payment by instalment as specified in the Policy Schedule

6.2.1 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.

6.2.2 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.

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.

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).

7. Misstatement of sex, age or Main Country of Residence

If any Covered Person's sex, age or Main Country of Residence is misstated, thereby causing the Company:

7.1 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, age and/or Main Country of Residence. If the Covered Person is not eligible for the coverage under this Policy based on his or her actual age or Main Country of Residence, 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, or

7.2 to receive a premium more than the prescribed rate, the Company will return the excess premium to the Insured and/or the Covered Person. However, this condition will not apply retroactively to the premiums paid for the past Policy Years.

8. 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 must notify the Insured. In case of any changes or extensions of coverage, conditions, exclusions, Endorsement or other under this insurance policy

However, this Renewal of the Policy under clause 8 will not apply with the Insuring Agreement for Health Insurance (Inpatient).

9. 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.

10. 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:

10.1 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.

10.2 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.

11. Change of country of residence

The Insured must report to the Company if any of the Covered Person changes his or her Main Country of Residence, which may affect his or her entitlement to the benefits under the Policy. If the Insured fails to do so, the Company will comply with the provisions specified in clause 7, misstatement of sex, age or Main Country of Residence, of the general conditions.

12. Addition or removal of Covered Persons

If the Insured wishes to add or remove Covered Persons, the Insured may do so immediately by completing an insurance application as required by the Company and submit it to the Company.

If the mother of a baby is the sole Covered Person under this Policy, the Insured may add the newborn baby as her Dependent within 30 days from the date of the birth, provided that the benefits and coverage of the mother who is the Covered Person under this Policy remain in effect.

If the mother of a baby is not covered under this Policy, the coverage for the baby can be obtained when the baby is discharged from Hospital and subject to any medical underwriting.

Addition or removal of the Covered Persons will be effective when written notice of that addition or removal is given by the Insured to the Company, and the Company agrees to it with the premium proportionately adjusted.

13. 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 6 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 20 Termination of the Insurance Policy

5. When the Company refuses to renew the Insurance Policy under Clause 8 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).

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.

14. Medical Examination

The Company reserves the right to examine the medical history of the Insured as deemed appropriate for this Insurance Policy and may have the autopsy performed as necessary and to the extent permitted by the law at the Company's expense.

In the case that the Insured does not allow the Company to examine his/her medical history in support of consideration for disbursement of the sum insured, the Company may refuse to provide coverage to the Insured.

15. Notice and Claim

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

16. 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

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.

17. 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.

18. Currency Exchange Rates

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.

19. Condition precedent

The Company may deny its liability under this insurance agreement, unless the Insured, the Covered Persons, or their beneficiaries or representatives, fully observe and comply with the insurance agreement and the conditions of this Policy.

20. Termination of the Policy

1) The Insured shall be entitled to terminate this Insurance Policy by sending a written notice to the Company and be entitled to receive a refund of the insurance premium after deduction of the insurance premium for the period of effectiveness hereof at the rate of short-term premium indicated 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

2) 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.

However, in the case that the Insured terminates the Insurance Policy under 1) 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.

21. 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").

22. 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.

23. Waiting Period

The Company will not pay benefits under this policy for;

The illnesses occurring during the – days (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

However, in the case that the Company approves additional benefits under Clause 10, 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.

24 . Change of Occupation

If the Insured suffers an injury and illness while under a remunerated occupation which is considered more hazardous than which had been previously declared to the Company, the Company shall pay the compensation equal to the coverage amount of which the previously paid premium can buy the new occupation. If the occupation is a declined risk, the Company will terminate the Policy and refund the premium to the Insured on a pro-rata basis as from the date of receiving such evidence of change. However, if there was a previous claim done within the Policy Year, no refund of premium will be provided.

If the Insured changes to an occupation which the Company considers as less hazardous, the Company will reduce the premium and refund it to the Insured on a prorata basis as from the date of receiving such evidence of change.

25. Reinstatement

Upon the Policy expiration due to the Insured's failure to pay the insurance premium within the specified period under Clause 6, 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.

26. 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 20 Termination of the Policy.

27. Return of Membership Card

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.

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. **A Pre-existing Condition, disease, Injury, or Illness including any Associated Medical Conditions or complications or consequential conditions arising therefrom and conditions which were not disclosed to the Company before the date of the insurance agreement.**
2. **Congenital conditions whether or not manifest and/or diagnosed or known about at birth unless allowed for by the benefits table and accepted by the Company in writing.**
3. **Treatment of physiological and/or all types of neurological development, cognitive development, developmental milestones, learning development problems or disorders, speech delays, educational problems, behavioural problems, physical development including assessment or grading of such problems.,**
4. **Any beautification treatment or cosmetic Surgery, or treatment of skin problems, acne, blemish, freckle, dandruff, hair loss, ear or body piercing, tattooing, weight control, liposuction or removal of fat deposits, or elective Surgery, except for reconstructive Surgery due to a covered Accident with the Company's written consent.**
5. **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.**
6. **Treatment of any Medical Condition that arises during pregnancy or childbirth (delivery) if the pregnancy was a result of any form of assisted conception including artificial insemination or elective/non-Medically Necessary caesarean section.**
7. **Services in connection with, investigations into and Treatment of varicocele, fertility/infertility, contraception, assisted reproduction, sterilization (or its reversal) or any consequence of any of them or of any Treatment for them.**
8. **Human Immunodeficiency Virus (HIV) infection, acquired immune deficiency syndrome (AIDS) except as specified otherwise in this Policy.**
9. **Venereal diseases, or sexually transmitted diseases, varicocele, impotence, or consequences thereof, gender confirmation or transgender Surgery.**
10. **Circumcision, except if it is Medical Necessary.**
11. **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.**
12. **Routine medical examinations, requests for admission to a Hospital or medical center, or requests for Surgery, or rest cures, diagnosis for any cause not directly related to the admission in the Hospital, medical center, or clinic, except as specified otherwise in the Covered Person's plan in this Policy.**
13. **Checks and treatment for abnormality of vision, Lasik, expenses for a vision-aid device or for treatment of abnormality of vision, except as specified otherwise in the Covered Person's plan this Policy.**
14. **Treatment or Surgery related to teeth or gums, dentures, crowns, root canal treatment, fillings, orthodontics, polishing, extraction, or root implants except as necessary due to accidental Injury (excluding dentures, crowning, and root canal treatment or root implants), except as specified otherwise in the Covered Person's plan this Policy.**
15. **Treatment or therapy for drug addiction, smoking, alcoholism or use of psychoactive substances.**
16. **Treatment of symptoms or diseases related to mental disorders, psychiatric diseases, behavioral or personality disorders, including attention deficit disorder, autism, stress, eating disorders or anxiety.**
17. **Treatment for all types of sleep disorder including sleep apnoea, sleep study test, snoring.**
18. **Treatment which is in a trial stage, has not been established as being effective or which is Experimental or pioneering medical or surgical techniques and medical devices not approved by the relevant authorities, government regulatory board and clinical trials for medicinal products which your insured chooses to receive even though usual, customary and Conventional treatment for the condition is available.**

    However, the Company will pay if, before the treatment begins, it is established that the treatment is recognized as appropriate by an authoritative medical body and the Company has agreed in writing, with the Physician, what the fees will be. For established treatment, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced in published medical journals for specific purposes to be considered proven safe and effective therapies.

19. **The use of a drug or any off-label drug which has not been established as being effective or has not been approved by Food and Drug Administration (FDA), which is experimental or within clinical trials, unless with the pre-approval in writing by the Company.**
20. **Any inoculations or vaccinations (excluding rabies vaccination after an animal attack and tetanus vaccination after an Injury), except as specified otherwise in the Covered Person's plan this Policy.**
21. **Treatment offering temporary relief of symptoms rather than dealing, when it is reasonable to do so, with the underlying condition, prescription of medicine that does not immediately respond to or treat the Injury or Illness or the diagnosis of Injury or Illness or the treatment or diagnosis for cause that is not a Medical Necessity or in accordance with the Medical Standards, or is not directly related to the admission in the Hospital, medical center, or clinic.**
22. **A treatment by an approach that is not a Conventional Treatment, including an alternative medical approach, except as specified otherwise in this Policy.**
23. **Expenses arising from Medical Treatment that a Covered Person, who is a Physician, prescribes for himself or herself, or expenses arising from Medical Treatment by a Physician who is the parent, parents in law, spouse, child, siblings and brother or sister in law of the Covered Person.**
24. **Suicide, attempted suicide, self-inflicted Injury, or attempted self-inflicted Injury, whether by oneself or with the assistance of someone else, and while sane or insane, including an Accident caused by consumption or injection of a drug or poisonous substance, or overdose of medications.**
25. **An Injury caused by the action of the Covered Person while under the influence of alcohol, addictive substances, or harmful narcotics to the extent of being unable to control one's mind. The term "under the influence of alcohol" means a blood alcohol level of 150 milligrams percent or more, according to the results of a blood test.**
26. **An Injury arising while the Covered Person is engaging in a brawl or fight or taking part in inciting a brawl or fight.**
27. **An Injury arising while the Covered Person is committing an indictable felony or is being arrested or is avoiding arrest.**
28. **Any costs incurred as a result of engaging in, competing in or training for any sport for which the Insured Person receive a salary or monetary reimbursement, including grants or sponsorship (unless the Insured Person receive travel costs only).**
29. **An Injury sustained from playing professional sport or from taking part in dangerous sports or activities including but not limited to:**
    - **base jumping, cliff diving,**
    - **flying in an unlicensed aircraft,**
    - **martial arts, free climbing,**
    - **mountaineering with or without ropes,**
    - **scuba diving to a depth of more than 10 meters, or to a depth of more than 30 metres if you hold an appropriate diving qualification or you are being instructed by an appropriately qualified diving instructor, for example an instructor recognised by PADI (Professional Association of Diving Instructors),**
    - **any activity at a height of over 5,000 metres above sea level,**
    - **trekking to a height of over 2,500 meters,**
    - **bungee jumping,**
    - **Hangliding,**
    - **paragliding or micro lighting,**
    - **parachuting,**
    - **potholing,**
    - **skiing off piste or any other winter sports activity carried out off piste.**
30. **An Injury arising while the Covered Person is embarking on or disembarking from, or traveling in, an aircraft not registered for carrying passengers and operated as a commercial aircraft or while the Covered Person is piloting or acting as a crew member in any aircraft.**
31. **An Injury arising while the Covered Person is piloting or acting as a crew member in any aircraft.**
32. **An Injury arising while the Covered Person serves as a soldier, policeman or policewoman, or a volunteer, and engages in war or crime suppression.**
33. **War, invasion, acts of foreign enemies, warlike operations (whether declared or not), civil war, which means a war fought by people living in the same country, uprising, insurrection, terrorist act, riot, strike, civil commotion, revolution, coup d'etat, proclamation of martial law, or any events that result in the proclamation or maintenance of martial law or criminal acts, illegal acts.**

34. **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**
35. **Radioactive explosion, or any nuclear component or harmful substance that may cause an explosion in a nuclear process.**
36. **All kinds of orthotics and prostheses, such as a walking stick, eyeglasses, lenses, hearing aids, speech devices, heart pacemakers, medical devices and durable medical supplies, respirators, oxygen machines, vital sign monitors (pulse, blood pressure, body temperature), support aids, wheelchairs, prosthetic parts, ie. artificial limbs and artificial eyes, except heart valves, skull or hip prostheses, and knee prostheses.**
37. **A treatment during 90 days after birth, for a child born from unnatural pregnancy or pregnancy by artificial insemination or any child conceived by assisted conception/assisted pregnancy.**
38. **Treatment in a health hydro, spa, fitness centre, nature cure clinic or any similar place.**
39. **A psychiatric treatment as an Inpatient and Outpatient except as specified otherwise in the Covered Person's plan in this Policy**.
40. **Rehabilitation as an Inpatient.**
41. **Cryopreservation, expenses for harvesting, acquiring and preserving organs or storage of stem cells as a preventive measure against possible disease/illness/injury; or any implantation or re-implantation of living cells or living tissue, whether autologous or provided by a donor unless this has been pre-approved and agreed by the Company in writing.**
42. **Traveling for treatment outside the coverage area even if it is done in accordance with medical advice while within or outside the Area of Cover.**
43. **The costs of collecting donor organs for transplant surgery or any administration costs involved even if such transplants are allowed by the terms of this plan.**
44. **Cosmetic products or toiletries such as, but not limited to shampoos, soaps, tooth-pastes, mouthwash, lotions, moisturizers, cleanser, shower gels, regardless whether Medically Necessary or prescribed by a Physician or acknowledged as having therapeutic effects; contraceptives, proprietary headache and cold cures, artificial tear drop/ gel, vitamins or minerals which may be bought over the counter, without prescription, , products classified as organic substances, vitamins or minerals (except during pregnancy or to treat diagnosed, clinically significant vitamin deficiency syndromes), nutritional or dietary consultations and supplements, including, personal items such as but not limited to, telephone charges.**
45. **Hormone replacement therapy unless there is a direct result of medical intervention or medical indication. The Company will pay the Physician's fees including consultations, cost of hormone implants or patches (excluding hormone tablets) up to a maximum of 18 months from the first date of treatment.**
46. **Microbial studies or genetic testing, including any counselling made necessary following the tests, even when those tests are undertaken to establish whether or not the Covered Person may be genetically disposed to the development of a medical condition in the future.**
47. **Treatment costs incurred by a Covered Person when in a coma, in a vegetative state (a state of profound unconsciousness and/or sign of awareness or a functioning mind) or under artificial life maintenance including medical intervention such as mechanical intervention for more than 12 months. The Company will, however, pay for any active Treatment costs of an eligible Medical Condition incurred within the first 12 months of the coma or vegetative state or artificial life maintenance subject to any Waiting Period stated under "Terminal Care" in the benefit table provided this is available under the Covered Person's Plan choice.**
48. **Robotic surgery or unless this has been pre-approved and agreed by the Company in writing.**
49. **Treatment required as a result of negligence or malpractice. The Covered Person must take all reasonable steps to recover the loss from the third party or third-party insurer.**
50. **Treatment directly related to surrogacy, whether the Covered Person is acting as a surrogate, or is the intended parent.**
51. **Any treatment needed as a result of work related accident or injury where the cost of such treatment is recoverable under a Workman's Compensation policy or similar cover required by Government Act prevailing in the country where the work-related accident or injury took place or elsewhere at the time of injury or accident.**

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 for Personal Health Insurance

Additional Definitions

Multiple Birth	means	the birth of more than one baby from a single pregnancy.
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.

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

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 9 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 the loss ratio of each Covered person is more than 400 percent.

If the Company add co-payment due to (1) or (2), 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.

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

Benefits	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.	as specified in the policy documents		
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	as specified in the policy documents		
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			

Benefits	Sum Insured (Baht)	Maximum (Days or Times)	Maximum Sum Insured (Baht)
Article 9: Medical fee for Treatment of chronic kidney failure by hemodialysis through vascular access for each policy period	as specified in the policy documents		
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	as specified in the policy documents		
Co-Payment	as specified in the policy documents		

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 90 days before and 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 90 days before or after such 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

The Company shall pay the medical fee arising out of consequential treatment at the Outpatient Department of the Hospital Health Facility within 90 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.

Insuring Agreement - Congenital Condition

Insuring Agreement:

While this Policy is in effect, the Company will pay for the Inpatient Treatment of newborn baby's Congenital Conditions within sixty (60) days from the date of birth for a covered child, as provided under the specific plan in the Benefit Schedule less any Deductible payable by each Covered Person for the costs of Medically Necessary services up to the maximum Lifetime Limit including any post-hospitalisation follow-up within ninety (90) days following the baby's discharge from hospital.

Any Congenital Conditions impacting the Covered Person later in life that was not evident or diagnosed within the first sixty (60) days of birth, shall not be covered regardless of the Covered Person's age when they first manifested.

Congenital Conditions declared to the Company at time of application are considered as Pre-Existing Conditions.

The benefit becomes available if:

1. the parent of the newborn baby has been covered under the Plan for three hundred sixty-five (365) consecutive days or more when the baby is born; and
2. the newborn baby is added into the parent's policy within thirty (30) days from birth, and the parent must be a Covered Person; and
3. both parent and baby have been continuously covered under the Policy and the Policy is in force when the Treatment is received.
4. either parent has not had any kind of fertility treatment.

Exclusions (apply to Insuring Agreement for Congenital Condition)

This Policy does not cover benefits for any claims directly or indirectly arising from:

1. baby is conceived via assisted conception/assisted pregnancy.
2. multiple birth after assisted conception/reproduction.
3. baby is an adopted child or born from a surrogate parent

This benefit is paid from the baby's plan.

No other benefits will be payable for the remaining policy year, once the benefit limit for this benefit is reached.

Section for Personal Accident Insurance

Additonal Definitions

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
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.
Partial Permanent Disability	means	A disability that renders a permanent inability to perform any regular duties of one's own occupation but does not prevent the engagement in other work for remuneration.

Additional Conditions

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.

Insuring Agreement
Cost of Dental Service due to an Accident

Insuring Agreement:

While this Policy is in effect, if a Covered Person sustains an Injury from an Accident, causing damage to his or her natural teeth, the Company will pay Medically Necessary, Customary and Reasonable Medical Charges, for Emergency restorative dental Treatment following an Accident within seven (7) days from the date of occurrence of the Accident, according to the actual amount, but not exceeding the Maximum Benefits per Policy Year specified in the Benefit Schedule less any Deductible payable by each Covered Person for the costs of Medically Necessary services.

Exclusions

This Policy does not cover:

1. damage to teeth due to consumption of food or drink or any foreign bodies contained in such food or drink.
2. normal wear and tear of teeth.
3. tooth brushing or any oral hygiene procedure.
4. the injury was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn.
5. the damage is not apparent within seven (7) days of the impact which caused the Injury; or
6. the injury was caused by any means other than extra-oral impact.
7. Damage sustained to crowns, dentures, bridge work, or existing false teeth;
8. Injuries caused by Accidents or events not covered by this Policy;
9. Costs for Treatment that has not yet taken place, even if it is being provided as part of a treatment package.

Insuring Agreement
Loss of Life, Dismemberment, Loss of Sight, Loss of Hearing, Loss of Speech, or Permanent Disability from Accident (PA.2)

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 after 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.
10.	50% of the sum insured	For the loss of hearing in both ears or the loss of speech.
11.	15% of the sum insured	For the loss of hearing in one ear.
12.	25% of the sum insured	For the loss of a thumb (both phalanges).
13.	10% of the sum insured	For the loss of a thumb (one phalanx).
14.	10% of the sum insured	For the loss of an index finger (three phalanges).
15.	8% of the sum insured	For the loss of an index finger (two phalanges).
16.	4% of the sum insured	For the loss of an index finger (one phalanx).
17.	5% of the sum insured	For the loss of any finger (at least two phalanges) other than a thumb or an index finger.
18.	5% of the sum insured	For the loss of a big toe.
19.	1% of the sum insured	For the loss of any one toe (at least one phalanx) other than a big toe.

The Company will compensate for only one item of loss with the highest amount of compensation. In the case of a total permanent loss of a finger or toe under items 12 to 19, for which no compensation under items 1 to 9 is claimable, the Company will compensate for the respective items of the actual loss, provided that the aggregate amount of compensation will not exceed the sum insured as specified in the Benefit Schedule.

In the case of a Partial Permanent Disability, other than the loss of taste or smell, for which no compensation as specified under items 2 to 19 is claimable, the Company will pay compensation according to the opinion of the Company's Physician, but no more than 50 percent of the sum insured specified in the Benefit Schedule.

Throughout the insurance period, the aggregate amount of compensation paid by the Company for the consequences covered hereunder will not exceed the sum insured specified in the Benefit Schedule. If the amount of compensation paid by the Company under this coverage agreement has not yet reached the full amount of the sum insured, the Company will provide coverage hereunder until the expiration of the insurance period, in accordance with the balance of the sum insured.

Claim for benefits for loss of life

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
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.

Extended Endorsement - Section for Personal Health Insurance Treatment for AIDS / HIV

Additional Definitions

AIDS	means	Acquired Immune Deficiency Syndrome which is caused by AIDS virus infection and shall inclusively mean opportunistic infection Malignant Neoplasm or infection or any sickness by HIV (Human Immune Deficiency Virus). Opportunistic infection shall include but not limited to Pneumocystis Carinii Pneumonia, Organism or Chronic Enteritis, Virus and/or Disseminated Fungi Infection. Malignant Neoplasm shall include but not limited to Kaposi's Sarcoma, Central Nervous System Lymphoma and/or other serious diseases presently known as the symptom of Acquired Immune Deficiency Syndrome or caused by sudden death, sickness or disability. In this regard, AIDS shall include HIV (Human Immune Deficiency Virus), Encephalopathy Dementia and virus spreading.

Coverage:

While this Policy is in effect and after the expiration of a waiting period 24 after the Policy Commencement Date of the Policy or the date when a Covered Person is included under this Policy, and subject to the condition that the Insured has paid a renewal premium, the Company will pay Customary and Reasonable Medical Charges for Treatment of AIDS / HIV as a result of occupational accident or blood transfusion less any applicable Deductible payable by each Covered Person for the costs of Medically Necessary services for Inpatient Treatment of HIV/AIDS when proven to be caused by occupational accident or blood transfusion.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Extended Endorsement - Section for Personal Health Insurance Inpatient Psychiatric Treatment

Additional Definitions

Psychiatrist	means	a person obtaining a medical degree and having the psychiatry professional license pursuant to the law in the area in which the service is provided.

Coverage:

While this Policy is in effect and after the expiration of a waiting period 10 months after the Policy Commencement Date of the Policy or the date when a Covered Person is included under this Policy, if a Covered Person suffers from a psychiatric Illness that requires Inpatient Treatment, the Company will pay Customary and Reasonable Medical Charges at a Hospital providing evidence-based Treatment of psychiatric illness up to the actual amount, but not exceeding the maximum number of covered days per period of cover and/ or the Maximum Benefits per Policy Year specified in the Benefit Schedule less any Deductible payable by each Covered Person for the costs of Medically Necessary services.

The Covered Person must obtain pre-authorization from the Company before obtaining Treatment. Treatment must be under the direct control of a psychiatrist licensed to practice medicine by the relevant authority in the country where the Treatment is given. In case of psychotherapy, the psychotherapist must be recognized by the Company and registered in the Health Facility in which the Treatment is received.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Extended Endorsement - Section for Personal Health Insurance Health Check-Up

Coverage:

While this Policy is in effect, the Company will pay for a routine physical health examination taken by the Covered Person to verify a normal state of health according to the actual amount, but not exceeding the Maximum Benefits per Policy Year specified in the Benefit Schedule subject to both Deductible and Co-payment where applicable by each Covered Person for the costs of Medically Necessary services.

This benefit excludes a check-up for any test or consultation to follow-up on a medical condition to seek diagnosis or already diagnosed.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Extended Endorsement - Section for Personal Health Insurance Vaccinations

Coverage:

While this Policy is in effect, the Company will pay Customary and Medical Charges for vaccinations received by the Covered Person, if it is Medically Necessary including vaccinations recommended by the WHO when traveling to another country and malaria prophylaxis, according to the actual amount, but not exceeding the Maximum Benefits per Policy Year specified in the Benefit Schedule subject to both Annual Deductible and Co-payment where applicable by each Covered Person for the costs of Medically Necessary services.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Extended Endorsement - Section for Personal Health Insurance Optical Care

Additonal Definitions

Ophthalmologist	means	a person (other than the Covered Person, or his or her family member) who is duly registered with the Medical Council and is licensed to practice the ophthalmology profession in the locality in which the services are provided.
Optician / Optometrist	means	a person (other than the Covered Person, or his or her family member) who is duly registered and is licensed to perform eyesight tests and prescribe corrective lenses or spectacles in the locality in which the services are provided.

Coverage:

It is agreed that during the effective period specified herein and after the expiration of a waiting period 6 months, following the inclusion of a Covered Person who is insured for Optical Care and while the Policy remains in effect, the Policy will extend its optical care coverages and benefits.

The Company agrees to pay benefits according to the actual expenses necessarily and reasonably incurred, but no more than the amount of benefits specified in the Benefit Schedule, for an eye examination, visual acuity test, corrective eyeglasses and spectacle lenses (i.e. frames and corrective lenses) to correct vision, performed and prescribed by an Optician, Optometrist or Ophthalmologist.

Exclusions

This attachment does not cover benefits for any claims directly or indirectly arising from:

1. cost of tinted lenses, sunglasses, non-corrective contact lenses or eyeglasses, irrespective of whether they are prescribed by an Optician, Optometrist or Ophthalmologist or
2. Lasik or any similar treatment.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Extended Endorsement - Section for Personal Health Insurance Maternity Normal (Routine) Pregnancy and Delivery

Coverage:

It is agreed that during the effective period specified herein and after the expiration of a waiting period 10 months. The Company agrees to pay maternity benefits that cover expenses incurred in a Hospital, Inpatient childbirth, and Physician's fees for each pregnancy and child delivery, according to the actual amount but not exceeding the Maximum Benefits per Policy Year as specified in the Benefit Schedule.

Terms and Conditions:

1. The Covered Person must have been covered for Maternity Cover under this Policy for at least ten (10) consecutive months and is a female not under the age of 18.
2. For birth through vaginal delivery and Medically Necessary caesarean section, the Company will pay for the delivery costs up to the limit shown in this benefit in the benefits table. Any complications arising from such delivery, after the delivery of the child, will be paid as per the Agreement from 'Pre- and post-natal complications' benefit.
3. For birth through elective or non-Medically Necessary caesarean section, the Company will pay for the delivery costs up to the costs of a normal delivery. The complications arising from such delivery will be paid up to the remainder of the 'Pregnancy and Delivery' limit.
4. If the Company is not able to determine that a caesarean section is Medically Necessary, it will be considered an elective caesarean section and is not Medically Necessary.
5. This benefit will not automatically be upgraded to a higher level of plan. In the case of an upgrade in cover this benefit will be restricted to the level of the original plan until the female Covered Person has been covered under the upgraded plan for a period of not less than ten (10) consecutive calendar months and has renewed the upgraded plan.

Exclusions

This attachment does not cover benefits for any claims directly or indirectly arising from:

1. The cost of parenting class or other classes relating to pregnancy and childbirth;
2. The cost for treatment that has not yet taken place, even if it is being provided as part of a treatment package;
3. Medical Treatment for pregnancy as a result of assisted means or any form of assisted conception or pregnancy by artificial insemination; and
4. Medical Treatment outside the Area of Cover, even if due to an Emergency.
5. Medical Treatment and costs for home childbirth delivery, Physician/ specialist fees, midwife, home nursing in connection with home delivery unless due to an Emergency.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Extended Endorsement - Section for Personal Health Insurance
Prenatal and Postnatal Complications

Coverage:

While this Policy is in effect and after the expiration of a waiting 10 months, following the inclusion of a Covered Person in this Policy who is insured for Maternity Cover, the Company will pay Medically Necessary, Customary and Reasonable Medical Charges, for Treatment of prenatal and postnatal complications sustained by the Covered Person, not including the childbirth and delivery fees, according to the actual amount, but not exceeding the Maximum Benefits per Policy Year specified in the Benefit Schedule.

Terms and Conditions

1. This Benefit is only available for female Covered Persons over the age of 18 years and applies to the mother alone.
2. The post-natal complications benefit only pays for Treatment received within ninety (90) days following the delivery of child.
3. This benefit will not automatically be upgraded to a higher level of Plan. In the case of an upgrade in cover these benefits will be restricted to the level of the original Plan until the Covered Person has been covered under the upgraded Plan for a period of not less than 10 consecutive calendar months and has effected the annual renewal of the upgraded Plan.
4. This benefit pays for treatment of an eligible medical condition which is due to, and occurs to, the female Covered Person during the pregnancy prior to the delivery or after the delivery of child. The list of eligible pre- and post-natal complications include the following:
   - 4.1 Antiphospholipid syndrome,
   - 4.2 Cervical incompetence,
   - 4.3 Ectopic pregnancy,
   - 4.4 Gestational diabetes (if the Covered Person has exclusions because of past medical history related to diabetes, then this will not be covered during pregnancy),
   - 4.5 Hydatidiform mole – molar pregnancy,
   - 4.6 Hyperemesis gravidarum,
   - 4.7 Obstetric cholestasis,
   - 4.8 Pre-eclampsia / Eclampsia,
   - 4.9 Rhesus (RH) factor,
   - 4.10 Miscarriage requiring immediate surgical treatment
   - 4.11 Post-partum haemorrhage
   - 4.12 Retained placental membrane.

Exclusions

This benefit does not cover for any claims directly or indirectly arising from:

1. pre- and post-natal complications if the pregnancy was a result of assisted means or any form of assisted conception or elective/non-Medically Necessary caesarean section birth.
2. costs of delivery of any child whether such delivery is by normal, by caesarean section or by any other assisted means.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Additional Endorsement: Section for Personal Health and Accident Insurance

While this Policy is in force and subject to general terms and conditions under this additional endorsement attached to the Policy, if the Covered Person sustains injury from an Accident or Illness after the waiting period, which requires medical Treatment, the Company will pay expenses for the Medically Necessary, Customary and Reasonable Medical Charges, within the Medical Standards up to the actual medical expenses but not exceeding the Maximum Benefits per Policy Year as stated in the Benefit Schedule in respect of this additional endorsement, as follows:

Additional Endorsement: Section for Personal Health and Accident Insurance Hospice and Palliative Care

Insuring Agreement:

While this Policy is in effect and after the expiration of a waiting period 12 months from the Policy commencement date or the date when a Covered Person is included under this Policy, 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, that his or her Injury or Illness reaches its terminal stage and can no longer have Treatment which will lead to his/her recovery. The Company's pre-authorisation is required in writing and in advance prior to the Covered Person's admission. To receive benefit payment, the Covered Person must continue to renew this Policy every year, without decrease in the benefits.

The following Hospice and palliative care services would be covered:

1. Hospital or hospice accommodation
2. nursing care
3. prescribed medicines
4. physical, psychological, and social care

If there is any upgrade 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 twelve (12) months after the change.

Additional Endorsement: Section for Personal Health and Accident Insurance
International Medical Emergency Assistance Service

Additional Definitions:

Designated Physician	means	a Physician designated by the Company to provide advice on the Covered Person's Medical Condition, appropriateness, whether it is Medical Necessary and related to the Medical Treatment of the Covered Person in the country in which the Covered Person receives Medical Treatment.
Emergency Assistance Service Center	means	an office or organization appointed by the Company to be its representative to assist a Covered Person who sustains an Illness or Injury while travelling outside Thailand, according to the service the Company agrees to provide to the Covered Person as specified in the Policy.
Emergency Assistance	means	the evacuation of a Covered Person to another Hospital that has medical equipment, either in the country, or in another country near the country in which the Covered Person sustains an Injury or Illness, or the repatriation of the Covered Person to his or her Main Country of Residence.
Home Country	means	the country that the Covered Person has declared to the Company as his or her domicile, from which the Covered Person holds a passport.

Insuring Agreement

While this Policy is in effect, if a Covered Person sustains an Illness or an Injury from Accident that necessitates an immediate Treatment as an Inpatient in a Hospital, the Company will pay expenses for the international Emergency Assistance Service as described below.

1. The Emergency Assistance Service will be operated by an international Emergency Assistance Service Center that provides this service on behalf of the Company.
2. The Emergency Assistance Service can be provided in the following situations:
   2.1 the Covered Person is hospitalized as an Inpatient while travelling outside his or her Main Country of Residence, and the Designated Physician is of the opinion that a medical care that is appropriate or adequate for her or her Medical Treatment is not available or
   2.2 the Covered Person is hospitalized as an Inpatient while traveling in his or her Main Country of Residence, and the Designated Physician is of the opinion that a medical care that is appropriate or adequate for his or her Medical Treatment is not available.
   2.3 after the Emergency Assistance Service under 2.1 or 2.2 is provided and when the Covered Person can be discharged from the Hospital, the Company will pay expenses for repatriating the Covered Person to his or her Main Country of Residence by a regularly scheduled commercial airline or any other mode of transportation the Company considers appropriate.

   The Company will not repatriate the Covered Person to his or her Home Country if the Covered Person is treated in a Hospital in the Main Country of Residence.

   The Company has the right to decide whether to use a regularly scheduled commercial airline or another mode of transportation, as the Company considers appropriate, including the date and time of repatriation of the Covered Person.

   The Company will cover the costs of repatriating the Covered Person if the Company have agreed to cover the Emergency evacuation. The Company will not cover the cost of evacuating or repatriating the Covered Person, if the Covered Person decides to travel elsewhere for Treatment and the Emergency Assistance Service Centre believes the nearest medical facilities are adequate for the Covered Person's Treatment. This includes if the Covered Person decides to travel back to the Main Country of Residence for the treatment.
3. If the Designated Physician is of the opinion that the Covered Person who is under the age of 18 must be accompanied by a person who is at least 18 years old during a journey, jointly with the Emergency Assistance Service Center, the Company will pay Customary and Reasonable Medical Charges for the travelling and accommodation of the accompanying person during an Emergency evacuation of the Covered Person who is under the age of 18 until the Emergency evacuation is completed. The Company will not cover the accompanying person's further costs once the Covered Person reaches the evacuation destination.

4. If the Designated Physician is of the opinion that it is medically necessary for the Covered Person to be accompanied by a person who is at least 18 years old during a journey, jointly with the Emergency Assistance Service Center, after completion of the Emergency evacuation, the Company will pay expenses for the traveling of the accompanying person back to his or her Main Country of Residence that is not the Home Country by a regularly scheduled commercial airline. The accompanying person must be related to the Covered Person, such as a family member of the Covered Person under the same policy, or his or her spouse, sibling, or parent.
5. If the Covered Person dies while he or she is in a foreign country, the Company will pay expenses for repatriating the mortal remains (i.e. transporting the body back to a port or airport) to the Covered Person's Main Country of Residence or Home Country. The relevant exclusions for Emergency evacuation and repatriation also apply to repatriation following death.
6. The Company will not be responsible for any delay or inability to provide the Emergency Assistance Service, provided that the delay or inability is not caused by negligence on the part of the Company, the Emergency Assistance Service Center, or the Company's representative.
7. The Company will not be responsible for any delay or inability to provide the Emergency Assistance Service due to any of the following events:
    7.1 the Emergency Assistance Service is prohibited by the law of the country in which the service is about to be provided or
    7.2 the delay or inability to provide the Emergency Assistance Service is due to an external factor beyond the control of the Company, such as riot, failure of aircraft, flight delay, or denial of visa and
    7.3 The Company will not be responsible for the death of the Covered Person during the provision of an Emergency evacuation service, unless the death is due to failure or negligence on the part of the Company, or an agent providing the service on behalf of the Company, or is covered under the insuring agreement for loss of life, dismemberment, loss of sight, loss of hearing, loss of speech, or permanent disability from Accident.
8. The entitlement to the service does not mean that Treatment following evacuation or repatriation will be eligible for benefit. The benefits for medical expenses of the Covered Person after the Emergency evacuation will be in accordance with the terms and conditions applicable to his or her selected plan

Request for Emergency Assistance Service while the Covered Person is outside his or her Main Country of Residence

1. If the Covered Person sustains an Illness or Injury while he or she is outside the Main Country of Residence, the Covered Person must contact the Emergency Assistance Service Center.
2. The Emergency Assistance Service Center will evaluate the situation and give advice if it is necessary to evacuate the Covered Person.
3. If it is necessary to evacuate the Covered Person, the Emergency Assistance Service Center will coordinate the evacuation of the Covered Person to a nearby suitable place for the Covered Person to receive Medical Treatment under his or her insurance plan.
4. If the Covered Person is under the age of 18, or the Emergency Assistance Service Center considers it appropriate, the Covered Person can have a person who is at least 18 years old accompany him or her during the Emergency evacuation service.

Request for Emergency Assistance Service while the Covered Person is in his or her Main Country of Residence

1. If the Covered Person sustains an Illness or Injury while he or she is in the Main Country of Residence, the Covered Person must contact the Emergency Assistance Service Center.
2. The Emergency Assistance Service Center will evaluate the situation and give advice if it is necessary to evacuate the Covered Person to a Hospital that is medically equipped.
3. If it is necessary to evacuate the Covered Person, the Emergency Assistance Service Center will coordinate the evacuation of the Covered Person to a nearby Hospital or country that is medically equipped.
4. After the Covered Person is evacuated to a medically equipped facility, the Covered Person will receive Medical Treatment under his or her insurance plan.
5. If the Covered Person is under the age of 18, or the Emergency Assistance Service Center considers it appropriate, the Covered Person can have a person who is at least 18 years old accompany him or her during the Emergency evacuation service.

If the Covered Person dies while he or she is outside the Main Country of Residence:

His or her family must contact the Emergency Assistance Service Center in order to repatriate the mortal remains of the Covered Person to the Main Country of Residence or Home Country.

The Emergency Assistance Service Center will evaluate the necessity of the Emergency Assistance Service and manage the evacuation as suitable for the provision of service.

The Emergency Assistance Service does not cover the Covered Person's entitlement to Medical Treatment. The entitlement to Medical Treatment will be in accordance with the terms and conditions under the Covered Person's insurance plan.

Exclusions:

This benefit does not cover any claims directly or indirectly arising from:

1. any Medical Conditions that do not necessitate an immediate Medical Treatment in a Hospital as an Emergency Inpatient Treatment, or do not prevent the Covered Person from traveling or continuing to work
2. the medical condition is directly or indirectly caused by a deliberately self-inflicted injury, suicide or an attempt at suicide
3. the medical condition is in any way connected with alcohol abuse, drug abuse or substance abuse
4. the medical condition is a result of engaging in or training for any sport for which you receive a salary or monetary reimbursement, including grants or sponsorship (unless you only receive travel costs)
5. the Covered Person's engagement in base jumping, cliff diving, wingsuit jumping, piloting an aircraft not registered for carrying passengers and operated as a commercial aircraft, aircraft piloting instruction, aircraft piloting course, martial arts, free climbing, bouldering, hiking, mountaineering with or without ropes, diving at a depth of more than ten (10) meters, trekking or mountain climbing over two thousand five hundred (2,500) meters above sea level, bungee jumping, canyoning, rappelling, gliding, paragliding, piloting a small plane, microlighting, parachuting, potholing, cave climbing, cliff skiing, skiing off piste, or any winter sports involving cliff jumping or carried out of piste.
6. an evacuation of the Covered Person from a vessel, oil rig, or any offshore facility
7. any expenses without the consent of the Company, including an Emergency evacuation arranged or undertaken by the Covered Person himself or herself without the consent of the Company
8. any services that the Covered Person fails to report to the Company within 30 days from the date of occurrence of the Injury or Illness becoming an Emergency (unless this was not reasonably possible)
9. the Medical Condition is a result of nuclear, biological or chemical contamination, war (whether declared or not), act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons or any event similar to one of those listed and
10. while the Covered Person travels in a country or area listed as a prohibited area by the ministry of foreign affairs of that country, the Government or any Regulatory Department in the principal country of residence

Additional Endorsement: Section for Personal Health and Accident Insurance
Medical Treatment without Hospital Confinement (Admission) (Outpatient treatment)

Coverage:

While this Policy is in effect, if a Covered Person is included under this Policy for this benefit and sustains an Injury from an Accident or an Illness that necessitates treatment by a Physician, the Company agrees to pay the benefits for Medical Treatment as an Outpatient to the Covered Person according to the actual amount or the limit of liability per day, but not exceeding the Maximum Benefits per Policy Year according to the entitlement as specified in the Benefit Schedule, whichever is less and subject to both Annual Deductible and Co-payment where applicable. This coverage includes the following.

1. Physician's fees

1.1 The Company will pay the benefits for Medical Treatment as an Outpatient to the Covered Person who is treated by a Physician as a result of an eligible Injury or Illness, but no more than the actual amount paid, or the Maximum Benefits per Policy Year specified in the Benefit Schedule, as well as for the diagnosis by a Physician in order to obtain a second opinion. However, the Covered Person must obtain the prior consent of the Company for each of the diagnoses to be sought for the purpose of obtaining opinions from subsequent Physicians.

1.2 Fees for other examinations and tests, such as a laboratory test, pathology, radiology (X-rays), ultrasound scans.

1.3 Advanced Medical Imaging (Magnetic Resonance Imaging (MRI), Computed Tomography (CT), and/or Positron Emission Tomography (PET), performed on the advice of a Specialist. A copy of the medical referral will be required, and this will include one consultation only to obtain the results of the diagnostic test.

1.4 Prescribed Outpatient medication and dressings for the treatment of a confirmed diagnosis or medical condition up to 30 days within the period of cover. For any Prescribed Medication required for a period of more than 30 days are subject to compulsory pre-approval by the Company.

2. For the treatment by a Chiropractor, acupuncturist, homeopath, osteopath, traditional Chinese Physician, Podiatrist, Dietician, Nutritionist, the Covered Person must obtain Pre-authorization from the Company before receiving the therapy or treatment, and the therapy or treatment must be performed by a person licensed to practice in the field of the therapy or Treatment received by the Covered Person. All Treatment must be under the supervision and control of the Covered Person's attending Physician/ Specialist Physician who has conducted examination and diagnosis and planned the course of Treatment that clearly specifies the duration and the expected outcome of the Treatment. The Covered Person should obtain a non-contradiction for the use of such alternative treatment from the treating Physician / Specialist Physician.

3. Prescribed Physiotherapy

Treatment must be given by a qualified practitioner who is recognized by the Company and registered to practice in the location where the Treatment is given. Treatment given by a physiotherapist must be under the medical supervision of a Physician / Specialist Physician. Medical supervision means that the reason for referral, where applicable, has been initiated by the Physician / Specialist Physician who has defined a diagnosis. There must be a clear Treatment plan from the physiotherapist with an end point and expected outcome. A copy of the medical referral letter will be required. After the fifth (5^{th}) session, if the Covered Person requires more physiotherapy sessions, the Covered Person must obtain Pre-authorization from the Company and the Company reserves the right to request another medical referral letter from the attending Physician / Specialist Physician.

Exclusions:

This attachment does not cover benefits for any claims directly or indirectly arising from:

1. Any complications from alternative treatment.
2. More than one (1) visit or session per day.
3. Home visits.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Additional Endorsement: Section for Personal Health and Accident Insurance Dental Care

Additional Definitions:

Dentisty	means	examination, diagnosis, curing, or treatment of diseases, disorders and conditions of the teeth, organs related to teeth, dental organs, intraoral organs, jaw and maxillofacial bone, including surgical or any other procedures for the purpose of curing, restoring, and rehabilitating intraoral organs, jaw and maxillofacial bones, as well as intraoral dental services.
Dentist	means	a person (other than the Covered Person, or his or her family member) who is qualified as a dentist with a degree in dentistry, duly licensed and registered with the relevant statutory dental board or council in the country where the dental treatment is provided.

Coverage:

It is agreed that, while the Policy remains in effect and after the expiration of a waiting period 6 months (applies to Major restorative Dental Treatment only), the Policy will extend its dental care coverages and benefits subject to Annual Deductible and Co-payment where applicable.

The Company agrees to pay dental care benefits following the inclusion of a Covered Person who is insured for this benefit and requires treatment performed by a Dentist as a result of dental disease diagnosis, according to the actual expenses necessarily and reasonably incurred, but not exceeding the Maximum Benefits per Policy Year specified in the Benefit Schedule. This benefit covers:

1. teeth polishing and scaling (twice per policy year)
2. tooth fillings (standard amalgam or composite)
3. oral examination
4. dental x-rays
5. dental extraction (excluding wisdom tooth extraction or surgical removal)
6. complex dental extraction (e.g. wisdom teeth extraction or surgical removal)
7. apicectomy (molars, pre-molars)
8. removal of impacted, buried or unerupted teeth
9. removal of roots
10. root canal treatment
11. bridgework and crowns
12. inlays and onlays and
13. treatment of gum disease.

Remarks

- No.1-5 means Routine Dental Treatment
- No.6-13 means Major restorative Dental Treatment

Exclusions:

This attachment does not cover benefits for any claims directly or indirectly arising from:

1. expenses for mouthwashes, fluoride products, toothpastes
2. expenses for mouth guards, gum shields, or any dental appliances
3. a treatment by means of burial of any artificial device (including dental implants), oral preparation before burial of artificial device or before crowning;
4. teeth whitening;
5. orthodontics;
6. a request for treatment or dental Surgery that is not advised by a Dentist, any medical service not necessary for a treatment, including any treatment or cosmetic Dentistry for beauty only, and not for restoration of normal function of organs or for oral hygiene;
7. oral and maxillofacial surgical procedures or any treatment by an oral maxillofacial specialist;
8. not performed by a general Dentist
9. treatment, repair, or any Dentistry services relating to tooth jewellery

10. Dentistry treatment due to damage or an Injury arising from playing, training, or competing in contact and collision sports, such as boxing, martial arts, rugby, American football, hockey, or lacrosse, unless mouth protection is worn according to the type of the sports or sporting activity, and
11. expenses for all kinds of veneer, orthotics and prostheses, including dentures or any dental prosthetics.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Additional Endorsement: Section for Personal Health and Accident Insurance
Surgical Medical Implants/ Prosthetic Implants

Coverage:

It is agreed that during the effective period specified herein and after the expiration of a waiting period (Not applicable). The Company agrees to pay benefits according to the actual expenses necessarily and reasonably incurred for Surgical Medical Implants/ Prosthetic Implants subject to verification that such medical implants are FDA approved, used for its intended purpose and proven to be effective (not under clinical trial, assessment or research nature), but not exceeding the Maximum Benefits per Policy Year specified in the Benefit Schedule.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Additional Endorsement: Section for Personal Health and Accident Insurance Parental accommodation expenses

Coverage:

It is agreed that during the effective period specified herein and after the expiration of a waiting period (Not applicable). The Company agrees to pay benefits according to the actual expenses necessarily and reasonably incurred for Parental accommodation expenses for one parent to stay in the same room while a dependent child who is a Covered Person under the age of 18 is receiving Treatment for an eligible Medical Condition in a Hospital within the Area of Cover, which will be paid by the Company under the child's benefits and coverage, but not exceeding the daily limit, maximum number of days and Maximum Benefits per Policy Year specified in the Benefit Schedule.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Additional Endorsement: Section for Personal Health and Accident Insurance Nursing at home or convalescent home

Coverage:

It is agreed that during the effective period specified herein and after the expiration of a waiting period (Not applicable). The Company will cover the Customary and Reasonable Medical Charges for home nursing or in a convalescent home services subject to the per Lifetime limit as stated under the plan in the Benefit Schedule, when the Company has accepted a claim under Inpatient Treatment above, subject to Pre-Authorization and that it meets all the following criteria:

1) prescribed by the Covered Person's treating Specialist Physician
2) starts immediately upon the Covered Person's discharge from Hospital
3) nursing care provided by one (1) qualified nurse per day, where the nurse is needed to provide medical care, not personal assistance.

Exclusions:

This attachment does not cover benefits for any claims directly or indirectly arising from:

- nursing care where provided by a nurse who usually lives with the Covered Person, or who is a member of the Covered Person's family.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Additional Endorsement: Section for Personal Health and Accident Insurance
Artificial Limbs

Coverage:

It is agreed that during the effective period specified herein and after the expiration of a waiting period (Not applicable). The Company will cover charges as provided under the specific plan in the Benefit Schedule the cost associated with fitting artificial limbs, including the artificial limbs, its maintenance, consultations and necessary medical or surgical procedures. This benefit is only payable following a Surgery or an Accident for an eligible Medical Condition provided that the Covered Person has been continuously covered under the Policy since before the Accident or Surgery happened.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Additional Endorsement: Section for Personal Health and Accident Insurance Medical Aids and Durable Medical Equipment

Coverage:

It is agreed that during the effective period specified herein and after the expiration of a waiting period (Not applicable). The Company will cover charges as provided under the specific plan in the Benefit Schedule for instruments, devices or durable medical equipment which are prescribed by the Physician when it immediately follows a Covered Person's eligible Inpatient, Day-care or Emergency ward Treatment under the Policy. These appliances, devices and durable equipment such as and limited to the items listed below must be Medically Necessary as an aid to the function or capacity of the Covered Person:

1. abdominal binder,
2. post-surgical mastectomy bra
3. compression stocking
4. hearing aids
5. speaking aids (electronic larynx)
6. wheelchairs
7. crutches
8. corrective splint
9. air boots
10. arm sling
11. brace

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Additional Endorsement: Section for Personal Health and Accident Insurance
Emergency treatment outside Area of Cover

Coverage:

It is agreed that during the effective period specified herein 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 thirty (30) days per trip and within the Maximum Benefits per Policy Year which includes Treatment required in the event of an Accident, or the sudden illness which presents an immediate threat to the Covered Person's health. Treatment by a Physician, or Specialist Physician must commence within twenty-four (24) hours of the Emergency event and require inpatient treatment. Cover is not provided for any curative or follow-up non-Emergency Treatment nor does it cover charges relating to maternity, pregnancy, childbirth or any complications of pregnancy or childbirth.

Please advise contact the Company if the Covered Person is moving outside Area of Cover for more than thirty (30) days.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Exclusions:

This Policy does not cover benefits for any claims directly or indirectly arising from:

1. special nurse care, unless with the written consent of the Company and in accordance with the Medical Standards.
2. any charges which are incurred for social or domestic reasons or for reasons which are not directly connected with Treatment.
3. When the Covered Person is admitted as an Inpatient if these Treatments are purely for the convenience of the Covered Person or the Physician and can be reasonably rendered in an Outpatient setting.
4. Inpatient Hospice and Palliative Care.
5. Treatment for any Medical Condition if a member has travelled outside his Area of Cover to get treatment (whether or not that was the only reason) or for any Treatment which was, or may have reasonably been known about, before travel commenced.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Additional Endorsement: Section for Personal Health and Accident Insurance
No Claim Discount In case of Good Claim Record

Coverage:

It is hereby agreed that during the period of this Policy being in force, while this insurance Policy is effective after the waiting period has passed.

In the conclusion of compensation claims under this insurance Policy (A full period of 1 year or more) , if the Company has not paid claim for compensation under the insurance agreement during the preceding full year of insurance, and the Insured has renewed the Policy of the previous policy, the Company will reduce the premium to the Insured as 5% of the renewal premium provided there has been no requests for compensation under the insurance agreement during the preceding full year of insurance.

The Company will reduce the premium only when the Insured has renewed the insurance policy with the Company and only for the coverage agreements that have been renewed.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Additional Endorsement: Section for Personal Health and Accident Insurance Annual Deductible

Additional Definitions:

Deductible	means	the amount of covered charges 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 within a Policy Year.

Coverage

It is agreed that during the effective period specified herein, while the Policy remains in effect and the waiting period has lapsed, the Policy will include an additional annual Deductible condition. The Company agrees to pay benefits to the Covered Person according to the Deductible conditions.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Additional Endorsement: Section for Personal Health and Accident Insurance Co-Payment

Additional Definitions:

Co-Payment	means	liability shared between the Company and the Covered Person for medical expenses payable pursuant to a benefit amount after the deduction of any Deductible. The Covered Person's Co-payment will be determined in terms of an amount per time, or an amount for a single Illness, or a percentage as specified in the Policy of the covered expenses as specified in the Benefit Schedule.

Coverage:

It is agreed that during the effective period specified herein, while the Policy remains in effect and the waiting period has lapsed, the Policy will include an additional Co-payment condition. The Company agrees to pay benefits according to the Co-payment conditions.

If anything contained in this endorsement is in contrary to the Policy, the terms under this endorsement will supersede. All other terms, conditions and exclusions remained unchanged.

Summary of Terms and Conditions
SwitchCare 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

<table>
<tr><th>Benefits</th><th>Sum Insured (Baht)</th><th>Maximum (Days or Times)</th><th>Maximum Sum Insured (Baht)</th></tr>
<tr><td colspan="4">1. Inpatient Benefits</td></tr>
<tr><td>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.</td><td colspan="3" rowspan="15">as specified in the policy documents</td></tr>
<tr><td>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</td></tr>
<tr><td>Sub-article 2.1 Medical fee for examination</td></tr>
<tr><td>Sub-article 2.2 Medical fee for treatment, blood and blood component service fee, and nurse service fee</td></tr>
<tr><td>Sub-article 2.3 Medicine fee, parenteral nutrition fee and medical supplies fee</td></tr>
<tr><td>Sub-article 2.4 Medicine fee and disposable supplies fee (Medical Supplies 1) for take away</td></tr>
<tr><td>Article 3: Physician's examination fee (Physician) for each policy year</td></tr>
<tr><td>Article 4: Operation (surgery) and procedure fee for each policy year</td></tr>
<tr><td>Sub-article 4.1 Operating room fee and procedure room fee</td></tr>
<tr><td>Sub-article 4.2 Medicine fee, parenteral nutrition fee, medical supplies fee, and surgery and procedure fee</td></tr>
<tr><td>Sub-article 4.3 Physician's fee for Physicians performing surgery and procedure (including assistant) (Physician fee)</td></tr>
<tr><td>Sub-article 4.4 Physician's fee for anesthetist (Physician fee)</td></tr>
<tr><td>Sub-article 4.5 Medical fee for organ transplantation</td></tr>
<tr><td>Article 5: Day surgery</td></tr>
<tr><td colspan="4">2. Non-Inpatient Benefits</td></tr>
<tr><td>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</td><td colspan="3">as specified in the policy documents</td></tr>
</table>

Benefits	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	as specified in the policy documents		
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			
3. Congenital Condition			
Personal Accident Insurance Section			
1. Cost of Dental Service due to an Accident	as specified in the policy documents		
2. Loss of Life, Dismemberment (PA.2)			
Endorsement: Personal Health Insurance			
1. Treatment for AIDS / HIV	as specified in the policy documents		
2. Inpatient Psychiatric Treatment			
3. Health Check-Up			
4. Vaccinations			
5. Optical Care			
6. Maternity Normal (Routine) Pregnancy and Delivery			
7. Prenatal and Postnatal Complications			
Additional Endorsement: Personal Health and Accident Insurance			
1. Hospice and Palliative Care	as specified in the policy documents		
2. International Medical Emergency Assistance Service			
3. Dental Care			
4. Medical Treatment without Hospital Confinement (Admission) (Outpatient treatment)			
5. Surgical Medical Implants/ Prosthetic Implants			
6. Parental accommodation expenses			
7. Nursing at home or convalescent home			
8. Artificial Limbs			
9. Medical Aids and Durable Medical Equipment			
10. Emergency treatment outside Area of Cover			
11. No Claim Discount In case of Good Claim Record			
Deductible	as specified in the policy documents		
Co-Payment	as specified in the policy documents		

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.

AXA Nationwide Network

AXA Insurance Public

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