Policy Guide

Luma PRIME

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Disclaimer: This Policy Guide is the mere English translation of the original Policy Wording. The original Thai Policy Wording is the only legally binding version.

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According to the declaration provided in the application form which is part of this Insurance Policy; and in return of the premiums that the Insured must pay under the General Terms and Conditions, General Exclusions, Insuring Agreements and Extended Clauses of this Policy, the Company offers the following Insurance Agreement:

Section 1: Definition

Words or expressions to which specific meanings have been attached in any part of this Insurance Policy shall bear the same meaning wherever they shall appear, unless otherwise specified.

1. The COMPANY	refers to	the company that issued this Insurance Policy [The Navakij Insurance Public Company Limited].
2. POLICY	refers to	the Policy Schedule, Table of Benefits, General Terms and Conditions, General Exclusions, Insuring Agreements, Extended Clauses, Application Form, Renewal Insurance Certificate, Special Terms, Endorsements and Summary of the General Terms and Conditions, Insuring Agreements and General Exclusions of this Insurance Policy, which are all part of this Insurance Agreement.
3. The INSURED	refers to	the person named as insured in the Insurance Policy Schedule or the Insurance Application Form and/or the Renewal Insurance Certificate and/or Insurance Policy Endorsements (if any).
4 DEPENDENTS	refers to	any dependent(s) of the Insured who are listed in the Insurance Policy Schedule as insured as follows: 1) SPOUSE OF THE INSURED or the person who lives with the Insured under a spousal relationship. The Insured can only have one Spouse whose age must be not more than **70** years upon the first Insurance Policy start date of the Spouse. 2) CHILDREN refer to the children of the insured, adopted children, stepchildren, children under custody, and any other children who rely on sole support from the Insured and lives with the Insured in a parent-child relationship. The children must not be older than **25** years old, not yet married and still studying.

5. COVERED PERSONS	refers to	the Insured and/or Dependent(s) of the Insured who are listed in the Insurance Policy Schedule.
6. ACCIDENT	refers to	a sudden event from an external cause leading to consequences that the Covered Person did not intend or expect.
7. INJURY	refers to	a body injury caused directly and solely from an accident and is independent from other causes.
8. ILLNESS	refers to	the symptoms and/or disorders of the body as a result of a disease.
9. DOCTOR	refers to	a person who has obtained a Doctor of Medicine degree and has a professional license in the branch of medicine to practice under the local laws where they operate.
10. SPECIALIST (Other than the treating doctor)	refers to	a Doctor who has obtained a diploma or certificate in a particular field from the General Medical Council or equivalent institution under the local laws where they operate. The Specialist, who must not be the Treating Doctor, is the Doctor who consults or treats the Patient in collaboration with the Treating Doctor.
11. DENTIST	refers to	a person who has obtained the Doctor of Dentistry degree and has a professional license to practice dentistry under the local laws where they operate.
12. NURSE	refers to	a person who has obtained a license to practice nursing profession under the local laws where they operate.
13. MEDICAL FACILITIES	refers to	places designated for practicing medical profession and public health under the local laws where they operate.
14. HOSPITAL	refers to	any medical facility which provides medical services, which can receive patients overnight or treat diseases or injuries continuously 24 hours a day and is licensed or registered to operate as a "hospital" under the local laws where they operate.
15. CLINIC	refers to	any medical facility which provides medical services without being able to accept patients overnight and is authorized or registered to operate as a "clinic" under the local laws where they operate.

16. INPATIENT	refers to	a Patient who needs to be admitted at a hospital or a medical facility as a registered inpatient for medically necessary treatment following an injury or illness for at least 6 consecutive hours; including where the Patient dies within 6 hours after admission.
17. OUTPATIENT	refers to	a Patient who has been admitted for injury or illness in the outpatient department or in the emergency department of a hospital or medical facility without medical necessity to stay as an Inpatient.
18. MEDICAL TREATMENT	refers to	the provision of medical and public health services for diagnosis, treatment, relief, care and rehabilitation necessary for health and livelihood.
19. MEDICAL STANDARDS	refers to	criteria or guidelines for medical treatment of injury or illness according to the principles under the local standards where these treatments are being applied, as follows: (1) Professional standards and related professional regulations (2) Healthcare Standards (3) Pharmaceutical and medical device standards (4) Principles of Patient non-discrimination
20. MEDICALLY NECESSARY	refers to	the need for medical services or other services of a hospital or medical facility for diagnosis and treatment of injury or illness, according to the following conditions: (1) In accordance with the diagnosis, and treatment according to the state of the illness or injury of the Covered Person. (2) In accordance with Medical standards. (3) Not primarily for the convenience of the Covered Person or family of the Covered Person or the medical service provider.
21. CUSTOMARY AND REASONABLE MEDICAL CHARGES	refers to	medical service rates or treatment fees of hospitals or medical facilities where the Covered Person is receiving treatment that shall not be higher than that of other patients who were admitted to the same hospital or medical facility at the same time.
22. ALTERNATIVE MEDICINE	refers to	the treatment of injury or illness by locally licensed medical professionals who provide services in traditional Thai medicine or traditional Chinese

		medicine or chiropractic or other fields outside modern medicine.
23. DEDUCTIBLE	refers to	the first part of the eligible medical expenses that the Covered Person is responsible for paying according to the Insurance Agreement.
24. TERRORISM	refers to	an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.
24. TERRORISM	refers to	an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.
25. POLICY YEAR	refers to	the period of one year from the date that the insurance policy becomes effective or from the anniversary of the insurance policy the following years.
26. INSURANCE FRAUD	refers to	fraudulent claim of benefits under the insurance policy or providing false evidence in claims, including intentionally causing injury or illness to claim compensation.
27. HEALTH INSURANCE CARD	refers to	a card issued by the Company to each Covered Person, whereby the coverage is subject to the Terms and Conditions of the insurance policy.
28. SANATORIUM	refers to	a medical facility that specializes in the treatment of various types of tuberculosis.
29. PREVENTORIUM	refers to	medical facilities for patients who are in a non-contagious phase of tuberculosis.
30. MEDICAL CONDITION	refers to	any disease or illness or injury.

31. EMERGENCY	refers to	a sudden, severe, unforeseen acute medical condition or injury requiring immediate medical treatment, that without treatment commencing within 48 hours of the Emergency event could result in death or serious impairment of bodily function.
32. COUNTRY OF RESIDENCE	refers to	the country in which the Covered Person normally resides, for a period of no less than **180** days per period of coverage, from the Start Date of the Policy or at each subsequent renewal date of the Policy.
33. THE COUNTRY OF ORIGIN	refers to	the country of nationality/citizenship, as stated in the insurance application form.

Section 2: General Terms and Conditions

1. Insurance Agreement

This Insurance Agreement is based upon the Company's trust of the declaration from the Covered Person in the application form, and additional declarations (if any), that the covered person has signed as evidence of accepting insurance coverage according to the Insurance Agreement; the Company thereby issues this Insurance Policy.

In the event that a Covered Person knowingly falsely declare according to the first paragraph or conceal the truth without informing the Company, the Company when aware of the true facts, may decide to increase the premium level or void the Policy. As per clause 865 of the Civil and Commercial Code, the Company can void the policy.

The Company cannot deny acceptance of responsibility by using declarations outside what the Covered Person has declared according to the first paragraph.

2. Incontestability of Insurance Agreement

The Company will not contest or challenge the validity of this Insurance Policy while: The Covered Person has been alive for 2 years from the start date of this Policy; or This Policy has been in force for two years or more from the first day this Insurance Policy becomes effective; or on the date the Company approves to increase the benefits of this Insurance Policy; whichever occurs later. In case the Company approves to increase the benefit, the Company will only contest or challenge the validity of this Insurance Agreement only on the part of the increased benefit.

In the event the Company becomes aware of information that entitles the Company to void this Insurance Policy according to the first paragraph but did not exercise the right to void within one month (1 month) from the date the information is known, the company may not void the Insurance Policy.

The Company will not contest or challenge the validity of this Insurance Agreement using facts outside the declaration in the application form, in accordance with paragraphs one and two.

The Company will not contest or challenge the validity of this Insurance Policy in the event the Covered Person is injured from an accident. The Company will pay benefits under this Insurance policy as per the notification for reimbursement according to this Insurance Policy; and when the Company approves to pay the benefits for a forementioned accident, the Insurance Policy will terminate from the day after the right for reimbursement commences under this Insurance Policy. The Company will return the premiums proportionally to the insured by deducting premium only on the part of the insuring agreement that was used to pay for the injury, according to the period where the cover was given. For the coverages that were not eligible for cover, the company will refund the full premiums.

3. Completeness of Insurance Agreement and Insurance Agreement wording amendments

This Insurance Policy, including the Insuring Agreements and Extended Clauses constitute the Insurance Agreement. Any wording changes in the Insurance Agreement must be approved by the Company and recorded in this Insurance Policy or Extended Clause, in order to be complete.

4. Premium Payment and Commencement of Coverage

4.1 Annual Insurance Premium payment

4.1.1 Annual Insurance Premium payment will be due immediately or before coverage is initiated by the Insured, and coverage will be effective on the date specified in the Insurance Policy Schedule and/or Renewal Insurance Certificate.

4.1.2 Insurance Premium payment in the renewal year must be paid within 31 days from the date the Insurance Policy Year ends as specified in the Insurance Policy Schedule, and the Company shall not exercise their right to contest the validity of this Insurance Agreement nor restart the terms for pre-existing conditions and waiting periods (if any).

4.1.3 If the Insured does not pay the Insurance Premium for the renewal year within the specified time, it shall be deemed that the Insured does not wish to renew the Insurance Policy and the coverage under this Insurance Policy shall be terminated from the expiry date of the previous Insurance Policy as specified on the Insurance Policy Schedule.

4.2 Insurance Premium Payments by Installments for …. consecutive months. (Can specify 2,3,4,5 or 6)

4.2.1 Insurance Premium payment of the first installment will be due immediately or before coverage is initiated by the Insured, and coverage will come into effect on the date as specified in the Policy Schedule and/or renewal Insurance certificate.

4.2.2 Premiums for the next installment must be paid within 31 days from the date the Insurance Policy Year ends as specified in the Insurance Policy Schedule, and the Company shall not exercise their right to contest the validity of this Insurance Agreement nor restart the terms for pre-existing conditions and waiting periods (if any).

If the Company is unable to collect the aforementioned Insurance Premiums, the coverage under this Insurance Policy will be terminated on the last day of the coverage which the premium has been paid for.

4.3 Insurance Premium Payments by Installments for every …. months. (Can specify monthly, 3 months or 6 months)

4.3.1 Insurance Premium payment of the first installment will be due immediately or before coverage is initiated by the Insured, and coverage will come into effect on the date as specified in the Policy Schedule and/or renewal Insurance certificate.

4.3.2 Premiums for the next installment must be paid within 31 days from the date the Insurance Policy Year ends as specified in the Insurance Policy Schedule, and the Company shall not exercise their

right to contest the validity of this Insurance Agreement nor restart the terms for pre-existing conditions and waiting periods (if any).

If the Company is unable to collect the aforementioned Insurance Premiums, the coverage under this Insurance Policy will be terminated on the last day of the coverage which the premium has been paid for.

4.4 In the event of a benefit claim within the grace period and where the Company has not received the insurance premiums, the Company will deduct the insurance premium amount equivalent to the insurance premium that has not been paid for that Insurance Policy Year from the amount of benefits to be reimbursed under this Insurance Policy and pay the remaining benefits to the Insured or the Beneficiary (in case of death).

5. Misdeclaration of Age or Gender

If the declaration of Age or Gender of the Covered Person has been mis-declared, resulting in the Company receiving a premium less than the premium that should have been received, the amount of benefits the Covered Person will receive according to this Insurance Policy will be equivalent to the coverage corresponding to the paid premium for the correct Age and Gender, if the Age or Gender of the Covered Person is correct. If, based on the correct age or gender, the Covered Person is not eligible to receive cover under this Insurance Policy, the Company will not pay for any benefits and will refund the received premium back instead.

If the company receives an insurance premium exceeding the specified insurance premium, the company will refund the excess insurance premium back to the Insured.

6. Renewal in case of policy anniversary

This Insurance policy may be renewed upon the anniversary of the Insurance Policy until the insured person's age is **99 years**, without the need to show any proof. Nevertheless, if the Company accepts the renewal of this Insurance Policy, the Company reserves the right to:

6.1 Adjust the premium rate in accordance with the increasing age and risk profile of the Covered Person(s), as per the premium rates approved by the Regulator.

6.2 Change underwriting conditions and insuring agreement terms of the Insurance Policy for the renewal year, according to necessity. The Company shall notify the Insured in case of any change or extension of coverage in the terms and conditions, exclusions, insuring agreements, Extended Clauses or other material changes of the Insurance Policy.

6.3 The company reserves the right to not renew the Insurance policy in any of the following scenarios:

> 6.3.1 If there is evidence that the Covered Person did not declare the true facts in the application form, renewal request, health declaration or other additional declarations relating to the health Insurance policy, which are material facts that would have caused the Company to request a higher premium or refuse the Insurance Agreement or accept to insure with conditions.

6.3.2 The Covered Person claims for treatment of injury or illness which are not Medically Necessary.

In case of non-renewal of the Insurance Agreement for the above reasons, the Company must inform the insured in advance in writing by registered mail or any other means by which the insured consents to; not less than 30 days prior to the expiry date of this Insurance Policy as specified in the Insurance Policy Schedule and/or certificate of insurance renewal and/or Extended Clauses (if any).

However, the General Terms and Conditions for renewal in case of insurance policy anniversary under Clause 6 are not applicable for the Insuring Agreement for Inpatient treatments.

7. Premium adjustment

The Company may adjust the premium rate at the anniversary of the Insurance policy, in accordance with the increasing age and risk profile of the Covered Person(s), as per the insurance premium rates approved by the Registrar.

8. Change in Coverage Benefits

Subject to the terms & conditions of this Insurance Policy, if any Covered Person's benefits are adjusted to a higher coverage at the time the Insurance policy is valid or at the renewal year of the Insurance Policy, such change shall be effective on the first day of the subsequent month after acknowledgement of the change of benefits from the insured under the following conditions:

8.1. If the Covered Person sustains Injury or Illness before the increase of benefits, the maximum limit of benefits to be reimbursed for the medical treatment of the Injury or Illness occurring before the increase shall not exceed the original maximum benefit amount before the increase.

8.2. If the Covered Person was already covered for an Injury or Illness under the original benefits including pre-existing conditions before the increase of benefits, the maximum benefit amount to be paid shall not exceed the original benefit amount before the increase.

Furthermore, the Insured shall notify the Company in writing for any change in coverage benefits, with agreement from the Company for such change.

9. Termination of the Insurance Policy

9.1. The coverage for the Insured is terminated if any of the following incidents occur, whichever comes first.

9.1.1. When the insured has not paid the insurance premium within the specified time frame as per **Clause 4 of the General Terms and Conditions** ("Premium Payment and Commencement of Coverage"), the coverage under this Insurance policy will be terminated on the last day of the coverage for which the premium has been paid for

9.1.2. On the date of the expiration of the insurance period as specified on the Insurance Policy Schedule and/or renewal Insurance certificate in the event that the Covered Person age has reached **99** years during the policy year.

9.1.3. When the insured dies from a cause which is not covered by this Policy, or is admitted to prison or correctional facility. The premium shall be returned to the Insured or to the Beneficiary on a pro-rata basis by the Company (depending on the case), unless the Company has paid all benefits in full for the Insurance policy year (if any) as shown in the Policy Schedule and/or renewal Insurance certificate or the benefits table of the Insurance policy.

9.1.4. When the Insured or the Company cancels the Insurance policy according to **Clause 15 of the General Terms and Conditions** ("Cancellation of the Insurance Policy")

9.2 Coverage for each Dependent under this insurance policy will end when one of the following events occurs, whichever comes first.

9.2.1. On the anniversary date of the insurance policy, when a dependent no longer qualifies as a Dependent as per the definition.

9.2.2. When the insurance policy ends in accordance with clause 9.1

9.2.3. When the dependent has not paid the insurance premium within the specified time frame as per Clause 4 of the General Terms and Conditions ("Premium Payment and Commencement of Coverage"), the coverage under this Insurance policy will be terminated on the last day of the coverage for which the premium has been paid for.

9.2.4. When a Dependent dies from a cause which is not covered by this Policy, is admitted to prison or correctional facility. The premium shall be returned to the Insured or to the Beneficiary on a pro-rata basis by the Company (depending on the case), unless the Company has paid all benefits in full for the Insurance policy year (if any) as shown in the Policy Schedule and/or renewal Insurance certificate or the benefits table of the Insurance policy.

9.3 When the Company does not renew this Insurance policy in accordance with **Clause 6 of the General Terms and Conditions** ("Renewal of the Insurance Policy"). The Company must inform the insured in advance in writing by registered mail or any other means by which the insured consents, not less than 30 days prior to the expiry date of this Insurance policy as specified in the Insurance policy table and/or Extended Clause (if any).

9.4 The coverage under this Insurance policy shall terminate when the Company has paid up to the maximum benefit as shown in the Schedule and/or renewal Insurance certificate. The Company will continue to provide coverage for the remaining benefits for which the maximum limit has not been reached and until the end of the Insurance period.

9.5 This insurance policy and all insurance under this insurance policy will end at 24:00 Thailand time on the end date of the insurance policy.

The termination of this insurance policy will not impact any right to claims that exist prior to the termination of this insurance policy. Premium received by the Company after the termination of this insurance policy will not create any liability for the company, but the Company will return such premium.

10. Reinstatement of Insurance policy

Shall the coverage of this Insurance policy end because the insured does not pay the premium within the specified period according to **Clause 4 of the General Terms and Conditions** (Premium Payment

and Commencement of Coverage), the insured may request to reinstate the coverage of this Insurance policy within 90 days from the Insurance premium due date, with prior approval from the Company. Shall the Company consent to this Insurance policy to be effective at the request of the insured, the coverage of this Insurance policy for injury or illness shall resume from the date of approval to renew this Insurance policy onwards. The Company shall not exercise their right to contest the validity of this Insurance Agreement nor restart the terms for pre-existing conditions and waiting periods (if any).

When the Company consents to the reinstatement of the Insurance policy, the insured shall pay the premium of this Insurance policy on a pro rata basis for the period of coverage, from the date the Company has approved the renewal of this Insurance policy.

11. Medical Examination

The Company has the right to check the medical records and diagnostics of the Covered Person(s) as necessary with this Insurance Policy, and has the right to perform an autopsy in case of necessity and when not against the law, at the expense of the Company

In the event that the Covered Person(s) does not consent to the Company checking the medical history and diagnosis for consideration of the payment of the benefits, The Company may refuse coverage under this Insurance Policy to the Covered Person(s).

12. Notifications and Claims

The Covered Person or the Beneficiary or the representative of the Covered Person, as the case may be; must notify the Company of any injury or illness that may lead to a claim for benefits under this Insurance Policy without delay. In the event of a death, the Company must be notified immediately, unless it can be proven that there are reasonable grounds causing the Company not to be notified immediately but is still notified as soon as possible.

13. Proof of Claims

The Covered Person or the Beneficiary or the representative of the Covered Person, as the case may be, must submit all evidence as requested by the Company at their own expense, within thirty days (30 days) from the date of request; in line with what is specified in the additional General Terms and Conditions of the Insuring Agreements or Extended Clauses sections of this Insurance Policy.

Failure to submit evidence within that period does not impair the right to claim if it can be demonstrated that there are reasonable grounds for not submitting such evidence within the specified period of time but is still submitted as soon as possible.

14. Reimbursement of Claims

The Company will pay for claims of benefits or General Service Rates within 15 days from the receipt of completed & correct proof of claims documents. In case of death, the benefit will be paid to the Beneficiary. Other claims will be paid to the Covered Person.

In case of suspicion that the claim may not be in accordance with the Insuring Agreement of this Insurance Policy; the Company has the right to extend the payment date as necessary, but no later than 90 days after the Company received the completed document.

In case the Covered Person has received treatment outside Thailand, the Company shall reimburse the eligible claim amount using the exchange rate of the payment date as shown in the receipt.

If the Company is unable to reimburse the claim within the aforementioned period, the Company will pay 15% in annual interest for the reimbursement amount, starting from the date the payment is due.

15. Cancellation of the Insurance Policy

15.1 In case of annual premium payment

15.1.1 The Company will cancel this Insurance Policy by sending a notice at least 30 days in advance by registered mail to the Insured, at the last address provided to the Company; or by any other means by which the Insured consents, if there is clear evidence to the Company that the Covered Person has committed insurance fraud in order to benefit themselves or others from this insurance. Furthermore, the Company shall not be responsible for claims as a consequence of the aforementioned act.

In such an event, the Company will return the premium to the insured by deducting insurance premiums for the period of time that this insurance policy has already been in force.

In case the insured cancels the insurance policy according to clause 15.1.2 and the Company has paid the maximum benefit amount as per the insurance policy year (if any) and as specified on the Table of Benefits, the Company will not return the premium.

15.1.2 The Insured may cancel this Insurance Policy by giving notice to the Company in writing. The Insured is entitled to an insurance premium refund after deduction of the insurance premium for the period the policy is already in force; as per the short-term premium rate shown in the following table:

15.2 In case of insurance premium payment according to Clause 4.2 of the General Terms and Conditions (Insurance Premium Payments by Installments for… consecutive months) or Clause 4.3 (Insurance Premium Payments by Installments for every … months)

15.2.1 The Company will cancel this Insurance Policy by sending a notice at least 30 days in advance by registered mail to the Insured, at the last address provided to the Company; or by any other means by which the Insured consents, if there is clear evidence to the Company that the Covered Person has committed insurance fraud in order to benefit themselves or others from this insurance. Furthermore, the Company shall not be responsible for claims as a consequence of the aforementioned act.

In such an event, the Company will return the premium to the insured by deducting insurance premiums for the period of time that this insurance policy has already been in force.

In the case of monthly installments, the Insurance Policy will end on the last day of the period of coverage which the premium has been paid for and the Company shall not be liable to return the premium to the Insured.

In case the insured cancels the insurance policy according to clause 15.2.2 and the Company has paid the maximum benefit amount as per the insurance policy year (if any) and as specified on the Table of Benefits, the Company will not return the premium.

15.2.2 The Insured may cancel this Insurance Policy by notifying the Company in writing and the Insured shall be entitled to receive a premium refund after deduction of the premium for the period of coverage that has already been in force. However, in case of monthly installments, the Insurance Policy shall automatically end on the last day of the period of coverage which the premium has been paid for and the Company shall not be liable to return the premium to the Insured.

Short-term premium rate table

Insurance Period (Up to/month)	Percentage of 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

16. Dispute Resolution by Arbitration

In the event of a disagreement, dispute or any demands under this Insurance Policy between the person who is entitled to demand according to the insurance policy and the Company; and the entitled person would like and agree to settle the dispute by arbitration; the Company agrees and allow the case to be judged by arbitration according to the arbitration rules governed by the Office of the Insurance Commission (OIC).

17. Conditions Precedent

The Company shall be liable for reimbursement of claims under this Insurance Policy when the Covered Person, Beneficiary or representative of the said person (depending on the case) have fully complied with the Insurance Agreement and terms of the Insurance Policy.

18. Rights for Cancellation of the Insurance Policy (Free Look Period)

If the Insured wishes to cancel the policy for any reason, the insured can return the Insurance Policy to the Company within 15 days from the date of reception of the policy. The Company will refund

the premium after deducting the actual health checkup expenses and the operating costs of the Company **0** Baht per policy (If applicable) within **15** days from the notification date of the insurance policy cancellation. In the event where the Covered Person has already made a claim, the Insured will no longer be entitled to cancel this insurance policy according to this condition, but the Insured will still have the right to cancel according to Clause 15 ("Cancellation of the Insurance Policy").

19. Change of the Insured

In the event that the Insurance Policy ends due to the death of the Insured or the Insured reaching the age of **99**; the spouse or dependent child may request that the Insurance Policy be effective continuously by requesting to change to become the Insured in this Insurance Policy within 90 days from the end date of the validity of this Insurance Policy.

20. Dependents' rights for insurance application

In the event where the Spouse of the Insured is no longer eligible to this Policy due to divorce or in the event where the Child of the insure exceeds to age of **25** years old or gets married, the Spouse or Child of the insured may apply for the insurance coverage to continue. In such cases, the Company will continue to cover continuously from the original Insurance Policy and the Company will not bring the General Terms and Conditions on pre-existing condition and Waiting Period(s) to start again, with the following conditions.

20.1 The Dependent applies for Insurance Coverage within 90 days from the date of ineligibility as a dependent.

20.2 The amount of benefits does not exceed the original benefit amount.

21. Rights and Duties

21.1 Rights and duties of the Insured / Covered Person

21.1.1 The Covered Person must notify the Company as soon as possible should they change Country of Residence or return to their Country of Origin and plan to reside for more than 180 days per Insurance Policy Year.

21.1.2 If the Covered Person wishes to cancel or not renew the Insurance Policy, the Covered Person must return all Health Insurance Cards to the Company. The Company shall not be responsible or liable for any consequences of improper use of such Health Insurance Cards. The Covered Person shall be responsible to pay all claims and expenses to the Company in case the Health Insurance Card is used after the Insurance Policy has been canceled.

21.2 Rights and duties of the Company

21.2.1 In the event the Covered Person violates any material agreement of this Insurance Policy, the Company may refuse to pay benefits, and request for claims back from the Covered Person in order to compensate for expenses that the Company paid to the Covered Person.

21.2.2 In the event terms and/or conditions of this Insurance Policy is violated, the

Company may choose to allow such a violation for one time only. Nevertheless, such an allowance does not mean the Company has given the right to the Covered Person to violate terms and conditions in future events.

21.2.3 The Company will not pay for any benefits under this Insurance Policy in the event that a Covered Person or person acting on behalf of a Covered Person is found to intentionally report false or fraudulent statements. The Company may void the Insurance Agreement and in the event where the Company has already paid for any benefits, the Company has the right to claim a refund from the Insured or the Covered Person.

22. Governing Law

This insurance policy is governed by and construed in accordance with Thai law.

Section 3: General Exclusions

This insurance does not cover medical expenses or damage caused by Injuries or illnesses (including complications), symptoms or disorders caused by:

1. Injuries sustained while the Covered Person commit a serious crime or while being arrested or evading capture.
2. Injuries that occur while the Covered Person is engaged in motor racing, all kinds of boat racing, horse racing, all kinds of ski racing (including Jet skis), skating competition, boxing, parachuting/skydiving (unless parachuting to save lives), using or racing with a paramotor, parachute, gliding, boarding or descending or travelling in a hot air balloon, bungee jumping, diving with air tanks and underwater breathing equipment.
3. War, invasion, acts on foreign enemies, war-like acts whether declared or not, civil war, revolution, insurrection, civil commotion, population rising against the government, riot, strike, coup, declaration of martial law; or any event which led to the declaration or upholding of martial law.
4. Terrorism caused by acts of force or violence and/or intimidation by a person or any group of persons, whether acting alone, acting on behalf of, or in connection with any organization or any government; for political, religious, ideological or similar purposes; including the intention to cause the government and/or the public or any part of the public to be in a state of fear and panic.
5. Radiation or radioactive transmission from nuclear fuels or from any nuclear waste due to the combustion of nuclear fuel and from any form of nuclear disintegration.
6. Injuries resulting from consequences of the act of the Covered Person
    1) While under the influence of narcotic drugs or substances of harmful nature to the extent of being unable to maintain consciousness; or
    2) While under the influence of alcohol with the level of alcohol in the body at the time of examination equivalent to the blood alcohol level of 150 milligram percent or more, or
    3) While under the influence of alcohol until it is not possible to maintain consciousness in case no measurement was made or not possible to be made.

Section 4: Health Insurance Coverage

Under the rules, General Terms and Conditions, General Exclusions, Insuring Agreements and Extended Clauses of this Policy; and in return of the premiums that the Insured must pay; the Company offers coverage for the following Insuring Agreement, only for which the sum insured is specified in the Benefit Table and/or the Policy Schedule and/or the Renewal Insurance Certificate.

Health Insurance Coverage Section
Additional Definitions

1. Admission for treatment as an inpatient (Per Confinement)	refers to	an admission for treatment as in inpatient or major surgery without requiring an inpatient admission (day surgery) in the Medical Facility per time; and includes an admission for treatment as in inpatient or Major surgery without requiring an Inpatient admission in the Medical Facility no matter how many times for the same injury or illness, and is not yet cured, including related or continuous complications. Admission within 90 days from the last discharge from the Medical Facility is considered the same admission for treatment.
2. Maximum benefit per Insurance Policy Year	refers to	the maximum benefit per Insurance Policy Year in 2 scenarios: (1) In case of Inpatient, medical expenses will be calculated on the first day of inpatient stay that occur in that Insurance Policy Year, regardless of whether the inpatient stay ends within the same Insurance Policy Year or not. (2) In case of Outpatient, medical expenses will be calculated according to the date of medical treatment occurring in that Insurance Policy Year.
3. Major surgery	refers to	the surgery that passes through the body cavity, where general anesthesia or regional anesthesia is required.

4. Minor surgery	refers to	skin level surgery or subcutaneous layer or lining layer using local/topical anesthesia to local areas.
5. Major surgery without requiring an Inpatient admission (Day Surgery)	refers to	major surgery or major surgery replacement procedures or using special treatment tools that can replace major surgery, without needing Inpatient admission in a medical facility.
6. Copayment	refers to	the shared responsibility for eligible medical expenses between the Company and the Covered Person is responsible according to the benefit amount after deducting the amount of deductible (if any).
7. Simple Diseases	refers to	general minor illnesses in 5 disease groups according to ICD-10 classification (1) Upper Respiratory Tract Infection (2) Influenza (3) Acute Diarrhea (4) Vertigo and (5) Other diseases declared by the Company without the appearance of diseases or complications or leads to severe symptoms or illnesses. However, for the Simple Diseases in the 5 disease groups, the Company will not declare more than what is specified in the guidelines announced by the Registrar. The Company will attach the list of Simple Diseases to the individual health insurance policy for the insured; and when there is a change in the list of diseases.
8. Insurance Premium in the renewal year refers to	refers to	the insurance premium in the renewal year in the event of the anniversary of the insurance policy (Renewal) or in the event that the insurance policy reinstatement as approved by the registrar. The aforementioned Insurance Premium in the renewal year will not factor in the copayment and insurance premium discount as per the terms and conditions of Renewal.

Additional Terms & Conditions (applicable only to Health Insurance Coverage Article)

1. Pre-existing condition

The company will not pay benefits under this insurance policy for chronic disease, injury or illness (including complications), or untreated injury; prior to the date this Insurance Policy first becomes effective, unless

(1) The Insured has informed the Company and the Company agrees to accept such risk(s) without terms of exclusion; or

(2) Chronic disease, injury or illness (including complications) that are asymptomatic, have not been treated or diagnosed by a doctor, or have not been seen or consulted by a doctor within 5 years before the date this Insurance Policy becomes effective for the first time; and during the 3 years from the date this Insurance Policy first becomes effective.

2. Period of non-coverage (Waiting Period)

The company will not pay benefits under this insurance policy for

1) Any illness that occurs within the period of **0** days from the first date of coverage under this insurance policy or the date that the Company approves to increase the benefits of this insurance policy, whichever occurs later, or

2) Any of the following illnesses that occur within the period of **…** days from the first date of coverage under this insurance policy or the date that the company approves to increase the benefits of this insurance policy, whichever occurs later

- Tumors, cysts or any type of cancers (60 days)
- Hemorrhoids (120 days)
- All kinds of hernia (120 days)
- All kinds of gallstones (120 days)
- Varicose veins in the legs (120 days)
- Endometrial hyperplasia (120 days)

However, in the event that the Company approves the addition of benefits according to the general terms & conditions for changes in coverage benefits, the Company will not cover only the increased benefits.

The Company will not apply this period of non-coverage (waiting period) if the Covered Person suffers an injury or requires an emergency surgery that is not caused by any pre-existing diseases.

3. Coverage Territory

The Covered Person must reside in a country listed in the list of Countries of Residence for a period of no less than **180** days per Insurance Policy year for reimbursement of claims related to medical treatments in the Coverage Territory as chosen by the Covered Person.

Country of residence:
Thailand

Coverage Territory:
(Please refer to the Plan Summary)

Zone A	Zone B	Zone C
Worldwide excluding the United States.	Worldwide excluding USA, Canada, Switzerland, Israel, Japan, Hong Kong, Bahamas, China	Worldwide excluding USA, Canada, Switzerland, Israel, Japan, Hong Kong, Bahamas, China, Russia, United Kingdom, Singapore, Taiwan, Brazil

For countries outside the Coverage Territory chosen by the Covered Person, coverage is limited to emergencies that occur during a travel for business or tourism for a period of up to 90 days per trip, but not more than 180 days per Insurance Policy year and up to the maximum amount of benefits as specified in each of the Insuring Agreements and/or Extended Clauses as selected by the Covered Person. The maximum amount of liability shall not exceed (as mentioned in the plan summary) baht per Insurance Policy year.

Additional Exclusions (applicable only for Health Insurance Coverage Section)
This insurance does not cover medical expenses or damage caused by injury or illness (including complications) or symptoms or disorders caused by

1. Conditions as a result of congenital abnormalities or congenital incomplete body organ formation systems or genetic diseases or developmental disorders of the body; unless the insurance policy has been effective no less than one year (1 year) and symptoms appear after the insured has reached the age of **16** years old.

2. Treatment or surgery for beauty/aesthetic purposes or skin problems, acne, blemishes, freckles, dandruff, hair loss or body weight control, surgery that can be replaced with other treatments, unless it is a reconstruction of wounds due to a covered accident.

3. Pregnancy, miscarriage, abortion, childbirth, pregnancy complications, treatments for infertility (including investigations and treatment), sterilization or contraception, except choriocarcinoma

4. AIDS or venereal or sexually transmitted diseases. AIDS (Acquired Immune Deficiency Syndrome) shall include immunodeficiency caused by HIV virus infection and includes opportunistic infections or infections or any illness in which a blood test shows positive for HIV (Human Immunodeficiency Virus). Opportunistic infections include, but are not limited, infections that causes pneumonia (Pneumocystis carinii Pneumonia), infections that causes Chronic Enteritis, viral and/or fungi infections, malignant neoplasm that include, but is not limited to, Kaposi's Sarcoma, Central Nervous System Lymphoma and/or other serious diseases, which are now known as symptoms of AIDS (Acquired Immunodeficiency Syndrome) or which leads to sudden death, illness or disability in those who have it. AIDS (Acquired Immune Deficiency Syndrome) shall include immunodeficiency virus (HIV) that causes dementia (Encephalopathy Dementia).

5. Treatment, prevention, use of medication or substance in order to slow down ageing and degeneration. Use of hormone replacement therapy before or during menopause. Male or female sexual dysfunction treatment. Treatment of gender dysphoria and gender transformation.

6. Health check-up, request for inpatient admission in a medical facility or request for a surgery, convalescence or rehabilitation, or rehabilitation by simply resting in a medical facility; in order to have a general care assistant or examination or treatment that is not related to the disease that led to the admission in the medical facility. Diagnosis of injury or illness, treatment or investigations for the cause that is neither medically necessary nor in accordance with medical standards.

7. Diagnosis and treatment of vision disorders including LASIK, and costs of equipment to aid vision.

8. Diagnosis and treatment or surgery on teeth or gums, dentures, crowns, root canal treatment, fillings, orthodontics, scaling, dental implants except in case of necessity due to accidental injury (this does not include the cost of dentures, crowns, root canal treatment or implant insertion).

9. Treatments and therapy relating to addiction of drug, tobacco, alcohol or any psychoactive substances.

10. Diagnosis and treatment of symptoms or diseases relating to mental health, psychiatric or behavioral or personality disorders; including ADHD, autism, stress, eating disorders or anxiety

11. Diagnosis and treatment that are experimental in nature. Treatment and investigation of sleep apnea, sleep disorders and snoring.

12. Any preventive inoculations or vaccinations against diseases, except for rabies vaccination after an animal attack and tetanus vaccine after an injury.

13. Non-modern medical treatments and investigations, including alternative medicine.

14. Medical expenses arising from treatment and investigation given by a medical practitioner/doctor who is the covered person himself/herself; as well as expenses arising from medical investigations and treatments from doctors who are parents, spouses or children of the Covered Person.

15. Suicide, attempted suicide, self-harm or attempted self-harm, whether it is by himself/herself or allowing others to act on their behalf, whether the Covered Person has a mental disorder or not; including accidents when the Covered Person eats, drinks or injects poisonous substances into the body and overuse of medications prescribed by the doctor.

16. Medical expenses (except for emergencies) incurred outside the Coverage Territory according to the additional terms and conditions as stated in ("Coverage Territory").

17. Medical expenses for admission to a sanatorium or preventorium or disease control facility, which have not been officially certified by that country.

18. Participation in sporting competitions and training for official sporting competitions or playing

dangerous sports. However, the first-time session of a dangerous sport is covered if the training is guided by a professional instructor with a specific athletic certificate.

19. Care provided in a nursing home, or expenses incurred for assistance to a person in their daily activities, even if said person has been declared temporarily or permanently disabled.

20. Vehicle fees for medical treatment transport, except for local ambulance service fees, to the appropriate and closest medical treatment facility

21. Expenses not directly related to the medical treatment during an admission in a medical facility. Personal expenses including telephone fees and television rental fees.

22. Costs of non-medicinal products not intended to treat disease, such as sunscreen, cosmetics and products which claim medicinal benefits.

23. Accommodation expenses in relation with medical treatment

24. Expenses incurred before the date the insurance policy becomes effective

25. Consequences arising from intentional actions by the Covered Person

Insuring Agreement

Inpatient Treatment

Under the rules, General Terms and Conditions, General Exclusions, Insuring Agreements and Extended Clauses of this Policy; and in return of the premiums that the Insured must pay; the Company offers coverage for the following Insuring Agreement, only for which the sum insured is specified in the Benefit Table and/or the Policy Schedule and/or the Renewal Insurance Certificate.

The benefits under this insuring agreement will be paid when the Covered Person has an injury or illness after the waiting period has been reached, for a medically necessary inpatient treatment in a medical facility. The Company will pay benefits for expenses incurred from medical treatments that are Medically Necessary and in accordance with Medical Standards, according to the General Service Rates.

The Company offers coverage according to the following Benefit Table, according to actual expenses, not more than the benefit amount specified in the Table of Benefits or Extended Clauses/Extended Clauses (if any).

Table of Benefits

Table of Benefits	**Coverage (THB)**
1. Hospitalization Benefits	
Section 1: Room and board fees including hospital service charges (inpatient) per policy year	as specified in plan summary
In the event that the Insured Person receives a stay in an Intensive Care Inpatient Room (ICU), payment will be made for the room and board including hospital service charges (inpatient)	
Section 2: Medical service fees for diagnosis or treatment, blood transfusion service & blood component fees, nursing service fees, drug fees, parenteral nutrition fees and medical supply fees per policy year	
Subsection 2.1 Medical service fees for diagnosis	
Subsection 2.2 Medical service fees for treatment, blood transfusion service & blood component, nursing service	
Subsection 2.3 Drug fees, parenteral nutrition fees and medical supply fees	
Subsection 2.4 Home medication fees and home medical supply fees (medical supplies 1).	
Section 3: Medical professional fee (Doctor) per policy year	
Section 4: Medical expenses for surgery and surgical procedures per policy year	
Subsection 4.1 Operating room fees and operating procedure room fees	

Table of Benefits	Coverage (THB)
Subsection 4.2 Medication expenses, parenteral nutrition expenses, medical supplies expenses and equipment expenses for surgery and surgical procedures	
Subsection 4.3 Medical professional fees for surgery or surgical procedures including doctor's fee (including surgical assistant doctor)	
Subsection 4.4 Anesthesiologist Practitioner Fees (Doctor fee)	
Subsection 4.5 Medical expenses for organ transplant	
Section 5: Major surgery that does not require an inpatient admission (day surgery)	
2. Benefits in case no inpatient admission is required	
Section 6: Medical expenses for diagnostic examinations before and after a directly related inpatient stay or medical fees for outpatient follow-up treatments after discharge from a directly related inpatient stay per policy year	as specified in plan summary
Subsection 6.1 Medical expenses for diagnostic examinations within 45 days before and after a directly related inpatient admission	
Subsection 6.2 Medical expenses for outpatient follow-up treatments after discharge from a directly related inpatient stay (per confinement), within 45 days (not including diagnostic examinations)	
Section 7: Outpatient medical expenses in case of injury, within 24 hours from an accident (per event)	
Section 8: Rehabilitation expenses after an inpatient admission, per admission (or per policy year)	
Section 9: Medical expenses for the treatment of chronic kidney disease by kidney dialysis, per policy year	
Section 10: Medical expenses for the treatment of cancer & tumor by radiotherapy, interventional radiology and nuclear medicine, per policy year	
Section 11: Medical expenses for cancer treatment by chemotherapy, per policy year	
Section 12: Emergency ambulance service fees	
Section 13: Medical Expenses for minor surgery	
Deductible	as specified in plan summary
Copayment	as specified in plan summary

Maximum benefit per insurance policy year (as specified in plan summary)

1. Inpatient Benefits

In case the Covered Person requires an inpatient admission, the Company will pay for medical service fee benefits as follows:

Section 1: **Room and board fees including hospital service charges (inpatient) per inpatient admission**

- The Company will pay benefits for room and meals, including inpatient service fees.
- In the event that the Covered Person is required to stay in an Intensive Care Inpatient Room (ICU), the Company will pay benefits for room and board including hospital service charges (inpatient). The company will pay for actual expenses.

Section 2: Medical service fees for diagnosis or treatment, blood transfusion service & blood component fees, nursing service fees, drug fees, parenteral nutrition fees and medical supply fees

The Company will pay benefits for medical service fees for diagnosis or treatment, blood transfusion service & blood component fees, nursing service fees, drug fees, parenteral nutrition fees and medical supply fees in the event where the Covered Person is required to stay as an Inpatient as follows:

Sub-Section 2.1 Medical service fees for diagnosis

The Company will pay benefits for laboratory diagnostics, pathological diagnostics, radiological diagnostics and medical imaging, combined radiation service for diagnosis, nuclear medicine for diagnosis, Electrocardiogram examination (ECG), Doctor's fee for interpretation of such diagnosis (if any) and other medical fees for diagnosis.

Sub-Section 2.2 Medical service fees for treatment, blood transfusion service & blood component fees and nursing service fees

The Company will pay benefits for medical services for treatment in case the Covered Person receives a combined radiation therapy for treatment, radiotherapy, nuclear medicine for treatment (including brachytherapy), physiotherapy and occupational therapy, blood service fee, medical device service fee, physical equipment service fees (excluding equipment), fees for packaged medical services for therapy and nursing service fees but not including special nursing care services.

Sub-Category 2.3 Drug fees, parenteral nutrition fees and medical supply fees

The Company will pay benefits for medication, intravascular nutrients and medical supplies, but not including medical supplies and equipment as follows:

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

(b) External prosthetics of the body; Physical Equipment and Artificial Equipment**.**

(c) Durable medical supplies used outside the body (medical supplies 2), such as medical instruments and durable medical supplies, hearing aids, glasses, contact lenses, glass lenses, respirators, oxygen equipment's, vital sign monitoring devices (pulse, blood pressure, temperature), various crutches, wheelchairs.

(d) Prosthetics such as prosthetic arms, prosthetic legs, prosthetic eyes.

Section 3: Medical professional fee (Doctor)

The Company will pay benefits for medical professional fees (Doctor) for diagnosis and treatment in case the Covered Person is admitted as an Inpatient in a medical facility.

Section 4: Medical expenses for surgery and surgical procedures

The Company will pay benefits for medical expenses arising from surgery and surgical procedures, while the Covered Person is required to stay as an inpatient in the medical facility.

Sub-Section 4.1 Operating room fees and operating procedure room fees

The Company will pay benefits for operating room fees, operating procedure room fees and medical equipment charges in the operating room and procedure room.

Sub-category 4.2 Medication expenses, parenteral nutrition expenses, medical supplies expenses and equipment expenses for surgery and surgical procedures.

The Company will pay benefits for medication expenses, parenteral nutrition expenses, medical supplies expenses and equipment expenses for surgery and surgical procedures in the operating or procedure room used for surgery.

Sub-Section 4.3 Medical professional fees for surgery or surgical procedures including doctor's fee (including assistant surgeon).

Sub-Section 4.4 Anesthesiologist Fees (Doctor fee)

The Company will pay benefits for anesthesiologist fees for the doctor to anesthetize or suppress the pain during surgery and procedures in accordance with the anesthesiologist service rates at the time of surgery or surgical procedures.

Sub-Section 4.5 Medical expenses for organ transplant

The Company will pay benefits for medical expenses arising from organ replacement surgery including liver, pancreas, kidneys, heart, lungs, caused by the organ being in its final stages and cannot resume function, and bone marrow transplantation with the use of Hematopoietic Stem Cells after Bone Marrow Ablation.

Section 5: Major surgery that does not require an inpatient admission (day surgery)

In the event where the Covered Person has received a major surgery that does not require an inpatient admission, the Company will pay benefits as if staying as an inpatient in a medical facility.

2. Benefits in case inpatient admission is not required

Section 6: Medical expenses for diagnostic examinations before and after a directly related inpatient admission or medical fees for outpatient follow-up treatments after discharge from a directly related inpatient admission.

The Company will pay benefits for medical expenses for diagnostic examinations before and after a directly related inpatient admission or medical fees for outpatient follow-up treatments after discharge from a directly related inpatient admission as follows:

Sub-Section 6.1: Medical expenses for diagnostic examinations within 45 days before and after a directly related inpatient admission

The Company will pay benefits for laboratory diagnostics, pathological diagnostics, radiological diagnostics and medical imaging, combined radiation service for diagnosis, nuclear medicine fee for electrocardiogram diagnosis, doctor's interpretation fee of the results of such diagnosis (if any) and other medical service fees for directly related diagnostics within 45 days prior to and after the inpatient admission.

Sub-section 6.2: Medical expenses for outpatient follow-up treatments within 45 days after discharge from a directly related inpatient admission

The Company will pay benefits for medical expenses arising from a continuous medical treatment in an outpatient department of a medical facility, within 45 days after discharge from a directly related inpatient admission: excluding the medical fees for diagnosis.

Section 7: Outpatient medical expenses in case of injury, within 24 hours from an accident (per event)

The Company will pay benefits for medical expenses related to injuries due to an accident, where the Covered Person requires medical treatment in an outpatient department of a medical facility; for injuries from a directly related accident within 24 hours from the time of each accident.

Section 8: Rehabilitation expenses after an inpatient admission

The Company will pay benefits for rehabilitation, physiotherapy, occupational therapy, fees for rehabilitation medicine doctor or physiotherapist, equipment and medical supplies; for follow-up outpatient medical treatment following a discharge as an inpatient in a medical facility; excluding nursing and clinical psychology expenses.

Section 9: Medical expenses for the treatment of chronic kidney disease by kidney dialysis

The Company will pay benefits for medical services for the treatment of chronic kidney disease by kidney dialysis.

Section 10: Medical expenses for the treatment of cancer or tumor by radiotherapy, interventional radiology and nuclear medicine

The Company will pay benefits for medical expenses for the treatment of cancer or tumor by radiotherapy, interventional radiology and nuclear medicine treatment (including brachytherapy) including radiologists fees.

Section 11: Medical Expenses for Cancer Treatment by Chemotherapy

The Company will pay benefits for medical expenses for cancer treatment by chemotherapy, as well as targeted therapy, including Treating Doctors' fees.

Section 12: Emergency Ambulance Service Fee

The Company will pay benefits for Emergency Ambulance Service Fee for transporting the Covered Person to or from the Medical Facility as required in an emergency & medically necessary situation. Cover includes medication, medical supplies and medical practitioner fees whilst in the ambulance. The expenses must be related and correspond to the Injury or Illness that led to the inpatient admission in the Medical Facility.

Section 13: Medical Expenses for Minor Surgery

The Company will pay benefits for medical expenses in treating injury or illness by Minor Surgery.

Additional conditions (applicable to Inpatient Treatment Insuring Agreement only)

1. Renewal in case of policy anniversary

This Insurance policy will be renewed upon the anniversary of the Insurance Policy until the insured person's age is **99** years, without the need to show any proof. The Company retains the right to adjust the premium rate according to Article 2 ("Premium Adjustment") as approved by the Registrar. However, the Company reserves the right not to renew this Insuring Agreement in any of the following cases:

1) If there is evidence that the Covered Person did not declare the true facts in the application form, renewal request, health declaration or other additional declarations relating to the health Insurance policy, which are material facts that would have caused the Company to request a higher premium or refuse the Insurance Agreement or accept to insure with conditions.

2) The Covered Person claims for treatment of injury or illness which are not Medically Necessary.

3) The Covered Person claims for hospital cash benefits from an inpatient treatment in a medical facility exceeding their true income when combining the claims from all companies.

In case of non-renewal of the Insurance Agreement for the above reasons, the Company must inform the insured in advance in writing by registered mail or any other means by which the insured consents to; not less than 30 days prior to the expiry date of this Insurance Policy as specified in the Insurance Policy Schedule and/or certificate of insurance renewal and/or Extended Clauses (if any).

In addition, for the renewal of the Inpatient Treatment Insuring Agreement, the company reserves the right to change the terms of the Insuring Agreement by adding conditions for the Covered Person to have copayments at the rates and criteria as follows:

(1) Not more than.....% of the covered expenses and reduction of premium..... % of the premium in the renewal year, or

(2) Not more than.....% (cannot exceed 30 percent) of the covered expenses and reduction of premium % in the renewal year according to the rules set by the company, in the event that the insured has a claim for simple diseases and is admitted to the hospital not less than 3 times per policy year and with the rate of claim for each Covered Person in the insurance policy year of 200% or more

(3) Not more than.....% (cannot exceed 30 percent) of the covered expenses and reduction of premium % in the renewal year according to the rules set by the company, in the event the rate of claim for each Covered Person in the insurance policy year of 400% or more

If the Company sets the condition for the Insured to have co-payments due to two or more cases under (1), (2) or (3) above, the company will set a copayment of not more than..... % (not more than 50 percent) of Covered expenses and a percentage % reduction in insurance premiums in the renewal year of not more than .....% (not exceeding 50 percent).

In the event that the company sets a condition for the insured to have co-payments, then later the rate of claim of the insured is reduced from the above criteria, the company can consider reducing the rate of copayment (Copayment) for the insured.

In the event that the Company sets the condition for the Insured to have co-payments, the Company will issue an Extended Clause document or an Extended Clause specifying the rates and co-payment criteria that are in accordance with the rates and criteria above. The insured will be informed at least 15 days prior to policy anniversary date, alongside the renewal notice of premium payment.

Adding conditions for the insured to have co-payments (Copayment) according to the rates and criteria under (1), (2) and (3) in the above conditions will apply only when there is an Extended Clause attached to the insurance policy specifying the conditions and criteria clearly from the first day that the insurance contract is agreed upon.

2. Premium adjustment

The Company may adjust the premium rate at the anniversary of the Insurance policy according to the following:

1) Age and occupation of each individual

2) Higher medical expenses or overall claim experience on the entire Insurance Policy portfolio. The Company must inform the Insured of the Premium Adjustment as per the insurance premium rates approved by the Registrar, not less than 30 days in advance and in writing by registered mail or any other means by which the insured consents to.

3. Submission of proof of claims

The Covered Person or their Representative, as the case may be, must submit the following evidence to the Company at their own expense:

1. A completed Claims form as specified by the Company

2. Doctor's report indicating the important symptoms, diagnosis and treatment
3. Original receipt with details of all expenses

The above evidence shall be submitted within 30 days from the date of discharge or the date of treatment from the medical facility or the clinic.

The receipt must be the original. The Company will return the original receipt that has been certified for the amount paid to the Covered Person so that they can claim for the remaining amount from another insurer.

However, if the Covered Person already received reimbursement from the state welfare/social security or from another insurer, the Company could allow the Covered Person to send copies of the receipt that has been certified for the amount paid; in order to claim for the remaining benefit.

Failure to submit evidence within that period does not impair the right to claim if it can be demonstrated that there are reasonable grounds for not submitting such evidence within the specified period of time but is still submitted as soon as possible.

Insuring Agreement

Outpatient Benefits
(For attachment to Health Insurance Coverage)

The Company will pay benefits to the Covered Person for medical treatment who are not hospitalized or hospitalized (outpatient) as a result of injury or illness after the waiting period has been reached. The Company will pay benefits for expenses incurred from medical treatments that are Medically Necessary and in accordance with Medical Standards, according to the General Service Rates, with a payment of not more than the amount that is actually required to be paid less the amount of the Deductible and/or Co-payment (if any), but does not exceed the maximum benefit amount specified in the Table of Benefits, whichever is the smaller for the coverage benefits as listed below:

1. General Practitioner Fees
The Company will pay benefits for General Practitioner fees.

2. Specialist fees
The Company will pay benefits for Specialist fees.

3. Medical expenses from Minor Surgery
The Company will pay benefits for medical expenses from minor surgeries that exceeds the limit of Article 13 Medical Expenses for Minor Surgery (from Insuring Agreement for Inpatient Benefits).

4. Laboratory tests, X-rays, diagnostic and pathological tests
The Company will pay benefits for laboratory tests, X-rays, diagnostics, and pathology tests.

5. Prescribed medicine
The Company will pay benefits for medication prescribed by a Doctor.

6. Prescribed Physiotherapy
The Company will pay benefits for physiotherapy prescribed by a Doctor, not more than the maximum amount specified in the Table of Benefits and not more than ... times (as specified in Plan Summary) per Insurance Policy Year.

7. Prescribed Hearing Aids and Orthopedic Appliances
The Company will pay benefits for Prescribed Hearing Aids and Orthopedic Appliances

<u>Additional conditions (applicable to Outpatient benefits Insuring Agreement only)</u>

Submission of proof of claims

The Covered Person or their Representative, as the case may be, must submit the following evidence to the Company at their own expense:

1. Claims form as specified by the Company

2. Doctor's report indicating the important symptoms, diagnosis, and treatment
3. Original receipt with details of all expenses

The above evidence shall be submitted within 30 days from the date of discharge or the date of treatment from the medical facility or the clinic. The receipt must be the original.

The Company will return the original receipt that has been certified for the amount paid to the Covered Person so that they can claim for the remaining amount from another insurer.

However, if the Covered Person already received reimbursement from the state welfare/social security or from another insurer, the Company could allow the Covered Person to send copies of the receipt that has been certified for the amount paid; in order to claim for the remaining benefit.

Failure to submit evidence within that period does not impair the right to claim if it can be demonstrated that there are reasonable grounds for not submitting such evidence within the specified period of time but is still submitted as soon as possible.

Additional exclusions (applicable only to outpatient benefit protection agreements)

This insurance does not cover the following expenses:

1. Medication, treatment, or diagnostic tests that are not related to the diagnosis, symptom or disorder as specified in the medical certificate/ doctor's report.
2. Medical aids other than those specified in Clause 7 ("Prescribed Hearing Aids and Orthopedic Appliances"), as prescribed by a doctor.
3. Examination and treatment of symptoms or diseases related to mental, psychiatric, or behavioral or personality disorders This includes attention deficit hyperactivity, autism, stress, eating disorders, or anxiety.
4. Treatment of Infectious Diseases (HIV) and Immune Deficiency (AIDS)
5. Vaccination
6. Alternative medicine in the treatment of osteopathy, homeopathy, orthopedic treatment, natural therapy, and acupuncture
7. General health checkup

Accident Insurance Coverage Section

Additional definitions

1. Any loss or damage	refers to	bodily injury suffered by the Insured as a result of an accident which causes death, dismemberment, loss of sight, disability or injury

Additional conditions and requirements (applicable only to accident insurance coverage)

1. Change of Occupation

If the Insured suffers an injury 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 for the new occupation.

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

2. Report of Accident

The Insured, the beneficiary or the representative of the Insured, whichever the case may be, must report the accident to the Company without delay. In the event of death, an immediate notice must be made to the Company unless it can be proved that the circumstances make it impossible to do so but the notification is given to the Company as soon as possible.

3. Being murdered by the beneficiary

If the person who is intentionally killed by the beneficiary, the Company will not pay any benefits according to the coverage specified under this insurance policy. In the event that there is only one beneficiary, the Company will return the paid premium by deducting the premium for the period that this insurance policy has already been in force and issued in accordance with the estate or the legal heir of the person who is covered.

However, if there is more than one beneficiary and some of the beneficiary did not participate in the deliberate in murdering of the Insured, the Company will pay benefits to the beneficiary who does not participate in the killing of the protected person in proportion to the specified proportions. In this case, the company will not return the premium.

4. Beneficiaries under insurance policy

The Insured can specify his/her beneficiary in the Insurance Policy. Upon the Insured's death, the benefit will be paid to such named beneficiary. However, if no beneficiary is named on the Insurance Policy, the benefit will go to the estate of Insured.

In case that there is only one beneficiary named in the Insurance Policy and the beneficiary died before or at the same time of the Insured, the Insured must inform the Company in writing for the change of beneficiary. If this is not done or cannot be done, the Company will pay compensation to the estate of Insured upon the Insured's death.

In case the Insured named more than one person as beneficiary and any beneficiaries die before the Insured, the Insured must inform the Company in writing for the change of beneficiary or the change of the benefits to the rest beneficiaries. If this is not done or cannot be done, the Company will pay compensation to the rest of persons named as beneficiary equally upon the Insured's death.

5.Coverage Territory

The Covered Person must reside in a country listed in the list of Countries of Residence for a period of no less than **180** days per Insurance Policy year (maximum 180 days) for reimbursement of claims related to medical treatments in the Coverage Territory as chosen by the Covered Person.

Country of residence:

Thailand

Coverage Territory:

Worldwide

<u>Additional exclusions</u> (applicable only for accident insurance coverage)

This insurance does not cover.

1. Any loss or damage caused by or due to the following reasons:

1.1 Suicide or attempted suicide or self-inflicted injury

1.2 Exposure to pathogens, parasites, except for infections with tetanus or rabies caused by accidental wounds

1.3 Medical or surgical treatment, unless necessary due to injuries covered under this insurance policy and done within the period specified in the insurance policy.

1.4 Miscarriage

1.5 Dental care or root canal treatment except dental treatment which is given within 7 days from the date of accident.

1.6 Replacement of or new sets of dentures, dental crowns, artificial denture

1.7 Food poisoning

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

1.9 Radioactive explosions or nuclear components or any other hazardous material that may explode in a nuclear process.

2. Any loss or damage incurred at the following time (Unless coverage is extended. An attachment has been issued to extend such protections.)

2.1 While the Covered person is taking off or landing, or by being in an aircraft that is not registered to carry passengers and is not operated by a commercial airline.

2.2 While the Covered Person is driving or acting as a full-time employee of any aircraft

2.3 While the Covered Person participates in a brawl or contributes to a quarrel.

2.4 While the Insured serves as a soldier, police, or a volunteer and participates in war or crime suppression. If the time served is more than 30 days, the Company shall refund the premium from the date of service until such service is ended. After such time, the Insurance Policy shall become effective again until the expiry date on the policy schedule.

Insuring Agreement

Loss of Life, Dismemberment, Loss of Sight, Loss of Hearing, Loss of Speech or Permanent Disability from accident

(For attaching to accident insurance coverage category)

Additional definitions:

Dismemberment	refers to	the loss of body organ from the wrist joint or the ankle joint, and the loss of use of that organ, which according to the medical indication, will never be able to function at any time in the future.
Loss of sight	refers to	complete blindness which is permanently incurable.
Total Permanent Disability	refers to	disability to the extent of being permanently unable to perform any professional activity or occupation on a full-time basis, or unable to perform three or more daily routines on their own.
Daily routine	refers to	the ability to perform the main six daily types as defined to medically evaluate patients who are unable to perform such tasks, consisting of: 1) The ability to move such as the ability to move from a chair to the bed on their own. 2) The ability to walk or move, such as the ability to walk or move from room to room on their own without the help of others or using aids. 3) The ability to dress, such as the ability to wear or undress on their own without the help of others or using aids. 4) The ability to bathe or clean oneself, such as the ability to take a bath, as well as to enter and leave the shower on their own without the help of others or using aids. 5) The ability to eat on their own without the help of others or using aids. 6) The ability to excrete, such as the ability to use the bathroom for excretion, as well as getting in

		and out of the bathroom on their own without the help of others or using aids.
Partial Permanent Disability	refers to	a disability to the extent of not being able to perform regular occupation on a full-time basis but can perform other work for remuneration.

Coverage

This Insurance covers loss or damage caused by Injury to the Covered Person arising from an Accident, loss of life of the Covered Person, Dismemberment, Loss of Sight, Loss of Hearing, Loss of Speech or Permanent Disability from accident within 180 days from the date of the accident or injuries causing the Covered Person to be treated as an Inpatient at a Hospital or Medical Facilities, and death due to Injuries.

The Company will pay the following claims:

1	100% of sum assured	For loss of life.
2	100% of sum assured	For being completely permanently disabled with clear medical indications that the person who is covered is completely permanently disabled or in the absence of a medical indication but has been completely permanently disabled for at least 12 consecutive months from the date of the accident.
3	100% of sum assured	For loss of both hands from the wrist joint or both feet from the ankle joint, or loss of sight for both eyes.
4	100% of sum assured	For loss of one hand from the wrist joint and one foot from the ankle joint.
5	100% of sum assured	For loss of one hand from the wrist joint and loss of sight in one eye.
6	100% of sum assured	For loss of one foot from the ankle joint and loss of sight in one eye.
7	60% of sum assured	For loss of one hand from the wrist.
8	60% of sum assured	For loss of one foot from the ankle.
9	60% of sum assured	For loss of sight in one eye
10	50% of sum assured	For permanent loss of hearing or speech.
11	15% of sum assured	For permanent loss of hearing in one ear.
12	25% of sum assured	For loss of a thumb (two joints)
13	10% of sum assured	For loss of a thumb (one joint)
14	10% of sum assured	For loss of an index finger (three joints)
15	8% of sum assured	For loss of an index finger (two joints)
16	4% of sum assured	For loss of an index finger (one joint)

17	5% of sum assured	For loss of each finger (not less than two joints) other than a thumb or an index finger
18	5% of sum assured	For loss of a big toe
19	1% of sum assured	For loss of each toe (not less than one joint) other than a big toe

For any one event, the Company shall compensate only one item under the Schedule, being that item has the highest limit except in the case of loss of fingers or toes according to items 12 to 19 and where the Covered Person cannot claim on items 1 to 9, the Company shall compensate on the actual losses on all items combined, but not exceeding the amount specified in the Policy Schedule or the Table of Benefits or Renewal Insurance Certificate.

In case of Partial Permanent Disability, which cannot be claimed under Items 2 to 19 and is not either a loss taste or a loss of smell, the Company will pay compensation according to the opinion of the Company's appointed doctor, but not exceeding 50% of the sum insured specified in the Policy Schedule or the Table of Benefits or Renewal Insurance Certificate.

In the aggregate, the total compensation for this Insuring Agreement cannot exceed the maximum limit stated in the Policy Schedule or Table of Benefits or Renewal Insurance Certificate. If the Company has not paid up to such maximum amount of limit of liability, the remaining benefit is still valid until the expiry of the Policy period.

<u>Additional Terms and Conditions</u> (applicable to Insuring Agreement - Personal Accident only) - Loss of life, Dismemberment, Loss of Sight, Loss of Earing, Loss of Speech or Permanent Disability from accident.

Claims and Claim Submission:

1 Claims for Death

1) Claim indemnification for Loss of Life Benefit

The Beneficiary or Representative of the Insured as the case may be, must submit the following documents to the Company at their own expense within 30 days from the date of loss of life of the Insured.

1. A completed Claim Form of the Company.

2. A Death Certificate.

3. Copy of the autopsy report certified by the case officer or issuing authority.

4. Copy of police report, certified by the case officer.

5. Copy of Identity card and the house registration of the Insured stating the Insured is “deceased".

6. Copy of Identity card and house registration of the Beneficiary.

Failure to submit such documents within that above stated period shall not diminish the right for claim indemnification if can be proven that there are practical reasons for not being able to do so and such documents have been submitted as early as possible.

2 Claims for Permanent Disability or Dismemberment

The Covered Person or their Representative, as the case may be, must submit the following evidence to the Company at their own expenses within 30 days from the date of the declared Permanent Disability or Dismemberment as declared by the Doctor.

1. A completed Claim Form of the Company

2. Doctor's report confirming Permanent Disability or Dismemberment

Failure to submit such documents within that above stated period shall not diminish the right for claim indemnification if can be proven that there are practical reasons for not being able to do so and such documents have been submitted as early as possible.

EXTENDED CLAUSES

(Please refer to Plan Summary for each Benefits per plan)

Extended Clause - Parent Accommodation related to a Covered Person aged under 18 years old

(Applicable to Inpatient Insuring Agreement - Luma Asia Care Individual Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

It is agreed that this Policy has extended coverage for **Parent Accommodation for the care of a Covered Person aged under 18 years old.**

The Company will pay benefits for accommodation expenses for one of the parents of a Covered Person aged under 18 years old while receiving medical treatment as an Inpatient in a Hospital or Medical Facility up to ..... baht per day and within a limit of ..... days per Inpatient stay. (As specified in the plan summary)

In addition, when combined with Benefits of Insuring Agreements and other Extended Clauses of health insurance coverage category under this insurance policy, the Company will pay benefits not exceeding Maximum benefit per policy year.

Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.

The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.

Extended Clause - Medical Equipment and Supplies

(Applicable to Inpatient Insuring Agreement - Luma Asia Care Individual Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

It is agreed that this Policy has extended coverage for Medical Equipment and Supplies as follows:

1. External fixation devices, accessories, supporting devices such as collar braces, waist support, but not including crutches or wheelchairs or walking sticks or other similar devices.

The Company will pay benefits for external fixation fixtures, accessories, supporting devices such as collar braces, waist support, but not including crutches or wheelchairs or walking sticks or other similar devices.

2. Prosthetic Implants and Appliances (medical supplies 3)

In addition, when combined with Benefits of Insuring Agreements and other Extended Clauses of health insurance coverage category under this insurance policy, the Company will pay benefits not exceeding Maximum benefit per policy year.

The Company will pay benefits for Prosthetic Implants and Appliances (medical supplies 3). Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.

The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.

Extended Clause - Reconstructive Surgery following accident

(Applicable to Inpatient Insuring Agreement - Luma Asia Care Individual Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

Additional Definitions:

Reconstructive Surgery	refers to	a surgery performed to allow the disabled organ to resume normal function.

It is agreed that this Policy has extended coverage for Reconstructive Surgery following accident.

The Company will pay benefits for Reconstructive Surgery following accident for expenses incurred as a result of necessary medical treatment, not exceeding the Medical Standards under Customary and Reasonable Charges, deducted the Deductible amount, and/or Copayment (if any), but not exceeding the maximum benefit amount specified in the benefit table, whichever is less.

In addition, when combined with Benefits of Insuring Agreements and other Extended Clauses of health insurance coverage category under this insurance policy, the Company will pay benefits not exceeding Maximum benefit per policy year.

Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.

The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.

Extended Clause - Psychiatric Treatment in a Hospital or Medical Facility

(Applicable to Inpatient Insuring Agreement - Luma Asia Care Individual Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

It is agreed that this Policy has extended coverage for Psychiatric Treatment in Hospitals or Medical Facilities.

Additional Definitions:

Psychiatric Treatment	refers to	the treatment of mental or neuropsychiatric disorders based on indications of international classification of diseases, such as The Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). Such disorders must be associated with depressive symptoms or an existing impairment in the ability to perform the daily activities (e.g., work or occupation) such symptoms must indicate the need for medical attention, not a symptom that comes from a specific event such as loss of relatives or close friends, relationship problems, learning problems and problems in adapting to culture.
Specialized Medical Facilities (for psychiatric Inpatient admission)	refers to	facilities that: 1) Primarily engaged in providing, on a full time Inpatient basis, a program for diagnosis, evaluation and effective treatment. 2) Provides medical care on a continuous 24-hour daily basis. 3) Maintains a written individual plan of treatment for each patient. 4) Is under the supervision of skilled Doctors and Nurses.

The Company will pay benefits for Psychiatric Treatment in Hospitals or Medical Facilities, including essential medical diagnosis, evaluation and medical expenses under the supervision of a Doctor during an Inpatient stay in a Hospital or Medical Facility or a Specialized Medical Facility, up to ..... days

(as specified in plan summary) per Policy Year for expenses incurred as a result of necessary medical treatment, not exceeding the Medical Standards under Customary and Reasonable Charges, deducted the Deductible amount, and/or Copayment (if any), but not exceeding the maximum benefit amount specified in the benefit table, whichever is less.

Limitation:

The Company will not pay for benefits or costs associated with Psychiatric Treatment in Hospitals or Medical Facilities or Specialized Medical Facilities as an Inpatient arising during a period of non-coverage during the first **10** months from the Policy commencement date or the date that the Company approves the increase in benefits of this Policy, whichever comes later.

In addition, when combined with Benefits of Insuring Agreements and other Extended Clauses of health insurance coverage category under this insurance policy, the Company will pay benefits not exceeding Maximum benefit per policy year.

Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.

The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.

Extended Clause - Fees for physical artificial equipment and surgery to insert artificial equipment into the body

(Applicable to Inpatient Insuring Agreement - Luma Asia Care Individual Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

It is agreed that this Policy has extended coverage for Fees for physical artificial equipment and surgery to insert artificial equipment into the body.

The Company will pay benefits for Fees for physical artificial equipment and surgery to insert artificial equipment into the body for expenses incurred as a result of necessary medical treatment, not exceeding the Medical Standards under Customary and Reasonable Charges, deducted the Deductible amount, and/or Copayment (if any), but not exceeding the maximum benefit amount specified in the benefit table, whichever is less.

In addition, when combined with Benefits of Insuring Agreements and other Extended Clauses of health insurance coverage category under this insurance policy, the Company will pay benefits not exceeding Maximum benefit per policy year.

Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.

The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.

Extended Clause - Nursing Care at Home or Inpatient Rehabilitation Facility

(Applicable to Inpatient Insuring Agreement - Luma Asia Care Individual Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

Additional Definitions:

Nursing Care at Home	refers to	medically necessary treatment and care given by a qualified nurse in the Covered Person's own home, related and resulting from an Inpatient or Outpatient treatment.
Inpatient Rehabilitation Facility	refers to	a place of residence for a person who needs nursing care and has significant disabilities preventing them from performing independent activities of daily living.

It is agreed that this Policy has extended coverage for Nursing Care at Home or Inpatient Rehabilitation Facility.

The Company will pay benefits for Nursing Care at Home or Inpatient Rehabilitation Facility for expenses incurred as a result of necessary medical treatment, not exceeding the Medical Standards under Customary and Reasonable Charges, deducted the Deductible amount, and/or Copayment (if any), but not exceeding the maximum benefit amount specified in the benefit table, whichever is less.

In addition, when combined with Benefits of Insuring Agreements and other Extended Clauses of health insurance coverage category under this insurance policy, the Company will pay benefits not exceeding Maximum benefit per policy year.

Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.

The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.

Extended Clause - Local Ambulance Service Fees (Inpatient)

(Applicable to Inpatient Insuring Agreement - Luma Asia Care Individual Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

It is agreed that this Policy has extended coverage for Local Ambulance Service Fees related to an Inpatient stay.

Additional Definitions

Local Ambulance	refers to	Local ambulance service costs incurred in the transfer of a Covered Person to a Hospital or between Hospitals for medically necessary Inpatient stays.

The Company will pay benefits for Local Ambulance Service Fees occurring for the transfer of a Covered Person to a Hospital or between Hospitals for medically necessary Inpatient stays, not exceeding the Medical Standards under Customary and Reasonable Charges, deducted the Deductible amount, and/or Copayment (if any), but not exceeding the maximum benefit amount specified in the benefit table, whichever is less.

In addition, when combined with Benefits of Insuring Agreements and other Extended Clauses of health insurance coverage category under this insurance policy, the Company will pay benefits not exceeding Maximum benefit per policy year.

Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.

The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.

Extended Clause - Expenses associated with medical treatments not requiring an overnight hospital stay (Day Care Treatment)

(Applicable to Inpatient Insuring Agreement - Luma Asia Care Individual Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

Additional Definitions:

Expenses associated with medical treatments not requiring an overnight hospital stay (Day Care Treatment)	refers to	medical treatment within the Hospital or Medical Facility that includes a Hospital Room and Nursing charges but does not medically require the patient to stay overnight and was discharged on the same day.

It is agreed that this Policy has extended coverage for Expenses associated with medical treatments not requiring an overnight hospital stay (Day Care Treatment).

The Company will pay benefits for Expenses associated with medical treatments not requiring an overnight hospital stay (Day Care Treatment) for expenses incurred as a result of necessary medical treatment, not exceeding the Medical Standards under Customary and Reasonable Charges, deducted the Deductible amount, and/or Copayment (if any), but not exceeding the maximum benefit amount specified in the benefit table, whichever is less.

In addition, when combined with Benefits of Insuring Agreements and other Extended Clauses of health insurance coverage category under this insurance policy, the Company will pay benefits not exceeding Maximum benefit per policy year.

Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.

The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.

Extended Clause - Medical Treatment of Cancer without requiring an Inpatient Stay (Daycare Treatment) or Outpatient

(Applicable to Health Insurance Coverage - Luma Asia Care Individual Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

It is agreed that this insurance policy has extended the coverage for cancer medical expenses in the case of treatment that does not stay overnight in the hospital (Day Care Treatment) or in the case of outpatient.

Additional Definitions

Expenses associated with medical treatments not requiring an overnight hospital stay (Day Care Treatment)	refers to	medical treatment within the Hospital or Medical Facility that includes a Hospital Room and Nursing charges but does not medically require the patient to stay overnight and was discharged on the same day.

When the Covered person is a cancer patient and is medically necessary to receive medical treatment in a hospital or Medical Facility after the waiting period, the company will pay the benefit amount for cancer treatment expenses that does not stay overnight in the hospital (Day Care Treatment) or in the case of outpatient.

The company will pay benefits for expenses incurred as a result of necessary medical treatment, not exceeding the Medical Standards under Customary and Reasonable Charges, deducted by the amount the of deductible amount, and/or Copayment (if any), but not exceeding the maximum benefit amount specified in the benefit table, whichever is less.

In addition, when combined with Benefits of Insuring Agreements and other Extended Clauses of health insurance coverage category under this insurance policy, the Company will pay benefits not exceeding Maximum benefit per policy year.

Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.

The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.

Extended Clause - Treatment of HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) in case of Inpatient and Outpatient

(Applicable to Health Insurance Coverage - Luma Asia Care Individual Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

It is agreed that this Policy has extended coverage for Treatment of HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) in case of Inpatient and Outpatient.

The Company will pay benefits for Treatment of HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) in case of Inpatient and Outpatient in a Hospital or Medical Facility or Clinic for expenses incurred as a result of necessary medical treatment, not exceeding the Medical Standards under Customary and Reasonable Charges, deducted by the amount the of deductible amount, and/or Copayment (if any), but not exceeding the maximum benefit amount specified in the benefit table, whichever is less.

The Company will pay for benefits up to **5 consecutive years** (5 years maximum) per lifetime providing that this Policy is being continuously renewed and related premiums have been paid to the Company.

Limitations:

The Company will not pay for benefits or costs associated with Treatment of HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome) in case of Inpatient and Outpatient arising during the waiting period of the first **24** months from the Policy commencement date or the date that the Company approves the increase in benefits of this Policy, whichever comes later.

In addition, when combined with Benefits of Insuring Agreements and other Extended Clauses of health insurance coverage category under this insurance policy, the Company will pay benefits not exceeding Maximum benefit per policy year.

Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.

The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.

Extended Clause - Treatment of conditions resulting from congenital abnormalities or congenital incomplete body organ formation systems or genetic diseases or developmental disorders of the body

(Applicable to Health Insurance Coverage - Luma Asia Care I
individual Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

It is agreed that this Policy has extended coverage for Treatment of conditions resulting from congenital abnormalities or congenital incomplete body organ formation systems or genetic diseases or developmental disorders of the body.

The Company will pay benefits for Care for Treatment of conditions resulting from congenital abnormalities or congenital incomplete body organ formation systems or genetic diseases or developmental disorders of the body after the date of Policy Inception and appears before the Insured reaches the age of **16** years, for expenses incurred as a result of necessary medical treatment, not exceeding the Medical Standards under Customary and Reasonable Charges, deducted the Deductible amount, and/or Copayment (if any), but not exceeding the maximum benefit amount specified in the benefit table, whichever is less.

Limitations:

The Company will not pay for benefits or costs associated with treatment of conditions resulting from congenital abnormalities or congenital incomplete body organ formation systems or genetic diseases or developmental disorders of the body arising during a period of non-coverage during the first **10** months from the Policy commencement date or the date that the Company approves the increase in benefits of this Policy, whichever comes later.

In addition, when combined with Benefits of Insuring Agreements and other Extended Clauses of health insurance coverage category under this insurance policy, the Company will pay benefits not exceeding Maximum benefit per policy year.

Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.

The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.

Extended Clause - Wheelchair equipment or crutches in case of an admission or Day Care Treatment

(Applicable to Health Insurance Coverage of Luma Asia Care Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

Additional Definitions:

Expenses associated with medical treatments not requiring an overnight hospital stay (Day Care Treatment)	refers to	medical treatment within the Hospital or Medical Facility that includes a Hospital Room and Nursing charges but does not medically require the patient to stay overnight and was discharged on the same day.

It is agreed that this Policy has extended coverage for Wheelchair equipment or crutches in case of an Inpatient or Day Care Treatment.

The Company will pay benefits for renting or buying Wheelchair equipment or crutches in case of an Inpatient or Day Care Treatment for expenses incurred as a result of necessary medical treatment, not exceeding the Medical Standards under Customary and Reasonable Charges, deducted the Deductible amount, and/or Copayment (if any), but not exceeding the maximum benefit amount specified in the benefit table, whichever is less.

In addition, when combined with Benefits of Insuring Agreements and other Extended Clauses of health insurance coverage category under this insurance policy, the Company will pay benefits not exceeding Maximum benefit per policy year.

Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.

The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.

Extended Clause – Vaccination

(Applicable to Outpatient Insuring Agreement - Luma Asia Care Individual Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

It is agreed that this Policy has extended coverage for Vaccination coverage.

Additional Definitions:

Vaccination	refers to	all immunization vaccinations and booster injections required under the regulation of the country in which Treatment is being given, any medically necessary travel vaccinations and malaria prophylaxis. The cost of consultation for administering the vaccine, as well as the cost of the drug, is covered under the Policy.

The Company will pay benefits for outpatient vaccination that are Medically Necessary, not exceeding the Medical Standards under Customary and Reasonable Charges, deducted by the Deductible amount, and/or Copayment (if any), but not exceeding the maximum benefit amount specified in the Table of Benefits, whichever is less.

In addition, when combined with Benefits of Insuring Agreements and other Extended Clauses of health insurance coverage category under this insurance policy, the Company will pay benefits not exceeding Maximum benefit per policy year.

Additional exclusions (applicable to Extended Clause - Vaccination only):

This Policy does not cover the following expenses:

1. Treatment of Infectious Diseases (HIV) and Immune Deficiency (AIDS)

Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.
The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.

Extended Clause - General Health Check-ups

(Applicable to Health Insurance Coverage - Luma Asia Care Individual Health and Accident Policy)

This Extended Clause shall be considered as part of this Policy.

It is agreed that this Policy has extended coverage for General Health Check-ups.

The Company will pay benefits for Care for General Health Check-ups for primary health screening including annual health check-up with Ultrasound, Mammogram, Pap Test or Thin-prep, Prostate Cancer Screening performed at a Hospital or Medical Facility, not exceeding the Medical Standards under Customary and Reasonable Charges, deducted the Deductible amount, and/or Copayment (if any), but not exceeding the maximum benefit amount specified in the benefit table, whichever is less.

In addition, when combined with the benefits of the Insuring agreement and other attachments of the Health Insurance Coverage category under the insurance policy, the company will pay benefits not more than the maximum benefit per policy year.

Additional exclusions (applicable to Extended Clause - General Health Check-ups only):

This Policy does not cover the following expenses:

1. Treatment of Infectious Diseases (HIV) and Immune Deficiency (AIDS)
2. Any physical examination for abnormalities, Injuries, or Illnesses.

Shall the clauses in this Extended Clause contradict the clauses in the Policy, the Extended Clause shall prevail.

The General Terms and Conditions and General Exclusions of this Policy shall remain in effect.