INSURANCE POLICY
AIA MedCare RIDER

TABLE OF CONTENTS

INSURANCE POLICY

AIA MedCare RIDER

I. DEFINITIONS

The words and phrases listed below will have the meanings attributed to them wherever they appear in this **AIA MedCare** rider (this "**Rider**") unless the context otherwise requires. The terms used in this Rider but not otherwise defined shall have the same meaning as provided in the terms and conditions of the Basic Policy. In case there is conflict with the terms and conditions of the Basic Policy, the terms and conditions of this Rider shall prevail.

1. **Accident:** a sudden, unintentional, unexpected, unusual, and specific event that occurs at an identifiable time and place which shall, independently of any other cause, be the sole cause of Bodily Injury.
2. **Ambulance:** a road vehicle, operated by a licensed service, provided and equipped for the transport and medical Treatment of an Insured Member.
3. **Appliances**: devices and equipment used as an integral part of a surgical procedure undertaken by a Medical Practitioner or Specialist.
4. **Basic Policy**: the terms and conditions relating to the basic product that this Rider attached to and forming part of the Insurance Policy.
5. **Benefits**: the insurance coverage provided by this Rider as shown in the Certificate of Insurance and/or Benefits Schedule.
6. **Benefits Schedule:** the table showing the maximum Benefits the Company will pay to the Insured Member for this Rider.
7. **Bodily Injury**: an abnormal bodily condition which occurs while this Rider is in force and is affected directly and independently of all other causes by violent, external, visible and accidental means only and is not therefore due to any illness or disease.
8. **Co-payment:** a specified percentage of overall Eligible expenses that the Insured Member will have to bear each claim as stated in the Benefits Schedule. The remaining Benefits limit will be reduced by the net value of Eligible expenses excluding any Co-payment. There are 2 (two) different Co-payments in the Benefits Schedule:

   (i) In-network Co-payment applies when the Insured Member receives Treatment at the Hospital or Provider within the Hospital Network.
   (ii) Out-of-network Co-payment applies when the Insured Member receives Treatment at the Hospital or Provider outside of the Hospital Network.

   Once the annual maximum limit for Co-payment has been reached as stated on the Benefits Schedule, the Insured Member won't have to bear any Co-payment within the Hospital Network for the rest of the Policy Year.
9. **Dentist:** a person who is duly licensed or registered to practice dentistry in the geographical area in which a service is provided but excluding the Insured Member, respective spouses, and all immediate family members of such persons.

10. **Disability:** an Illness or the entire covered Bodily Injury arising out of a single or continuous series of causes.
11. **Drugs, Dressings and other consumables charges:** essential drugs, dressings and medicines prescribed by a Medical Practitioner or Specialist and which the Company recognises are necessary for the Treatment of the Eligible Medical Condition.
12. **Eligible:** those Treatments and charges which are covered by this Rider. In order to determine whether a Treatment or charge is covered, all sections of this Rider should be read together and are subject to all the terms, Benefits and exclusions set out in this Rider. In the event of any disagreement between the Company, Insured Member and/or the Policy Owner all parties will submit to the advice of a qualified, acceptable, third party.
13. **Emergency:** a treatment needed in the event whereby immediate medical attention is required within 24 (twenty-four) hours for injury, illness or symptoms which are sudden and severe failing which will be life-threatening (e.g. accident and heart attack), or lead to significant deterioration of health.
14. **Experimental Treatment**: any treatment which has not been approved and licensed by the local health authority regulating health treatment (including drugs) where the treatment is received.
15. **Home Medication**: Prescription or medically necessary drugs dispensed for use at home. These medications are typically part of ongoing Treatment after discharge or for Out-patient care and must be recommended by a Physician or Medical Practitioner.
16. **Hospice**: a facility that offers palliative care which is the Treatment given on specific or general advice, for the purpose of offering temporary relief of symptoms and does not provide curative Treatment.
17. **Hospital:** an establishment that is legally licensed as a medical or surgical hospital under the laws of the country in which it is situated, and which is accepted by the Company as a valid provider offering treatment at a Reasonable and Customary Charges.
18. **Hospitalised** or **Hospitalisation:** admission in a Hospital for not less than a period of 6 (six) consecutive hours upon the recommendation of a Medical Practitioner or Physician or Specialist and continuous physical stay in a Hospital prior to the Insured's discharge. Hospitalisation shall be evidenced by a room and board charge by the Hospital and the admission date must fall within the Insured Member's insured period.
19. **Hospital Network** (only available in certain countries): the medical Providers from which the Insured Member is able to obtain Treatment for Eligible Medical Conditions. Insured Member is still responsible for any Co-payment which must be settled directly with the medical Provider at the time of Treatment.
20. **Illness:** a physical or mental defect marked by a pathological deviation from the normal healthy or normal state.
21. **In-Patient:** an Insured Member who is Medically Necessary to have a Treatment at Hospital for more than 06 (six) consecutive hours.
22. **In-patient Surgical Treatment**: surgical interventions which involve the use of manual and instrumental techniques to physically alter the body.
23. **In-patient Non-surgical Treatment**: medical interventions and therapies that do not involve invasive surgical procedures. Common medical interventions are providing

medication, physical therapy, health monitoring with the use of medical devices or injections.

24. **Intensive Care Unit (ICU):** a section within a Hospital which is designated as an intensive care unit by such Hospital and which is operating on a 24 (twenty-four) -hour basis solely for treatment of patients in critical medical condition and is equipped to provide special nursing and medical services not available elsewhere in such Hospital.

25. **Eligible Medical Condition**: Any disease, injury, or disorder that affects a person's health and is covered under this Rider.

26. **Medical Practitioner:** any person qualified in western medicine who is registered with the medical council of the country of his practice to render medical or surgical services and in providing such treatment, is practicing within the scope of one's licensing and training, but excluding the Insured Member, respective spouses, and all immediate family members of such persons.

27. **Medically Necessary:** treatment, service or procedure which in the opinion of the Medical Practitioner and the medical facility where the Medical Practitioner is working is appropriate and consistent with the Diagnosis and the generally accepted medical standards.

28. **Out-patient:** the Insured Member who receives Treatment at a recognized medical facility but is not admitted to a Hospital bed as an In-patient.

29. **Overall Annual Limit**: the maximum amount payable per Policy Year for each Insured Member.

30. **Per Disability:** any illness or injury from the same cause including any and all complications thereof as well as concurrent Disabilities from different cause during the same hospital confinement, except that after thirty (30) days following the latest discharge from Hospital, a subsequent Disability from the same cause shall be considered as new Disability. For cancer Treatment, all occurrences, recurrences, metastases, or secondary manifestations of cancer, shall be regarded as the same Disability as the initial cancer diagnosis, regardless of the time elapsed since the latest Hospital discharge.

31. **Psychiatrist:** a registered medical practitioner, who is licensed to render psychiatric treatment, but excluding the Insured Member, respective spouses, and all immediate family members of such persons.

32. **Physician or Surgeon**: a registered Medical Practitioner qualified and licensed to practice western medicine and who, in rendering such treatment, is practicing within the scope of his licensing and training in the geographical area of practice, but excluding the Insured Member, respective spouses, and all immediate family members of such persons.

33. **Physiotherapist:** a person who is qualified and licensed to practice as a Physiotherapist where the Treatment is given and who is accepted by the Company as a valid practitioner offering treatment at a Reasonable and Customary Charges, but excluding the Insured Member, respective spouses, and all immediate family members of such persons.

34. **Pre-Existing Condition:** Illnesses that the Insured Member has reasonable knowledge of. An Insured Member may be considered to have reasonable knowledge of a Pre-Existing Condition where the condition is one for which:

    (i) the Insured Member had received or is receiving treatment; or

    (ii) medical advice, diagnosis, care or Treatment has been recommended; or

(iii) clear and distinct symptoms are or were evident; or
(iv) its existence would have been apparent to a reasonable person in the circumstances.

35. **Provider:** A medical facility which is legally licensed to supply medical or surgical Treatment in the country in which it is provided and which is accepted by the Company as a valid provider offering Treatment at a Reasonable and Customary Charges.

36. **Reasonable and Customary Charges:** any fee or expense which is charged for Treatment, supplies or medical service that is medically necessary to treat the condition and which is in accordance with the standards of good medical practice for the care of an injured or ill person under the supervision or order of a Physician or Specialist and which does not in the Company's opinion or in the opinion of the Company's medical advisor:

(i) exceed the usual level of charges for similar Treatment, supplies or medical services;
(ii) include fees or charges that would not have been made if no insurance had existed;
(iii) exceed the upper bound of the fee benchmarks recommended by the government, the Ministry of Health in the country; or
(iv) exceed the Company's internal benchmarks for episodes of care with similar diagnoses or procedures performed.

37. **Specialist:** a medical or dental practitioner registered and licensed to practice western medicine in the geographical area of his practice where Treatment takes place and who is classified by the appropriate health authorities as a person with superior and special expertise in specified fields of medicine or dentistry, but excluding the Insured Member, respective spouses, and all immediate family members of such persons.

38. **Specified Illnesses:** the following medical conditions and its related complications:

(i) Hypertension, diabetes mellitus and Cardiovascular disease;
(ii) All tumours, cancers, cysts, nodules, polys, stones of the urinary system and biliary system;
(iii) All ear, nose (including sinuses) and throat conditions;
(iv) Hernias, haemorrhoids, fistulae, hydrocele, varicocele;
(v) Endometriosis including disease of the Reproduction system;
(vi) Vertebro-spinal disorders(including disc) and knee conditions.

39. **Surgery:** any of the following medical procedures:

(i) To incise, excise or electrocauterize any organ or body part, except for dental services.
(ii) To repair, revise, or reconstruct any organ or body part both invasive and non-invasive.
(iii) To reduce by manipulation a fracture or dislocation.
(iv) Use of endoscopy to remove a stone or object from the larynx, bronchus, trachea, esophagus, stomach, intestine, urinary bladder, or urethra.

40. **Treatment:** Surgical, medical or other medical procedures, the sole purpose of which is the cure or relief, within a reasonable time, of an Eligible Medical Condition.

41. **Waiting Period:** A period of time, expressed in number of days or months and starting from the Member Effective Date and during which Treatment is not covered under this Rider.

II. SUBJECT OF INSURANCE

This Rider has the body (health) as the subject of insurance.

III. SCOPE OF COVERAGE

A. CORE BENEFITS

1. **Daily Hospital Room and Board Benefit** reimburses charges for accommodation, including meals, while the Insured Member is admitted into a Hospital as an in-patient. The amount payable per day is up to the limit shown in the Benefits Schedule.

   If the actual daily hospital room and board charge is higher than the Insured Member's Hospital Room and Board benefit limit, the Insured Member will have to pay for the difference between the actual hospital room and board charge and the daily limit stated on the Benefits Schedule for the duration of the Hospital stay.

2. **In-patient Treatment Benefit** reimburses medical charges for In-patient Surgical Treatment and In-patient Non-Surgical Treatment that are Medically Necessary for the following if the Insured Member is confined in a Hospital ward or room:

   (i) Surgeon and anesthetist fees;
   (ii) Operating theatre room charges;
   (iii) Intensive Care Unit and other similar special medical units;
   (iv) Drugs, Dressings and other consumables charges;
   (v) Physician and Specialists visit fees, up to 03 (three) visits per Physician or Specialist per day;
   (vi) Basic medical care;
   (vii) Implants and internal prosthetics;
   (viii) Diagnostic and investigation charges, including laboratories;
   (ix) Diagnostic scans including MRI, CT Scan, PET Scan;
   (x) Spinal supports, knee braces, or air cast if they are part of the surgical procedure and integral to the Treatment;
   (xi) Physiotherapy sessions given by a licensed Physiotherapist during the hospitalisation;
   (xii) Dialysis;
   (xiii) Cancer Treatment;
   (xiv) Treatment provided with intention of relieving symptoms once the Insured Member is diagnosed with terminal illness;
   (xv) Up to 14 (fourteen) days' Home Medications prescribed before discharge and integral to the ongoing Treatment of the cause of hospitalisation.

   The amount payable per Policy Year is up to the limit shown in the Benefits Schedule.

3. **Out-patient Cancer Treatment Benefit** reimburses chemotherapy, radiotherapy, and immunotherapy for a covered Illness received as an out-patient as well as the consultation, medication, and diagnostic tests for and during these Treatments. The amount payable per Policy Year is up to the limit shown in the Benefits Schedule.

4. **Out-patient Dialysis Benefit** reimburses dialysis and consultation received as an Out-patient. The amount payable per Policy Year is up to the limit shown in the Benefits Schedule.

5. **Out-patient Surgical Procedure Benefit** reimburses consultation charges and procedure charges for surgical Treatment received as an Out-patient including pre-Surgery and post-Surgery consultation and investigations. The amount payable per Policy Year is up to the limit shown in the Benefits Schedule.

6. **Maternity Complications Benefit** reimburse the Eligible expenses incurred if the Insured requires Hospitalisation in a Hospital to undergo medical or surgical Treatment due to one of the following pregnancy complications as defined herein:

   (i) Ectopic pregnancy – Diagnosis by an obstetrician of a condition in which implantation of a fertilised ovum occurs outside the uterine cavity, and its subsequent complications; or

   (ii) Retained placenta – Diagnosis by an obstetrician of the retention of the placenta or other products of conception in the uterus after delivery; or

   (iii) Hydatidiform mole – occurrence of a histologically confirmed choriocarcinoma and/or molar pregnancy, and its subsequent complications; or

   (iv) Placenta praevia – Diagnosis by an obstetrician of the presence of placental tissue extending over the internal cervical os, resulting in an indication for cesarean delivery; or

   (v) Eclampsia – Diagnosis of or eclampsia by an obstetrician; or

   (vi) Post-partum haemorrhage – the ongoing bleeding secondary to an unresponsive and atonic uterus, a ruptured uterus, or a large cervical laceration extending into the uterus requiring hysterectomy. Proof of actual undergoing of hysterectomy is required; or

   (vii) Miscarriage requiring immediate surgical Treatment – Diagnosis by an obstetrician of the death of the foetus of the Insured after 13 (thirteen) weeks of pregnancy as a result of a sudden unforeseen and involuntary event and must not be due to a voluntary or malicious act

   This benefit does not cover costs associated with baby delivery, regardless of the mode of delivery (natural or C-section), except in the case of an Emergency C-section due to one of the above-mentioned pregnancy complications. For the avoidance of doubt, costs associated with baby delivery include, without limitation, Hospital daily charges, Physician visits, nursing and midwifery care, new-born nursing and new-born baby vaccinations administered in the Hospital.

   The amount payable per Policy Year for this benefit is up to the limit shown in the Benefits Schedule.

7. **Pre and Post Hospitalisation Out-patient Treatment Benefit:** prior to the hospitalisation and after discharge, the Insured Member may have to undergo pre-admission visits and post-hospitalisation follow-up consultant or therapy. The Company will reimburse consultation charges, prescribed medications, diagnostic tests and investigations, physiotherapy, osteopathy, and chiropractic Treatment related to the cause of hospitalisation and incurred within 90 (ninety) days prior to and after the hospitalisation the Insured Member stay. All the amount payable per hospitalisation is up to the limit shown in the Benefits Schedule.

8. **Emergency Ground Ambulance Transport Benefit** reimburses ground ambulance transport to and between Hospitals if the Insured Member is hospitalised due to an Emergency. The amount payable per hospitalisation is up to the limit shown in the Benefits Schedule.

9. **Accidental Emergency Care Benefit** reimburses consultation, investigation, and Treatment in an Accident and Emergency unit (or equivalent) following an Accident providing Treatment is given within 72 (seventy-two) hours following the Accident. Plaster and basic slings will be covered but not for durable medical Appliances or supports. This benefit

includes follow-up Treatment within 90 (ninety) days from the Accident taking place. The amount payable per Policy Year is up to the limit shown in the Benefits Schedule.

This benefit includes accidental damage to natural teeth. The Company would pay for consultation, investigation and Treatment in an Emergency ward, to stabilize the condition, clean the wound, remove any tooth debris. The Company will cover the following types of dental Treatment when they are needed following accidental damage caused by external impact to the mouth and jaw:

(i) the reasonable cost of replacing a crown

(ii) implants needed for clinical reasons (not cosmetic)

The Company will only pay for Treatment if the damage is noticed within 07 (seven) days of the accidental damage taking place and the Treatment takes place within 90 (ninety) days. However the Treatment following damage caused by any of the following will not be covered:

(i) normal wear and tear;

(ii) eating or drinking something that contains a foreign body;

(iii) boxing or playing rugby without wearing suitable mouth protection; or

(iv) brushing your teeth or any other oral hygiene procedure.

10. **Secondary Claim Benefit** will be provided if an Eligible claim for Daily Hospital Room & Board Benefit, or Out-patient Cancer Treatment Benefit, is reimbursed by another insurance policy or scheme. For each day of Hospital stay, or each day the Insured Member receives cancer Treatment as an out-patient, the Company will pay a cash amount as shown in the Benefits Schedule. This benefit is payable for 15 (fifteen) days at maximum per Policy Year. Once this benefit is paid, no other benefit will be payable for the same Treatment.

    For the avoidance of doubt, for the Daily Hospital Room and Board Benefit, or Out-patient Cancer Treatment Benefit received free of charge, no claim amount will be provided for the Secondary Claim Benefit.

B. OPTIONAL BENEFITS

Policy Owner can purchase one or more of the following optional benefits for the Insured Member(s) in addition to the Core Benefits. Please refer to the Benefits Schedule applicable to the Insured Member's plan for further information on the available optional benefits to the Insured Member.

11. **Optional Hospital Companion Benefit** covers the companion's accommodation fee while the Insured Member is hospitalised. The amount payable per Policy Year is up to the limit shown in the Benefits Schedule.

12. **Optional Durable Medical Equipment Benefit** reimburses durable medical equipment up to the amount shown in the Benefits Schedule provided the equipment:

    (i) provides therapeutic benefit to the Insured Member because of certain Medical Conditions and/or Illness; and
    (ii) is prescribed by a licensed Medical Practitioner; and
    (iii) does not serve primarily as a comfort or convenience item; and
    (iv) does not have significant non-medical uses.

    The amount payable per Policy Year is up to the limit shown in the Benefits Schedule.

13. **Optional Preventive Care Benefit** reimburses expenses incurred by the Insured Member for consultations, investigations, and vaccinations received for preventive purpose. The amount payable per Policy Year is up to the limit shown in the Benefits Schedule.

14. **Optional Out-patient Care Benefit** reimburses consultations, up to 90 (ninety) days' Home Medication, dressings and investigations the Insured Member received as an out-patient. The amount payable per visit is up to the amount shown in the Benefits Schedule. The amount payable per Policy Year is up to the limit shown in the Benefits Schedule.

    This benefit does not cover expenses or charges related to physiotherapy.

15. **Optional Dental Care Benefit** reimburses expense incurred by the Insured Member for Dentist consultations, tooth extraction, fillings, root canal Treatment, gingival Treatment, routine dental Treatment, crowns and bridgework and orthodontic Treatment. The amount payable per Policy Year is up to the limit shown in the Benefits Schedule.

    Policy Owner can only purchase this benefit if the Out-patient Care Benefit is chosen.

16. **Optional Vision Care Benefit** reimburses expenses incurred by the Insured Member for corrective lenses, spectacle frames and corrective contact lenses (sunglasses excluded). The amount payable per Policy Year is up to the limit shown in the Benefits Schedule.

    Policy Owner can only purchase this benefit if the Out-patient Care Benefit is chosen.

17. **Optional Hospice Care Benefit** reimburses charges for the accommodation, care, and nursing service provided by a registered Hospice to an Insured Member who is terminally ill due to a covered Accident or Illness. Terminally ill means, in the opinion of a registered Medical Practitioner, the Insured Member is highly likely to die in 12 (twelve) months or less. The hospice care must be prescribed and certified by a registered Medical Practitioner. The amount payable per Policy Year is up to the limit shown in the Benefits Schedule.

18. **Optional Mental Care Benefit** reimburses Reasonable and Customary Charges for In-patient and Out-patient Treatment of the Insured Member's mental health care, provided that the Insured Member is diagnosed by a Psychiatrist, with one of the following covered mental illnesses:

    (i) Major Depressive Disorder (MDD): Shall mean a severe mental disorder characterized by a persistent feeling of sadness and loss of interest, with clinically significant distress or impairment in social, occupational, or other important areas of functioning. The diagnosis of MDD must be confirmed by a Psychiatrist based on the DSM-5 criteria or any subsequent DSM update or alternative criteria that supersedes DSM.

    (ii) Obsessive Compulsive Disorder (OCD): Shall mean a chronic and long-lasting disorder characterized by both obsessions and compulsions, and has resulted in marked impairment in social or occupational functioning.The diagnosis of OCD must fulfil all of the following criteria:

        a. Diagnosis of OCD must be confirmed by a Psychiatrist based on the DSM-5 criteria or any subsequent DSM update or alternative criteria that supersedes DSM.
        b. The OCD must be classified as "severe" or "extreme" under the Y-BOCS / CY-BOCS (for child or adolescent) scale which is assessed by the Psychiatrist.

    (iii) Schizophrenia: Shall mean a psychotic disorder that is characterized by major disturbances in cognitive functioning, emotion and behaviour. The diagnosis of

Schizophrenia must be confirmed by a Psychiatrist according to DSM-5 criteria or any subsequent DSM update or alternative criteria that supersedes DSM.

(iv) Bipolar Disorder: Shall mean as manic-depressive illness also, a mental disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. The diagnosis of Bipolar Disorder must be confirmed by a Psychiatrist according to DSM-5 criteria or any subsequent DSM update or alternative criteria that supersedes DSM.

(v) Tourette Syndrome: Shall mean a neurological condition (affecting the brain and nervous system), characterised by a combination of involuntary noises and movements called tics. The diagnosis of Tourette Syndrome must be confirmed by a Psychiatrist based on the DSM-5 criteria or any subsequent DSM update or alternative criteria that supersedes DSM.

(vi) Postpartum Depression: Shall mean as postnatal depression also, a type of depression suffered by a mother following childbirth, typically arising from the combination of hormonal changes, psychological adjustment to motherhood, and fatigue. The diagnosis of Postpartum Depression must be confirmed by a Psychiatrist according to DSM-5 criteria or any subsequent DSM update or alternative criteria that supersedes DSM.

The amount payable per Policy Year for this benefit is up to the limit shown in the Benefits Schedule.

19. **Optional Maternity Delivery Benefit** reimburses hospital daily charges, surgeon and anesthetist fees, Physician visits, operating theatre charges, nursing and midwifery care, new-born nursing and new-born baby vaccinations administered in the Hospital, Newborn Complications, Prenatal and Postnatal treatment.

    a. Newborn Complications: any complications arising to the newborn and necessitating hospitalization, provided the mother is still covered by the Company, and Treatment takes place during the first 30 (thirty) days after birth.
    b. Prenatal and Postnatal Treatment: any consultations, ultrasound and Medically Necessary vitamins or supplements and investigations during pregnancy for prenatal treatment, and up to 30 days after delivery for postnatal treatment.

    The amount payable per Policy Year for this benefit is up to the limit shown in the Benefits Schedule.

20. **Optional In-patient Vitamins & Supplements Benefit** reimburses vitamins and supplements charges that are Medically Necessary and Prescribed by a Medical Practitioner or Physician during an In-patient Hospitalisation. Coverage applies only when such items are part of the Treatment plan for the underlying conditions during the Hospital stay. The amount payable per Policy Year for this benefit is up to the limit shown in the Benefits Schedule.

21. **Optional Out-patient Physiotherapy Treatment Benefit** reimburses Medically Necessary physiotherapy sessions prescribed by a Medical Practitioner when the Insured Member received as an Out-patient Treatment. Treatment following a Surgery, recovering from injury, or to manage chronic conditions such as arthritis or back pain. This benefit is payable for 15 (fifteen) sessions at maximum per Policy Year.

The parties reserve the right to add any new benefits to the Core Benefits and Optional Benefits as mutually agreed.

IV. INSURANCE BENEFITS

No.	Type of Coverage	Amount of Insurance
	Core Benefits	
1	Daily Hospital Room and Board Benefit	Up to benefit limit stated in the Benefits Schedule
2	In-patient Treatment Benefit	
2.1	In-patient Surgical Treatment Benefit	Up to benefit limit stated in the Benefits Schedule
2.2	In-patient Non-Surgical Treatment Benefit	
3	Out-patient Cancer Treatment Benefit	Up to benefit limit stated in the Benefits Schedule
4	Out-patient Dialysis Benefit	Up to benefit limit stated in the Benefits Schedule
5	Out-patient Surgical Procedure Benefit	Up to benefit limit stated in the Benefits Schedule
6	Maternity Complications Benefit	Up to benefit limit stated in the Benefits Schedule
7	Pre and Post Hospitalisation Out-patient Treatment Benefit	Up to benefit limit stated in the Benefits Schedule
8	Emergency Ground Ambulance Transport Benefit	Up to benefit limit stated in the Benefits Schedule
9	Accidental Emergency Care Benefit	Up to benefit limit stated in the Benefits Schedule
10	Secondary Claim Benefit	Up to benefit limit stated in the Benefits Schedule
	Optional Benefit	
11	Optional Hospital Companion Benefit	Up to limit stated in the Benefits Schedule
12	Optional Durable Medical Equipment Benefit	Up to limit stated in the Benefits Schedule
13	Optional Preventive Care Benefit	Up to limit stated in the Benefits Schedule
14	Optional Out-patient Care Benefit	Up to limit stated in the Benefits Schedule
15	Optional Dental Care Benefit	Up to limit stated in the Benefits Schedule
16	Optional Vision Care Benefit	Up to limit stated in the Benefits Schedule

17	Optional Hospice Care Benefit	Up to limit stated in the Benefits Schedule
18	Optional Mental Care Benefit	Up to limit stated in the Benefits Schedule
19	Optional Maternity Delivery Benefit	Up to limit stated in the Benefits Schedule
20	Optional In-patient Vitamins & Supplements Benefit	Up to limit stated in the Benefits Schedule
21	Optional Out-patient Physiotherapy Treatment Benefit	Up to limit stated in the Benefits Schedule

V. PREMIUM PAYMENT PROVISIONS

1. The Policy Owner can pay their Premium via the method specified by the Company. The validated deposit slip or premium deduction shown in your account statement shall be considered as proof of payment.
2. The frequency of Premium payments under this Rider shall always be same as frequency of Premium payment of the Basic Policy. The Rider frequency of Premium payment will change if the frequency of Premium payment of Basic Policy is changed by the Policy Owner.
3. The Company shall have the right to change the rate at which the premiums shall be calculated, (a) on any Policy Anniversary Date, or (b) on any Due Date provided the rate that is then being charged has been in effect for at least 12 (twelve) months, or (c) when the risks being insured against under the Policy have increased, or (d) when there is substantial changes to membership on which premium is based and provided further that the Company notifies the Policy Owner at least 30 (thirty) days in advance of such Due Date.

   Premium adjustments involving return of unearned premiums to the Policy Owner shall be limited to the period starting with the latest Policy Anniversary Date preceding the date of receipt by the Company of evidence that such adjustments should be made.
4. Other Premium payment provisions shall follow the Basic Policy.

VI. EXCLUSIONS

This Rider shall not cover:

1. Cosmetic surgery or Treatment, or Treatment of their complications, Treatment to remove hair or grow hair, change skin or eye color with the exception of reconstructive surgery after an accident or an Eligible Treatment; or
2. Treatment needed as a result of nuclear contamination, biological contamination or chemical contamination, whilst engaging in or taking part in any conflict, war, act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons, or any event similar to one of

those listed. This includes any Treatment needed as a result of the Insured Member exposing himself to needless peril, such as going to a place of civil unrest as an active onlooker or a spectator. For clarity, there is cover for Treatment required as a result of a terrorist act providing that terrorist act does not result in nuclear, biological or chemical contamination; or

3. Treatment resulting from engaging in military activity or professional sport activities; or
4. The use of a drug which has not been established as being effective or which is experimental. This means they must be licensed by the European Medicines Agency if the Insured Member is receiving Treatment in Europe, or the US Food and Drug Administration (FDA) if the Insured Member is receiving Treatment anywhere else in the world, and be used within the terms of that license; or
5. Treatment which has not been established as being effective or which is experimental. For established Treatment, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced in published medical journals for specific purposes to be considered proven safe and effective therapies; or
6. Fertility Treatment, sterility and contraception treatment, sex change, impotence and any complications arising from or related to such treatments; or
7. Treatment provided by a non-medical or non-licensed medical professional; or
8. Foetal surgery; or
9. Medical expenses that arise from, or are in any way related to, Human Immunodeficiency Virus (HIV) and/or HIV related Illnesses, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) and/or any mutant derivative or variations thereof, within the first year from the Member Effective Date; or
10. Expenses that are not for medical Treatment such as telephone, TV rent, newspaper, moisturizer, creams, toiletries, dietary supplements and vitamins, toothpaste or soap; or
11. Treatment that is not Medical Necessary, costs that are not usual, Reasonable and Customary in the area where Treatment is received; or
12. Treatment, procedure, or surgery for obesity such as, but not limited to, gastric banding or surgery, removal of surplus issue and fat; or
13. Treatment that is customarily done as an out-patient including drugs and dressings, consultations and investigations, including prenatal and postnatal visits except those out-patient Treatments allowed as stated in the Benefits Schedule; however, the Company will pay for out-patient Treatment up to the limit shown under Optional Out-patient Care Benefit, including medications, dressings, consultations and investigations if the Optional Out-patient Care Benefit has been purchased; or
14. Treatment on newborn complications, as well as prenatal and postnatal treatment; however, the Company will pay for these treatments if the Optional Maternity Delivery Benefit has been purchased; or
15. Preventative health screening, health check-up, vaccination, diagnostic procedures and investigations for the early detection of non-symptomatic disease; however, the Company

will pay for preventive health screening up to the limit shown in the Benefits Schedule if the Optional Preventative Care Benefit has been purchased; or

16. Vaccination for newborns; however, the Company will pay for the vaccination if the Optional Maternity Delivery Benefit has been purchased; or
17. Mental illness even if it requires Hospital admission; however, the Company will pay for mental illness expenses up to the limit shown in the Benefits Schedule if the Optional Mental Care Benefit has been purchased; or
18. Dental and gingival (or equivalent) care; however, the Company will pay for dental care up to the limit shown in the Benefits Schedule if the Optional Dental Care Benefit has been purchased; or
19. Vision correction; however, the Company will pay for vision care up to the limit shown in the Benefits Schedule if the Optional Vision Care Benefit has been purchased; or
20. Medical expenses incurred during the Waiting Period except for medical expenses arising following an accident occurred within the Waiting Period and subject to other exclusions; or
21. External prosthetics and durable medical appliances and support appliances other than those that are part of the surgical procedure and integral to the Treatment; however, the Company will pay for durable medical equipment up to the limit shown in the Benefits Schedule if the Optional Durable Medical Equipment Benefit has been purchased; or
22. The cost of collecting donor organs or issue or for any related administration costs (such as, but not limited to, the cost of a donor search); or
23. Additional charges for obtaining medical reports or filling in claim forms or other administrative charges; or
24. Treatment for addictions (such as alcohol addiction or drug addiction) or substance abuse (such as alcohol abuse or solvent abuse), or Treatment of any Illness or injury needed directly or indirectly as a result of any such abuse or addiction; or
25. Expenses or charges related to pregnancy; however, the Company will pay for these expenses if the Optional Maternity Delivery Benefit is purchased; or
26. Medical services provided by healthcare providers who are not duly licensed, or by healthcare providers blacklisted by the Company as notified by the Company from time to time, regardless of medical necessity; or
27. Any medical services, advice, diagnosis, or treatment provided through tele-consultation, telemedicine, or any other remote consultation methods, whether via phone, video call, mobile application, or online platform if the Optional Mental Care Benefit has been purchased.

VII. GEOGRAPHIC AREA

The Company offers 04 (four) options for geographic area of coverage for non-Emergency cases:

1. Zone 1: Cambodia, Thailand, Vietnam, Myanmar, Laos, and Malaysia

2. Zone 2: Asia
3. Zone 3: Worldwide exclude USA
4. Zone 4: Worldwide

For Emergency cases, the coverage is applicable for worldwide.

The geographic area applicable for the Insured Member's coverage is mentioned in the Benefits Schedule.

Policy Owner can change the geographic area at Policy Anniversary by sending the Company the written request.

VIII. BENEFICIARY

1. The Beneficiary of this Rider is the Insured Member.
2. Each Insured Member shall designate in writing a beneficiary or beneficiaries to whom the benefits under this Rider shall be payable in the event of death and such designation shall be filed with the Policy Owner.
3. If on the death of the Insured Member, no Beneficiary is nominated, or the person(s) nominated is/are dead, the moneys payable may be paid to successor. This is subject to the laws in force at the time.
4. During the Insured Member's coverage, he/she shall be entitled to change the Beneficiary by written notice to the Policy Owner. Such change shall take effect on receipt of such notice by the Policy Owner.

IX. ALTERATION

If a party wishes to make any alteration to any benefits or provisions under this Rider, the said alteration has to be agreed by the parties through an Endorsement. Any Endorsement to this Rider shall bind all Insured Members whether insured under this Rider before or on or after the effective date of the Endorsement. The Endorsement has to be signed by the Company's authorized officer.

X. RENEWAL CLAUSE

This Rider is issued for the term of one year and shall be renewed at the end of each Policy Year, at the Company's prevailing premium, provided the Company issue an official receipt for the payment of the premium due on the following Policy Year. The Company reserves the right to revise or adjust the rate of premium charged, terms and conditions at any Policy Anniversary Date, by notifying Policy Owner in writing.

XI. TERMINATION

The Rider shall automatically terminate upon:

(i) this Rider becomes expired, terminated, lapsed; or

(ii) the Basic Policy becomes expired, terminated, lapsed, cancelled, or is surrendered.

whichever occurs earlier.

Policy Owner can request in writing to the Company (in the Company's prescribed form) to terminate this Rider at any time. If Policy Owner requests to terminate the Policy on a date other than a Due Date, no refund of premiums (if any) shall apply. Termination shall be without prejudice to any claim originating prior to the effective date of termination.

The payment or acceptance of any premium after the termination of this Rider shall not create any liability on the Company's part but the Company shall refund any such premium without interest.

XII. CANCELLATION

(i) The Company reserves the right to cancel this Rider as at the Due Date by written notice of cancellation to Policy Owner before the Expiry Date on which such termination shall be effective. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

The payment or acceptance of any Premium after the cancellation of this Rider shall not create any liability on the Company's part, but the Company shall refund any such Premium without interest.

(ii) The Company will rely on the information provided to us in deciding whether or not to accept Your/Insured Member's application. All statements made in Your/Insured Member application are, in the absence of fraud, regarded as representations. In other words, both You and the Insured Member must answer all the questions in Your/Insured Member application accurately and reveal all the facts both of you/Insured Member knows, or ought to know. Otherwise, the Company can void the Policy or deny a claim or vary the terms and conditions of this Policy.

If the Company discovers that You or the Insured Member have made a claim that is fraudulent, your Policy or insurance of the Insured Member will become void immediately and the Company will not refund any Premium. The Company reserves the right to recover any payment the Company has made for fraudulent claims.

XIII. CLAIM PROCEDURES

1. PRE-AUTHORISATION

Pre-authorisation is the process by which the Insured Member needs to obtain approval from the Company prior to the Treatment for certain medical procedures or Treatments as indicated in the Benefits Schedule. If the Pre-authorisation is not completed before such medical procedures or Treatment, the Company reserves the right to review the Eligibility of the claim.

The Insured Members must submit a completed Pre-authorisation Form to the Company at least 5 (five) working days prior to the scheduled procedure or Treatment date. The

Company will review and respond to the Insured Members in writing prior to the commencement of the proposed medical Treatment.
Pre-authorisation does not guarantee payment of a claim in full, as Co-payment and annual limits may apply.
Benefits payable under this Rider are still subject to eligibility at the time charges are actually incurred, and to all other terms, limitations and Exclusions of this Rider.

2. QUALIFICATIONS OF THE CLAIMANT

The claimant can be the Insured Member or Beneficiary(ies) (in the event of death). The claimant shall be at least 18 (eighteen) years old.

3. NOTICE OF CLAIM

(i) Notice of a claim must be provided to the Company within 90 (ninety) days of the occurrence of any event which may give rise to a claim under this Rider. If the claimant fails to give the notice within this period, the Company will not invalidate any claim if it is shown to have been not reasonably possible to give such notice and that the notice was given as soon as was reasonably possible.

(ii) The notice can be submitted at AIA Office or contact Client Services (855) 86 999 242 or your life planner or email to Kh.claim@aia.com.

(iii) Proof of evidence including but not limited to original receipt, medical certificate, medical discharge letter, and any medical document shall be submitted together with the claim form to the Company. All medical documents must be obtained from medical facility which is legally licensed to supply medical treatment in the country. The Company reserves the rights to request any other document(s)/report(s) as the Company deems necessary for the purpose of processing the claim.

4. CLAIM TURNAROUND TIME

The Company reserves the rights to evaluate document(s)/report(s) and make decision on the claim within 15 (fifteen) working days of the date the Company has received the full document(s)/report(s) of the claim.

5. CLAIM REIMBURSEMENT METHOD

The Company will deposit the claim into the bank account provided by the claimant to the Company.

6. EXAMINATION

In case of a question or dispute concerning coverage, the Company reserves the right to require that a Physician or Medical Practitioner acceptable to the Company examine an Insured Member at the Company's expense.

XIV. CONFIDENTIALITY

Any information provided to the Company shall be treated as confidential and no personal information shall be disclosed to third party without prior consent unless required or approved by in force law or regulations.

XV. DISPUTE RESOLUTIONS

1. COMPLAINT PROCEDURES

Any complaint received will be addressed and analysed within a reasonable timeframe to determine the root cause and the appropriate course of action in accordance with the Company's standard operating procedures. Complaints can be submitted to the Company via email Kh.care@aia.com or by calling the phone number (855) 86 999 242.

2. DISPUTE RESOLUTIONS

For any dispute arising in relation to the conduct of insurance business, the disputing parties may bring the case to the Insurance Regulator of Cambodia for mediation before filing a lawsuit to arbitration or a competent court, except a criminal case.

XVI. JURISDICTION

This Policy shall be governed by jurisdiction of the Kingdom of Cambodia.