INSURANCE POLICY AIA ComCare

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INSURANCE POLICY

AIA ComCare

I. DEFINITIONS

In this Policy where consistent with the contents the singular shall include the plural, words importing the masculine gender shall include the feminine gender; and each of the following words and expressions shall have the following meanings:

1. **Accident** shall mean 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. **Accidental Disability Group 1** shall mean Complete and Permanently Irrecoverable Loss of the following:
   (i) one limb; or
   (ii) one eye; or
   (iii) both thumbs (2 joints/phalanges for each thumb); or
   (iv) both great toes (2 joints/phalanges for each great toe); or
   (v) four fingers (3 joints/phalanges for each finger) and one thumb (2 joints/phalanges for thumb) of the same hand; or
   (vi) four toes (at least 1 joints/phalanges for each toe) and one great toe (2 joints/phalanges for great toe) of the same foot
   (vii) hearing on one ear; or
   (viii) whole thumb (2 joints/phalanges); or
   (ix) whole index finger (3 joints/phalanges); or
   (x) whole middle finger (3 joints/phalanges); or
   (xi) whole ring finger (3 joints/phalanges); or
   (xii) whole little finger (3 joints/phalanges).
3. **Accidental Disability Group 2** shall mean Complete and Permanently Irrecoverable Loss of the following:
   (i) two limbs; or
   (ii) two eyes; or
   (iii) one limb and one eye; or
   (iv) speech; or
   (v) hearing of both ears.
4. **Accidental Injury** means death or Injury which results directly from Bodily Injury and occurs within 90 (ninety) days from the date of Accident.
5. **Active Service** shall refer to that an Insured Member who is actively at work and not working against medical advice and must be:
   (i) following his normal occupation; and
   (ii) working his normal number of contracted hours; and
   (iii) working at his normal place of business or at a location where business needs him to travel; and
   (iv) should not have been off work on medical leave for more than 2 weeks in the past year.

6. **Amount of Insurance** shall refer to the amount of coverage purchased as shown in the Certificate of Insurance or as revised by an Endorsement from time to time.
7. **Assessment Period** shall mean the period during which the Company will assess a condition before deciding whether the condition qualifies as being permanent. The Assessment Period will be for the minimum period time frame stated in the relevant definition and will not be longer than 12 (twelve) months (provided all required evidence has been submitted).
8. **Beneficiary** refers to the third party(ies) of a contract who is entitled to legal benefits from this Policy.
9. **Bodily Injury** shall mean an abnormal bodily condition which occurs while this Policy is in force and is effected 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.
10. **Cambodian Law** shall mean any and all applicable laws and regulations of the Kingdom of Cambodia in force and/or any amendments in relation thereof.
11. **Certificate of Insurance** refers to documents issued by the Company to certify the fact that the Policy Owner has purchased insurance from the Company.
12. **Company** refers to AIA (Cambodia) Life Insurance Plc.
13. **Complete and Permanently Irrecoverable Loss** shall mean physical loss of eye(s) or complete blindness, loss of arm(s) above the wrist, loss of leg(s) above the ankle, total and irrecoverable loss of hearing or loss of speech respectively.

    In this definition, Complete and Permanently Irrecoverable Loss of use of arm(s) and leg(s) is applicable if it is certified by a registered Hospital at provincial level or above that the loss lasts for at least 6 (six) months. Such certification could be carried out at any time within the Policy term and when the Policy is in full force.
14. **Covered Surgery** shall mean the various surgical operations or procedures defined or specified in the Critical Illness Table (Appendix II).
15. **Critical Illness Category** shall mean the category of Critical Illness Events as set out in the Critical Illness Table (Appendix II).
16. **Critical Illness Event** shall mean when the Insured Member is diagnosed to be suffering from a critical illness or actually undergoes a Covered Surgery for a critical illness as set out in the Critical Illness Table (Appendix II).
17. **Diagnosis** shall mean the definitive Diagnosis made by a Physician, as defined below, based upon such specific evidence, as referred in the definition of the particular Critical Illness Event concerned or, in the absence of such specific evidence, based upon radiological, clinical, histological or laboratory evidence acceptable to the Company. Such Diagnosis must be supported by the Company's Medical Director who may base his opinion on the medical evidence submitted by the Insured Member and/or any additional evidence which the former may require.

    In the event of any dispute or disagreement regarding the appropriateness or correctness of the Diagnosis, the Company shall have the right to call for an examination, of either the Insured Member or the evidence used in arriving at such Diagnosis, by an independent acknowledged expert in the field of medicine concerned selected by the Company and the

opinion of such expert as to such Diagnosis shall be binding on both Insured Member and the Company.

18. **Discharge** shall mean the departure of the Insured Member from the Hospital, following finalization of all formal procedures within the Hospital to end the Hospitalisation and billing of outstanding charges for full settlement, with no room or bed retained for the Insured Member at the Hospital.
19. **Due Date** shall mean the date for payment of premiums as stated in the Company's billing statement or any notification from the Company.
20. **Eligibility Date** shall mean the date a person becomes a Member as described in the Certificate of Insurance and updated Member Listing.
21. **Endorsement** shall mean a variation to this Policy.
22. **Grace Period** shall mean a period of 30 (thirty) days from the Due Date which will be allowed for payment of each subsequent premium. The Policy will remain in force during the Grace Period.
23. **Group 1 Illness/Surgery** shall mean the Critical Illness Event as defined in the Critical Illness Table (Appendix II)
24. **Group 2 Illness/Surgery** shall mean the Critical Illness Event as defined in the Critical Illness Table (Appendix II)
25. **Hospital** shall mean medical establishments in the list provided by the Company, which the Company may update from time to time, or any medical establishment duly constituted and registered for the care and treatment of sick and injured persons as paying bed-patients, which:
    (i) has facilities for Diagnosis and major Surgery;
    (ii) provides 24 hours a day nursing services by registered and graduate nurses;
    (iii) is under the supervision of a Medical Practitioner; and
    (iv) is not primarily a clinic, a place for alcoholics or drug addicts, a nursing, rest or convalescent home or a home for the aged or similar establishment.
26. **Hospitalisation** or **Hospitalised** shall mean be warded in a licensed Hospital for a minimum of 6 (six) consecutive hours with proof of room and board charged by the Hospital, provided the Hospitalisation is Reasonable and Customary.
27. **Injury** shall mean Bodily Injury caused solely by Accident.
28. **Insurance Contract** refers to written agreement between the Company and the Policy Owner in which the Company agrees to accept any specific risk, and in return receives premium paid by the Policy Owner.
29. **Insurance Policy** or **Policy** refers to a legal binding document issued by the Company stipulating major substance and detailed terms and conditions that are agreed between the Company and the Policy Owner in the Insurance Contract. Insurance Policy shall be attached with Certificate of Insurance or other related documents.
30. **Insured Members** shall mean Members who are insured under this Policy as per the Certificate of Insurance and Member Listing.
31. **Loss of Hearing** shall mean Complete and Permanently Irrecoverable Loss of hearing to the extent that the loss is greater than 80 decibels across all frequencies of hearing of both ears or one ear. Medical evidence in the form of an audiometry and sound-threshold test result

must be provided and certified by an Ear, Nose and Throat (ENT) specialist acceptable to the Company.

32. **Loss of Speech** shall mean Complete and Permanently Irrecoverable Loss of the ability to speak. A minimum Assessment Period of 6 (six) months applies. Medical evidence to confirm to the vocal cords to support this disability must be supplied by Ear, Nose and Throat (ENT) medical specialist acceptable to the Company.
33. **Medically Necessary** or **Medical Necessity** shall mean 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.
34. **Medical Practitioner** shall refer to 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 You, the Insured Member, respective spouses, and all immediate family members of such persons.
35. **Member** shall mean the persons described in the Certificate of Insurance.
36. **Members Classification** shall mean benefit entitlement of each Insured Member as stated in the Certificate of Insurance and Member Listing.
37. **Number of Night(s)** is counted by the difference between the date of admission to Hospital and the date of Discharge from the Hospital subject to the definition of Hospitalisation.
38. **Overseas** shall mean an area outside the Kingdom of Cambodia.
39. **Permanent neurological deficit with persisting clinical symptoms** shall mean symptoms of dysfunction in the nervous system that are present on clinical examination and expected to last throughout the lifetime of the Insured Member. Symptoms that are covered include numbness, paralysis, localised weakness, dysarthria (difficulty with speech), aphasia (inability to speak), dysphagia (difficulty swallowing), and visual impairment, difficulty in walking, lack of coordination, tremor, seizures, dementia, delirium, and coma.
40. **Physician** shall mean 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 You, the Insured Member, respective spouses and all immediate family members of such persons.
41. **Policy Anniversary Date** shall refer to the same date each year as the Policy Effective Date.
42. **Policy Effective Date** is the date when coverage under this Policy takes effect. The Policy Effective Date is shown on the Certificate of Insurance and the date from which the Policy Anniversaries Dates, Renewal Dates, and Due Dates are determined. Policy Effective Date is also the date of issue of any Endorsement indicated in the relevant Endorsement whenever the original term and coverage of this Policy are changed subsequently.
43. **Policy Owner** refer to the natural person or legal entity that purchases this Insurance Policy and therefore can exercise all rights, privileges and options available under this Policy.
44. **Pre-Existing Condition** shall mean illnesses that the Insured Member/You has/have reasonable knowledge of. An Insured Member/You 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.

45. **Pre-Surgical Procedure** shall mean the reimbursement of the Reasonable and Customary charges for Medically Necessary ECG, X-ray and laboratory tests which are performed for diagnostic purposes within the maximum number of days and Amount of Insurance as set forth in the Certificate of Insurance in a Hospital and which are recommended by a qualified Medical Practitioner. No payment shall be made if upon such diagnostic services, the Insured Member does not result in Surgery.
46. **Post-Surgical Procedure** shall mean the reimbursement of the Reasonable and Customary charges incurred in Medically Necessary follow-up treatment by a qualified Medical Practitioner, within the maximum number of days and Amount of Insurance as set forth in the Certificate of Insurance immediately following Discharge from Hospital after that said Surgery. This shall include medicines prescribed during the follow-up treatments.
47. **Provider** refers to a service provider engaged by the Company to provide the service under the Overseas Emergency Assistance benefit.
48. **Reasonable and Customary** No benefit shall be paid for Hospitalisation in excess of the general practice of other Hospitals of similar standing in the locality where the Hospitalisation is taking place, when providing like or comparable treatment, services or supplies for a similar Injury. The Company will determine the general practice by the Company's own experience in similar cases and the assessment the Company can receive from similar Hospitals within the region.
49. **Renewal Date** shall mean the Policy Anniversary Date, beginning 1 (one) year after the Policy Effective Date. Renewal is subject to conditions stated under the "Renewal Clause".
50. **Sickness** shall mean a physical condition marked by a pathological deviation from the normal healthy state.
51. **Surgery** shall mean a branch of medicine concerned with diseases and conditions requiring or amenable to operative or manual procedures which are performed in Operating Theatre as any of the following:
    (i) incision, excision by surgical blade or electrocautery to any organ or body part, except for dental services;
    (ii) surgical therapy, rehabilitate any organ or body part via invasive technique;
    (iii) reduce by manipulation a fracture or dislocation; or
    (iv) use of endoscopy to remove a stone or object (Foreign body) from the larynx, bronchus, trachea, oesophagus, stomach, intestine, urinary bladder, or urethra.
52. **Operating Theatre** is a facility, within a hospital, where it is designed and setup to create an aseptic environment, for the sole purpose of surgical operations.
53. **Partial Disability** or **Partially Disabled** shall mean Complete and Permanently Irrecoverable Loss of the following:
    (i) one limb; or
    (ii) one eye.

54. **Total Disability** or **Totally Disabled** shall mean Complete and Permanently Irrecoverable Loss of the following:
    (i) two limbs; or
    (ii) two eyes; or
    (iii) one limb and one eye.
55. **Second-Degree Burns** shall mean partial thickness of skin burns covering at least twenty percent (20%) of the surface of the Insured Member's body directly resulting from an Accident. The skin burns should be identified as needing treatment in a registered Hospital and require operative debridement. (Appendix I)
56. **Third-Degree Burns** shall mean full thickness of skin burns covering at least twenty percent (20%) of the total body surface area directly resulting from an Accident. The skin burns should be identified as needing treatment in a registered Hospital and require operative debridement. (Appendix I)
57. **Trip** or **Journey** shall mean the period of Journey or Journey commenced upon the Insured Member leaving the Kingdom of Cambodia and ceases upon the Insured Member's return directly to the Kingdom of Cambodia.
58. **You** or **Your** means the Policy Owner as shown in the Certificate of Insurance.

II. SUBJECT OF INSURANCE

AIA ComCare is a group life insurance product that have life and body as the subject of Insurance.

1. INSURED MEMBER PARTICIPATION

(i) The persons eligible for insurance under this Policy are Your present Insured Members who are 30 (thirty) days old to less than 70 (seventy) years old on their insurance effective date.
(ii) Insured Members will be eligible for insurance from their insurance effective date as stated in the Member Listing.
(iii) Insured Members whose participation has been terminated and who re-apply for participation shall be considered as new Insured Members.
(iv) In order to establish and continue this Policy, all Insured Members who fulfil the conditions necessary to participate as set forth in Section II.1.i above and have duly provided satisfactory proof of insurability are eligible to be insured under this Policy.
(v) You shall inform the Company when there is any Insured Member movement through updated Member Listing to be attached with a prescribed form as provided by the Company. The insurance effective date for the future Insured Members shall take effect on the Eligibility Date, subject to satisfactory proof of insurability, provided You notify the Company within 30 (thirty) days after the Eligibility Date, and You pay the premium required. If the Company are notified after 30 (thirty) days from the Eligibility Date, the insurance shall take effect on the date the Company receive the notification, subject to satisfactory proof of insurability, and premium required are receipt by the Company and the Company's acceptance.
(vi) Changes in Members Classification as specified in the Certificate of Insurance shall be effective only on Policy Anniversaries or at any other dates as may be agreed by the

parties and shall be subject to proof of health as stipulated in the Proof of Health section.

2. INSURED MEMBER TERMINATION

The insurance of an Insured Member shall terminate on the earliest happening of the following events:

(i) when an Insured Member is no longer a Member, the Insured Member's insurance termination date will be on the Member termination date or the notification date whichever is later, or

(ii) if the Certificate of Insurance states that Members are required to be in Active Service, the absence of an Insured Member from Active Service due to disability or leave of absence or temporary layoff shall not constitute termination of the Insured Member's status as an Insured Member unless and until You shall either notify the Company of such termination, in advance or within 30 (thirty) days from the termination date or stop making premium payment for the Insured Member's insurance; or

(iii) on the date when premium payment is discontinued for an Insured Member's insurance, and the Company have received notice from You that such Insured Member's insurance is to be terminated; or

(iv) on the date the Company or You terminate this Policy; or

(v) at the date which the Insured Member attains the age of 70 (seventy); or

(vi) the Company reserve the right to terminate this Policy on any Due Date when total number of Insured Members is fewer than the minimum number of Insured Members as stated in the Certificate of Insurance; or

(vii) the date on which the Insured Member enters full-time military, naval or air service; or

(viii) the date on which the Company communicate to You that the Policy ceases on account of war, or an act of war, such date being determined at the Company's discretion.

3. PROOF OF HEALTH

The Company may require satisfactory proof of health before an Insured Member is accepted for insurance where

(i) an Insured Member's age at renewal is 65 years or above; or

(ii) amount of Insurance in excess of the No-Evidence Limit as stated in the Certificate of Insurance; or

(iii) when there is an increase in the Amount of Insurance for an Insured Member.

Where such proof of health is not satisfactory to the Company, the whole benefit (for those aged 65 years or above) or that part of benefit which is in excess of the No-Evidence Limit (for those below 65 years) shall either not be granted or be granted, subject to special condition and/or extra premium as the Company may impose at the Company's discretion.

III. SCOPE OF COVERAGE

The Insured Member shall not be covered for any of the purchased Benefits after the 70th birthday of that said Insured Member.

1. GROUP FAMILY CARE BENEFIT

If an Insured Member dies while this benefit is in force, the Company will pay the claimant the Amount of Insurance as stated in the Certificate of Insurance and Member Listing

subject to the terms, conditions and exclusions herein contained, less any benefit paid out for Partial Disability and Total Disability for the said Insured Member in accordance with the provisions in this Policy.

2. GROUP REHABILITATION BENEFIT

If the Insured Member suffers from Partial Disability as defined above while this benefit is in force, the Company will pay the claimant the Amount of Insurance as stated in the Certificate of Insurance and Member Listing up to the Insured Member limits specified in the Certificate of Insurance and Member Listing subject to the terms, conditions and exclusions herein contained. Thereafter, no benefit will be payable for Partial Disability for the said Insured Member.

If the Insured Member suffers from Total Disability as defined above while this benefit is in force, the Company will pay the claimant the Amount of Insurance as stated in the Certificate of Insurance and Member Listing subject to the terms, conditions and exclusions herein contained, less any benefit paid out for Partial Disability for the said Insured Member in accordance with the provisions in this Policy. Thereafter, no benefit will be payable for Partial Disability or Total Disability for the said Insured Member.

The aggregate of the lump sum payments made under this benefit shall not exceed 100% (one hundred percent) of the Amount of Insurance of the Certificate of Insurance and Member Listing for Group Rehabilitation Benefit.

The aggregate of the lump sum payments made under the benefits for Group Rehabilitation Benefit shall not exceed 100% (one hundred percent) of the Amount of Insurance for Group Family Care Benefit.

3. GROUP ACCIDENTAL DEATH AND INJURY BENEFIT

If the Insured Member becomes disabled as defined under Accidental Disability Group 1 or suffers from Second-Degree Burns due to Accidental Injury as defined above, the Company will pay the claimant the Amount of Insurance as stated in the Certificate of Insurance and Member Listing subject to the terms, conditions and exclusions herein contained. Thereafter, no benefit will be payable for Accidental Disability Group 1 or Second-Degree Burns for the said Insured Member.

If, due to Accidental Injury, the Insured Member dies, becomes disabled as defined under Accidental Disability Group 2 or suffers from Third-Degree Burns as defined above, the Company will pay the claimant the Amount of Insurance as stated in the Certificate of Insurance and Member Listing subject to the terms, conditions and exclusions herein contained, less any benefit paid out for Accidental Disability Group 1 or Second-Degree Burns for the said Insured Member. Thereafter, no Group Accidental Death and Injury Benefit will be payable for the said Insured Member.

The aggregate of the lump sum payments made under this benefit shall not exceed 100% (one hundred percent) of the Amount of Insurance as specified in the Certificate of Insurance and Member Listing for this benefit and the said Insured Member.

4. GROUP RECOVERY BENEFIT

If the Insured Member(s) survives 30 days after the said Insured Member(s) is diagnosed to have suffered from a Critical Illness Event as defined under this plan, while this benefit is in

force and subject to the terms, conditions and exclusion, the Company would pay the claimant the Amount of Insurance of Group Recovery Benefit.

Payment of benefits shall be subject to the following terms and conditions:

(i) Recovery Benefit for Group 1 Illness/Surgery

If an Insured Member is diagnosed to have suffered a Critical Illness Event defined as Group 1 Illness/Surgery under this benefit, the Company will pay the claimant the Amount of Insurance as stated in the Certificate of Insurance and Member Listing up to the Insured Member limits specified in the Certificate of Insurance and Member Listing subject to the terms, conditions and exclusions herein contained. Thereafter, no benefit will be payable for Group 1 Illness/Surgery for the said Insured Member.

(ii) Recovery Benefit for Group 2 Illness/Surgery

If an Insured Member is diagnosed to have suffered a Critical Illness Event defined as Group 2 Illness/Surgery under this benefit, the Company will pay the claimant the Amount of Insurance as stated in the Certificate of Insurance and Member Listing, less any benefit paid for Group 1 Illness/Surgery for the said Insured Member. Thereafter, no benefit will be payable for Group 2 Illness/Surgery for the said Insured Member.

The aggregate of payments made for Group 1 Illness/Surgery and Group 2 Illness/Surgery for an Insured Member shall not exceed 100% (one hundred percent) of the Amount of Insurance for Group Recovery Benefit for the said Insured Member as stated in the Certificate of Insurance and Member Listing.

5. GROUP HOSPITALISATION BENEFIT

Group Hospitalisation Benefit covers the following expenses caused by Accidental Injury as defined in this Policy. If the Comprehensive Option is selected, Group Hospitalisation Benefit also covers the following expenses caused by Sickness as defined in this Policy.

(i) Daily Hospitalisation Allowance

While this benefit is in force, if the Insured Member is Hospitalised as prescribed by a qualified Medical Practitioner, provided the Hospitalisation is Reasonable and Customary, the Company shall pay the claimant a Daily Hospitalisation Allowance in the amount specified in the Certificate of Insurance and Member Listing multiply by the Number of Night(s) of Hospitalisation of the Insured Member, up to the Insured Member limits specified in the Certificate of Insurance and Member Listing and subject to the terms, conditions and exclusions herein contained.

Daily Hospitalisation Allowance is available for Hospitalisation in local and Overseas Hospitals.

(ii) Surgical Reimbursement

While this benefit is in force, if the Insured Member undergoes Surgery as required by a qualified Medical Practitioner, provided the Surgery is Reasonable and Customary, the Company shall pay the claimant the Surgical Reimbursement benefit in the Amount of Insurance specified in Certificate of Insurance and Member Listing. This benefit covers the Surgery, Pre- and Post-Surgical Procedure, up to the Insured Member limits specified in the Certificate of Insurance and Member Listing for the said Insured Member and subject to the terms, conditions and exclusions herein contained.

(iii) Overseas Emergency Assistance

While the benefit is in force, and up to the Insured Member limits specified in the Certificate of Insurance and Member Listing and subject to the terms, conditions and exclusions herein contained, the Company will provide the following coverages which will be organised and implemented using the means and services best adapted to the physical condition of the Insured Member by the Provider.

The Provider shall provide the following Services to the Insured Member calling the Provider when he travels outside the Kingdom of Cambodia for periods not exceeding 90 consecutive days per Trip.

Overseas Emergency Assistance consists of three services:

a. Emergency Medical Evacuation

While travelling outside the Kingdom of Cambodia, If the Insured Member requires Emergency Medical Evacuation as determined to be Medically Necessary by the Company or the Provider, the Provider shall arrange for such evacuation using the means best suited to do so, based on the medical severity of the Insured Member's condition.

All decisions on the means of transportation and the destination, to which the Insured Member should be transported, shall be made by the Company or the Provider and will be based solely upon Medical Necessity.

The expenses covered under this service will be expenses for services provided and/or arranged by the Company or the Provider for the transportation necessarily incurred as a result of providing the Emergency Medical Evacuation. The Company shall pay directly to the Provider or any third party.

Emergency Medical Evacuation refers to: (a) the Insured's medical condition warrants immediate transportation to the nearest Hospital where appropriate medical treatment can be obtained as determined at the Company's or the Provider's sole discretion; or (b) after being treated at an Overseas Hospital, the Insured Member's medical condition warrants transportation to the Kingdom of Cambodia to obtain further medical treatment.

b. Repatriation of Remains

If the Insured Member deceased while travelling outside of the Kingdom of Cambodia or gets into an Accident and dies as a result of the Accident within 365 days from the date of the Accident, the Company or the Provider shall make the necessary arrangements for the return of the Insured's mortal remains to the Kingdom of Cambodia.

This benefit covers expenses for services provided and/or arranged by the Company or the Provider for the transportation costs and expenses, necessarily incurred as a result of returning the Insured's mortal remains to the Kingdom of Cambodia. The Company shall pay directly to the Provider or any third party.

c. 24-Hour Worldwide Telephone Enquiry Services

While this benefit is in force, a 24-hour worldwide telephone enquiry service will be provided to the Insured Member for travel matters, before or during the Insured's Trip.

The 24-hour worldwide telephone enquiry service is limited to telephone enquiry services in relation to travel matters. The Company will not be held responsible for any costs or expenses (including any medical or legal costs, and costs for any other services) incurred by the Insured Member arising out of or in relation to following any advice or referral given by or from the 24-hour worldwide telephone enquiry service.

The 24-hour worldwide telephone enquiry service is provided on a best-effort basis and may not be available due to logistical problems, such as time, distance, location, or any other factors that are not within the control of the Company or the Provider. Without prejudice to the provisions "General Terms and Conditions of Overseas Emergency Assistance" below, the Company or the Provider shall not be held liable or responsible for any damages or losses whatsoever suffered by the Insured Member for the failure, delay or omission in the delivery of this 24-hour worldwide telephone enquiry services.

General Terms and Conditions of Overseas Emergency Assistance

a. In the event that authorization of payment and / or payment is made by the Company or the Provider or an authorized representative of the Provider for an emergency assistance claim which is not covered under this benefit, the Company or the Provider or an authorized representative of the Provider reserves the right to recover the said sum from the Insured Member.

b. The Company or the Provider cannot be held liable for any default or delay in the execution of services in the event of strikes, riots, any act of sabotage or terrorism, civil or foreign war, release of heat or irradiation coming from the splitting of nuclei of atoms, radioactivity, other Accidents, or case of natural catastrophe.

   All interventions by the Provider are conducted within the context of the national and international laws and regulations and are dependent on all necessary authorizations and permits being obtained from the relevant authorities.

c. The coverage under this benefit shall automatically terminate on the occurrence of the earliest of the following:
   - termination of the Policy or Insured Member termination; or
   - any specific loss for which any benefit of Repatriation of Remains is payable under this benefit; or
   - the Provider or an authorized representative of the Provider is not the Company's agent, and the Company shall not be held liable or responsible for the act or omission of such Provider.

IV. INSURANCE BENEFITS

Benefits of this Basic Plan include:

No.	Type of Coverage	Amount of Insurance
1.	**Group Family Care Benefit**	**% of Group Family Care Benefit**
	Death	100%
2.	**Group Rehabilitation Benefit**	**% of Group Rehabilitation Benefit**
2.1	Total Disability:	
	Loss of two limbs	100%
	Loss of two eyes	100%
	Loss of one limb and one eye	100%
2.2	Partial Disability:	
	Loss of one limb	Up to 50%
	Loss of one eye	Up to 50%
3	**Group Accidental Death and Injury Benefit**	**% of Group Accidental Death and Injury Benefit**
3.1	Accidental death	100%
3.2	Accidental Disability Group 2 or Third-Degree Burns:	
	Third-Degree Burns	100%
	Loss of two limbs	100%
	Loss of two eyes	100%
	Loss of one limb and one eye	100%
	Loss of Speech	100%
	Loss of Hearing of both ears	100%
3.3	Accidental Disability Group 1 or Second-Degree Burns:	
	Second-Degree Burns	Up to 50%
	Loss of one limb	Up to 50%
	Loss of one eye	Up to 50%
	Loss of both thumbs (2 joints/phalanges for each thumb)	Up to 30%
	Loss of both great toes (2 joints/phalanges for each great toe)	Up to 30%
	Loss of four fingers (3 joints/phalanges for each finger) and one thumb (2 joints/phalanges for thumb) of the same hand	Up to 30%
	Loss of four toes (at least 1 joints/phalanges for each toe) and one great toe (2 joints/phalanges for great toe) of the same foot	Up to 30%
	Loss of Hearing on one ear	Up to 15%
	Loss of whole thumb (2 joints/phalanges)	Up to 10%

	Loss of whole index finger (3 joints/phalanges)	Up to 8%
	Loss of whole middle finger (3 joints/phalanges)	Up to 6%
	Loss of whole ring finger (3 joints/phalanges)	Up to 5%
	Loss of whole little finger (3 joints/phalanges)	Up to 4%
4	**Group Recovery Benefit**	**% of Group Recovery Benefit**
4.1	Group 2 Illness/Surgery	100%
4.2	Group 1 Illness/Surgery	Up to 25%
5	**Group Hospitalisation Benefit**	**% of Group Hospitalisation Benefit**
5.1	Daily Hospitalisation Allowance	As stated in Certificate of Insurance
5.2	Surgical Reimbursement	As stated in Certificate of Insurance
5.3	Overseas Emergency Assistance	As stated in Certificate of Insurance

V. PREMIUM PAYMENT PROVISIONS

1. PAYMENT

Subject to the Company's minimum premium requirements, premiums may be paid on an annual mode at the premium rates applicable on the Effective Date.

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. PREMIUM RATE

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.

3. DEFAULT

After payment of the 1st (first) premium, failure to pay a subsequent premium on or before its Due Date will constitute a default in premium payment.

4. GRACE PERIOD

A Grace Period of 30 (thirty) days following the Due Date shall be allowed to You for the payment of any premium after the 1st (first) within each policy year. If any premium is not paid before the expiration of the Grace Period, this Policy shall automatically terminate at

the expiration of the Grace Period. You shall be liable to the Company for the premium for the time the Policy was in force during the Grace Period.

5. CURRENCY AND PAYMENT CHANNEL

All amounts payable either to or by the Company will be paid in the currency shown on the Certificate of Insurance or subsequent Endorsement. All amounts due from the Company will be payable by the channel specified by the Company.

6. REGULATORY IMPOSED CHARGES, FEES ETC.

The premium to be paid by the Policy Owner to the Company under this Policy is exclusive of any tax, and in the event the Company is required by law to remit the tax on the premium paid by the Policy Owner, the Company will calculate and collect from the Policy Owner any amount paid or payable under this Policy on account of any tax, such amount as calculated by the Company, shall be paid by the Policy Owner as additional to and without any deduction or set-off from the premium payable under this Policy to the Company. Tax is defined as any present or future, direct or indirect, tax including goods and services tax, levy, impost, duty, charge, fee, deduction or withholding of any nature, and any interest or penalties in respect thereof.

VI. EXCLUSIONS

1. EXCLUSIONS FOR GROUP FAMILY CARE BENEFIT

The Group Family Care Benefit does not cover death due to:

(i) Suicide, self-inflicted Injury, whether sane or insane, within 2 (two) years from the Policy Effective Date; or

(ii) a criminal offence committed or attempted to commit by You, or the Insured Member, or the Beneficiary; or

(iii) Human Immunodeficiency Virus (HIV) and/or any HIV-related illnesses including Acquired Immune Deficiency Syndrome (AIDS) and/or any mutations, derivation or variations thereof; or

(iv) drugs or stimulators or alcohol abuse, drunk driving, or their complications as determined by the law in force.

2. EXCLUSIONS FOR GROUP REHABILITATION BENEFIT

This Group Rehabilitation Benefit shall not cover any disability caused directly or indirectly, wholly or partly, by any 1 (one) of the following occurrences:

(i) willful exposure to danger or attempted self-destruction or self-inflicted injuries while sane or insane; or

(ii) service in the armed forces in time of declared or undeclared war or while under orders for warlike operations or restoration of public order; or

(iii) entering, exiting, operating, servicing, or being transported by any aerial device or conveyance except when the Insured Member is a fare-paying passenger or crew member on a commercial passenger airline on a regular scheduled passenger Trip over its established passenger route; or

(iv) for a disability resulting from a physical or mental condition which existed before the effective date of the Insured Member's coverage, which was not disclosed in the application or health statement; or
(v) a criminal offence committed or attempted to commit by You, or the Insured Member, or the Beneficiary; or
(vi) drugs or stimulators or alcohol abuse, drunk driving, or their complications as determined by the law in force.

3. EXCLUSIONS FOR GROUP ACCIDENTAL DEATH AND INJURY BENEFIT

Any Injury caused directly or indirectly, wholly or partly, by any one of the following occurrences shall not be considered as an Accidental Injury:

(i) assault or murder; or
(ii) strike, riot and civil commotion, rebellion or insurrection, or terrorist activity; or
(iii) a criminal offence committed or attempted to commit by You, or the Insured Member, or the Beneficiary; or
(iv) willful exposure to danger or attempted self-destruction or self-inflicted injuries while sane or insane; or
(v) war, declared or undeclared, or revolution; or
(vi) service in the armed forces in time of declared or undeclared war or while under orders for warlike operations or restoration of public order; or
(vii) making an arrest as an officer of the law; or
(viii) violation or attempted violation of the law or resistance to arrest; or
(ix) participation in any fight or affray; or
(x) racing on horse or wheels; or
(xi) accident occurring while or because the Insured Member is under the influence of alcohol, any non-prescribed drug or illegal drug; or
(xii) hernia, ptomaines or bacterial infection (except pyogenic infection which shall occur with and through an accidental cut or wound); or
(xiii) the intentional or negligent inhalation or consumption of poison, gases or noxious fumes; or
(xiv) entering, exiting, operating, servicing, or being transported by any aerial device or conveyance except when the Insured Member is a fare-paying passenger or crew member on a commercial passenger airline on a regular scheduled passenger Trip over its established passenger route; or
(xv) a disability resulting from a physical or mental condition which existed before the effective date of the Insured Member's coverage, which was not disclosed in the application or health statement.

4. EXCLUSIONS FOR GROUP RECOVERY BENEFIT

The Benefit for Critical Illness does not cover:

(i) any illness or Surgery other than Diagnosis of or Surgery for a Critical Illness Event as defined in this provision; or
(ii) the signs or symptoms of the Critical Illness Event defined under late-stage is manifested prior to or within 90 (ninety) days from each Insured Member's effective date of Group Recovery Benefit; or

(iii) the signs or symptoms of the Critical Illness Event defined under early-stage is manifested prior to or within 120 (one hundred and twenty) days from each Insured Member's effective date of Group Recovery Benefit; or

(iv) the Critical Illness Event arises directly or indirectly from a Pre-Existing Condition as defined, which existed prior to each Insured Member's effective date of Group Recovery Benefit; or

(v) the Critical Illness Event, where in the Company's opinion, was caused directly or indirectly by the existence of Acquired Immune Deficiency Syndrome (AIDS) or by the presence of any Human Immunodeficiency Virus (HIV) infection. The Company reserve the right to require the Insured Member to undergo a blood test for HIV as a condition precedent to acceptance of any claim. The exception is when HIV Infection is due to blood transfusion. For the purpose of this Policy,
   a. the definition of AIDS shall be that used by the World Health Organization in 1987, or any subsequent revision by the World Health Organization of that definition.
   b. infection shall be deemed to have occurred where blood or other relevant test(s) indicate in the Company's opinion either the presence of any HIV or antibodies to such a virus.

(vi) the Critical Illness Event is within the same or lower severity of the previous Critical Illness Event claim; or

(vii) any Critical Illness Event diagnosed to be due, directly, or indirectly, to a congenital defect or disease, which was manifested or was diagnosed before the Insured Member attains 17 (seventeen) years of age; or

(viii) any of the Critical Illness Event is caused by a self-inflicted Injury; or

(ix) any Critical Illness Event resulting directly from alcohol or drug abuse; or

(x) any Critical Illness Event resulting from a physical or mental condition which existed before the Insured Member's Policy Effective Date, and which was not disclosed in the application for insurance or health statement; or

(xi) donation of any of the Insured Member's organs.

5. EXCLUSIONS FOR GROUP HOSPITALISATION BENEFIT

- EXCLUSIONS FOR DAILY HOSPITALISATION ALLOWANCE/ SURGICAL REIMBURSEMENT

This benefit shall not cover any Hospitalisation or Surgical expenses caused directly or indirectly, wholly or partly, by any 1 (one) of the following occurrences:

(i) any expense incurred as a result of a Pre-Existing Condition; or

(ii) any expense incurred for sterilization, artificial insemination, investigation/ Diagnosis and treatment of infertility, including Birth control measures, genetic testing or counselling, treatment occasioned by or resulting from pregnancy, childbirth or abortion; or

(iii) any expense incurred for corrective aids, contact lenses, hearing aids and treatment of refractive errors unless necessitated by a Physician; or

(iv) any expense incurred for treatment of alcoholism, drug abuse or any other complications arising therefrom, consumption of non-prescribed drugs, accidental or intentional drug over dosage or any drug Accident; or

(v) any expense incurred for any form of dental care or Surgery unless necessitated by a Physician and caused by an Accident (excluding denture and related expenses); or

(vi) any expense incurred for cosmetic or plastic Surgery or any elective Surgery unless necessitated by a Physician; or

(vii) any expense incurred for routine health checks or convalescence, custodial care, rest only care; or

(viii) any expense incurred for treatment or Surgery for tonsils, adenoids, hernia, prostatic hypertrophy, hydrocele, sinusitis, circumcision or a disease of the female reproductive tract; or

(ix) any expense related to Human Immunodeficiency Virus (HIV) and/or any HIV-related illnesses including Acquired Immune Deficiency Syndrome (AIDS) and/or any mutations, derivation or variations thereof; or

(x) any expense incurred for medical service or treatment other than western medicines, including Acupuncture, acupressure, bonesetting, herbalist treatment, hypnotism, massage therapy, aroma therapy; and other forms of alternative treatments, Experimental, Investigational or Unproven Services except when authorised by the Company; or

(xi) any expense incurred for confinement in any Hospital which is primarily a rest or convalescent home or rehabilitation establishment or similar establishment, or a facility primarily involved in the care of alcoholics or drug addicts; or

(xii) any expense incurred for any Hospitalisation which is not Reasonable and Customary; or

(xiii) any expense incurred for other education services such as speech improvement, diabetic classes and nutritional services, or group support services; or

(xiv) any expense incurred for criminal acts of the Policy Owner, Insured Member or Beneficiary in violation of laws and regulations of the Kingdom Cambodia; or if the criminal acts occur outside the Kingdom of Cambodia, in violation of the laws and regulations of such country; or resistance to arrest; or

(xv) any expense incurred for any investigation, treatment or surgical operation for congenital disorder that gives rise to signs or symptoms, or is diagnosed, before the Insured Member attains 17 (seventeen) years of age; or

(xvi) any expense incurred due to non-Medically Necessary health services in the opinion of a Physician; or

(xvii) any expense incurred for services and supplies for smoking cessation programmes and the treatment of nicotine addiction; or

(xviii) any expense incurred for services rendered by a Physician with the same legal residence as the Insured Member or who is a member of the Insured Member's family, including spouse, brother, sister, parent or child; or services delivered by an agent of the Company; or

(xix) any expense incurred for clinical home care; custodial care in any setting; day care; hospice, private duty nursing; respite care unless prior approval is obtained from Network Physician and the Company; or

(xx) any expenses incurred for services and supplies provided by a mortician or undertaker, including but not limited to the cost of casket, embalming and/or cremation; or

(xxi) surgery expense due to reasons other than Accidental Injury if the Comprehensive Option not selected in the latest Certificate of Insurance and Member Listing; or

(xxii) any expense incurred for any of the exclusions under this Policy.

- EXCLUSIONS FOR OVERSEAS EMERGENCY ASSISTANCE

The following treatment, items, conditions, activities and their related or consequential expenses are excluded:

(i) any expense incurred as a result of a Pre-Existing Condition; or

(ii) more than one emergency evacuation for any single medical condition of the Insured Member during the Policy term, subject to a maximum of one year; or

(iii) any cost or expense not expressly covered by the benefit and not approved in advance and in writing by The Provider and/or not arranged by the Provider. This exception shall not apply to Emergency Medical Evacuation from remote or primitive areas when The Provider cannot be contacted in advance and delay might reasonably be expected in loss of life or harm to the Insured Member; or

(iv) any event occurring when the Insured is within the Kingdom of Cambodia; or

(v) any expense for Insured Member who is travelling outside the Kingdom of Cambodia contrary to the advice of a Medical Practitioner, or for the purpose of obtaining medical treatment or for rest and recuperation following any prior Accident, illness or Pre-Existing Condition; or

(vi) any expense for medical evacuation if the Insured Member is not suffering from a Serious Medical Condition, and/or in the opinion of the Provider Medical Practitioner, the Insured Member can be adequately treated locally, or treatment can be reasonably delayed until the Insured Member returns to Kingdom of Cambodia; or

(vii) any expense for medical evacuation where the Insured Member, in the opinion of the Provider Medical Practitioner, can travel as an ordinary passenger without a medical escort; or

(viii) any treatment or expense related to childbirth, miscarriage or pregnancy. This exception shall not apply to any abnormal pregnancy or vital complication of pregnancy which endangers the life of the mother and/or unborn child during the first 24 (twenty-four) weeks of pregnancy; or

(ix) any expense related to Accident or Injury occurring while the Insured Member is engaged in caving, mountaineering or rock climbing necessitating the use of guides or ropes, potholing, skydiving, parachuting, bungee-jumping, ballooning, hang gliding, deep sea diving utilizing hard helmet with air hose attachments, martial arts, rallying, racing of any kind other than on foot, and any organized sports undertaken on a professional or sponsored basis; or

(x) any expense incurred for emotional, mental or psychiatric illness, including psychosis, mental/nervous disorders, or sleep disturbance disorders; or

(xi) any expense incurred as a result of a self-inflicted Injury, suicide, drug addiction or abuse, alcohol abuse, sexually transmitted diseases; or

(xii) any expense related to Human Immunodeficiency Virus (HIV) and/or any HIV-related illnesses including Acquired Immune Deficiency Syndrome (AIDS) and/or any mutations, derivation or variations thereof; or

(xiii) any expense related to the Insured Member engaging in any form of aerial flight except as a passenger on a scheduled airline flight or licensed charter aircraft over an established route; or

(xiv) any expense related to the Insured Member engaging in the commission of, or the attempt to commit, an unlawful act; or

(xv) any expense related to treatment performed or ordered by a non-registered practitioner not in accordance with the standard medical practice as defined in the country of treatment; or

(xvi) any expense incurred as a result of the Insured Member in active service in the armed forces or police of any nation; active participation in war (whether declared or not), invasion, act of foreign enemy, hostilities, civil war, rebellion, riot, revolution or insurrection; or

(xvii) any expense which is a direct result of nuclear reaction or radiation; or

(xviii) any expense incurred for or as a result of any activity required from or on a ship or oil-rig platform, or at a similar off-shore location; or

(xix) any expense in respect of the Insured Member more than 70 (seventy) years old at the date of intervention; or

(xx) any expense, regardless of any contributory cause(s), involving the use of or release or the threat thereof of any nuclear weapon or device or chemical or biological agent, including but not limited to expenses in any way caused or contributed to by an Act of Terrorism or war; or

(xxi) any expense incurred due to reasons other than Accidental Injury if the Comprehensive Option not selected in the latest Certificate of Insurance and Member Listing.

6. SANCTION LIMITATION

(i) The Company may, on such notice in writing as the Company may decide, terminates this Policy at any time, whether with effect from inception of this Policy or otherwise, in circumstances where the Policy Owner or any person or entity connected with this Policy have exposed or may, in the Company's opinion, expose the Company to the risk of being or becoming subject to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America, or any other applicable economic or trade sanction laws or regulations. The Company shall not thereafter be required to transact any business with the Policy Owner in connection with this Policy, including but not limited to making or receiving any payments under this Policy.

(ii) Without prejudice to this Clause (i) above, this Policy shall not be deemed to provide cover and the Company shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose the Company to any, or any risk of, sanction, prohibition, or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union or United Kingdom or United

States of America, or any other applicable economic or trade sanction laws or regulations.

(iii) As an ongoing obligation, the Policy Owner shall immediately inform the Company if there are any changes to the identities, status, constitution, establishment, particulars and identification documents of the Policy Owner or any person or entity connected with this Policy.

VII. GEOGRAPHIC AREA

This Policy provides a worldwide coverage to the Insured.

VIII. THE BENEFICIARY

1. Each Insured Member shall designate in writing a beneficiary or beneficiaries to whom the benefits under this Policy shall be payable in the event of death and such designation shall be filed with the Policy Owner.
2. 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.
3. During the Insured Member's coverage, he 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.
4. In the event of death of the Insured Member, the claimant will provide to the Company the name(s) of the beneficiary or beneficiaries to whom the benefits shall be payable. Payment of the benefits to such beneficiary or beneficiaries shall release the Company of all liabilities for further claims and demands in respect thereto.

IX. ALTERATION

If a party wishes to make any alteration or waive any provisions in this Policy, the said alteration or waiver has to be agreed by the parties through an Endorsement. Any Endorsement to this Policy shall bind all Insured Members whether insured under this Policy 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 Policy is issued for the term of one year and shall be automatically 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 reserve the right to revise or adjust the rate of premium charged, terms and conditions at any Policy Anniversary Date, by notifying You by way of notice in writing at least 30 (thirty) days before such Policy Anniversary Date.

XI. TERMINATION

1. RIGHT OF TERMINATATION

This Policy may be terminated as at any Due Date by You by written notice of termination to the other party, not less than 31 (thirty-one) days before the Due Date on which such termination shall be effective. If You 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.

2. FREE LOOK PERIOD

You have the right to terminate this Policy by giving the Company a written notice and returning this Policy to the Company. The premiums that You have paid less any expenses which may have been incurred for any medical examination will be refunded to You. Such notice must be submitted by You in the Company's prescribed form and received directly by the Company within 21 (twenty-one) days from Effective Date.

XII. CANCELLATION

1. RIGHT OF CANCELLATION

(i) The Company reserves the right to cancel this Policy on any Due Date when total number of Insured Members is fewer than the minimum number of Insured Members as stated in the Certificate of Insurance.

(ii) The Company reserves the right to cancel this Policy as at any Due Date by written notice of cancellation to You, not less than 31 (thirty-one) days before the Due Date on which such termination shall be effective. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(iii) This Policy shall be cancelled by the Company, by written notice to You, due to Your violation of participation rules or material violation of the terms of the Policy.

(iv) This Policy shall be cancelled by the Company, by written notice to You, if You provided the Company with false information material to the execution of this Policy or to the provision of benefits under this Policy.

(v) In the circumstances described in the two scenarios directly above, the Company have the right to rescind this Policy retroactively to the Policy Effective Date and collect compensation from You for all claims reimbursed under this Policy, plus administrative fees.

(vi) This Policy shall be cancelled by the Company due to fraud or misrepresentation by You, or because the Insured Member knowingly provided the Company with false material information. The Company have the right to rescind coverage back to the Policy Effective Date.

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

2. INCONTESTABILITY

Notwithstanding anything to the contrary stated heretofore in this Policy, this Policy shall be incontestable except for non-payment of premium or for fraud, after it has been in force for one year from the Policy Effective Date. The original insurance on any Insured Member

and any subsequent additional insurance shall be incontestable except for non-payment of premium or for fraud after such insurance has been in force during his lifetime for one year from his insurance effective date and the effective date of each subsequent increase of insurance, respectively.

3. MISSTATEMENT OF AGE AND/OR GENDER

(i) If there is a misstatement of age and/or gender, the premium and/or benefits that would be payable shall be adjusted based on the correct age and/or gender of the Insured Member.

(ii) Where a misstatement of age or other relevant facts has caused an Insured Member to be insured hereunder when he is otherwise ineligible for any insurance, or where such statement has caused an Insured Member to remain insured when he would otherwise be disqualified in accordance with the terms and limitations of this Policy, his entire insurance shall be void and there shall be a return of premiums paid in respect of the Insured Member, provided always that where there is fraud on Your part or Insured Member, no premiums paid are to be returned.

XIII. CLAIM PROCEDURES

1. QUALIFICATIONS OF THE CLAIMANT

The Claimant can be the Policy Owner or Beneficiary(ies) that was assigned by the Policy Owner. The Claimant shall be at least 18 years old.

2. 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 Policy. 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 given at AIA Office or contact Client Services (855) 86 999 242 or inform Your Life Planner or email to **Kh.claim@aia.com**.

3. REQUIRED DOCUMENTS OR PROOF OF EVIDENCE

(i) Proof of Death

The Company, upon receipt of such notice, will provide the claimant with the appropriate forms for filing proof of death. If the forms are not given within 15 (fifteen) working days, the claimant by submitting written proof covering the occurrence and circumstance of death for which the claim is made shall be deemed to have complied with the requirements of this provision.

(ii) Proof of Disability

The Company, upon receipt of such notice, will provide the claimant with the appropriate forms for filing proof of disability. If the forms are not provided to the claimant within 15 (fifteen) days of receipt of such notice, the claimant by submitting

written proof covering the occurrence and circumstance of disability for which the claim is made shall be deemed to have complied with the requirements of this provision.

Proof of Disability shall be submitted to the Company, who shall determine if Disability as defined under this Policy is satisfied. The Company shall have the right to call for an examination of the Insured and/or the evidence used in arriving at such Disability, by such persons as the Company requires.

(iii) **Proof of Accidental Death, Disability or Burns**

The Company, upon receipt of such notice, will provide the claimant with the appropriate forms for filing proof of Accidental Death, Disability or Burns. If the forms are not provided to the claimant within 15 (fifteen) days of receipt of such notice, the claimant by submitting written proof covering the occurrence and circumstance of Accidental Death, Disability or Burns for which the claim is made shall be deemed to have complied with the requirements of this provision.

The Company shall determine if Accidental Death, Disability or Burns as defined in this Policy is satisfied and shall have the right to call for an examination of the Insured Member and/or the evidence used in arriving at such Accidental Death, Disability or Burns, by such person as the Company require.

(iv) **Proof of Critical Illness**

The Company, upon receipt of notice, will furnish to the claimant the appropriate forms for filing proof of Critical Illness Event. If the forms are not provided to the claimant within 15 (fifteen) days of receipt of such notice, the claimant by submitting written proof covering the occurrence, the character and the degree of the Critical Illness Event for which the claim is made shall be deemed to have complied with the requirements of this provision. Proof of Critical Illness Event must be furnished to the Company during the lifetime of the Insured Member and within 6 (six) months after the Diagnosis of such Critical Illness Event.

(v) **Proof of Hospitalisation**

The Company, upon receipt of such notice, will provide the claimant with the appropriate forms for filing proof of Hospitalisation and/or surgical procedures. If the forms are not provided to the claimant within 15 (fifteen) days, the claimant by submitting written proof covering the occurrence and circumstance of Hospitalisation and/or surgical procedures for which the claim is made shall be deemed to have complied with the requirements of this provision.

The Company shall determine if Hospitalisation and/or surgical procedures as defined in this Policy is satisfied and shall have the right to call for an examination of the Insured Member and/or the evidence used in arriving at such Hospitalisation and/or surgical procedures, by such persons as the Company require.

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. JUVENILE LIEN PROVISION

Regardless of the stated Amount of Insurance of this Policy, the Company's liability in the event of the death or disability of Insured Member before he attains the age of 4 (four) years shall be in accordance with the following schedule:

Age at death or disability (last birthday)	Percentage of benefit payable
Under 1 year old	20%
1 year old	40%
2 years old	60%
3 years old	80%
4 years old or above	100%

The lien schedule provided above shall also apply for the payment of any benefit provided under Group Family Care Benefit, Group Rehabilitation Benefit, and Group Accidental Death and Injury Benefit as a result of the Insured's death or disability for whatever cause.

XIV. CONFIDENTIALITY

Any information provided to the insurer shall be treated as confidential and no personal information shall be disclose 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.

XVII. OTHER PROVISIONS

1. DATA REQUIREMENT PROVISIONS

(i) You shall furnish the Company with information relating to future Insured Members and terminations of insurance for present Insured Members that the Company may require to administer the coverage. Upon the Company's request, not more than once a year, You shall provide the Company with a statement stating the date of birth, occupations and such other relevant data concerning the Insured Members which is considered to have an impact on the administration of the coverage and on the determination of future premium rates. Such information and records shall be available for the Company's inspection at any reasonable time.

(ii) You shall maintain a record with respect to each Insured Member under this Policy, showing the Insured Member's name, gender, age or date of birth, Amount of Insurance, the date insurance became effective, the date insurance terminated, changes, with dates noted, Members Classification, beneficiary designation and other pertinent information as may be necessary to carry out the terms of this Policy.

(iii) Clerical error in keeping the records shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated, but upon discovery of a clerical error, any necessary and appropriate adjustment in premiums and benefits shall be made.

(iv) You shall furnish the Company with all information and proof which the Company may reasonably require with regard to any matters pertaining to this Policy. All documents furnished to You by any Insured Member in connection with the insurance, and other records as may have a bearing on the insurance under this Policy, shall be open for inspection by the Company at all reasonable times.

(v) Any personal information collected or held by the Company with respect to each Insured Member under this Policy may be held, used and disclosed by the Company to individuals or organisations associated with the Company with regards to matters pertaining to the Insured Member's coverage.

(vi) It shall be Your responsibility to ensure that the personal information provided to the Company is accurate. You shall indemnify and keep indemnified the Company against any and all losses, costs, expenses, actions, proceedings suffered by the Company as a result of Your failure to carry out the aforesaid.

2. Any illegality, invalidity, or unenforceability of any clause of this Policy under the Cambodian law shall not affect the legality, validity, or enforceability of any other provisions in this Policy.

3. The Company's books and/or accounts shall be conclusive evidence of the state of accounts between the parties in this Policy. Any certificate by any of the Company's officers as to the moneys or liabilities for the time being due and remaining or incurred to the Company by the Insured shall be binding and conclusive evidence on the Insured in all courts of law and elsewhere.

4. If the Company delay or fail to exercise any rights/remedies under this Policy, it will not be deemed as a waiver. Any single/partial exercise of any right/remedy shall not prevent the Company from any other or further exercise of any other right/remedy. The rights and remedies provided in this Policy are cumulative and not exclusive of any other rights/remedies (whether provided by law or otherwise).

5. This Policy shall continue to be valid and binding for all purposes whatsoever despite any change by amalgamation, change of name, reconstruction or otherwise which may be made in the Company's constitution.

6. The terms and conditions stated in this Policy constitute the entire terms and conditions of this Policy. No prior inconsistent representation or statement made in relation to this Policy whether orally or in writing shall form part of this Policy.

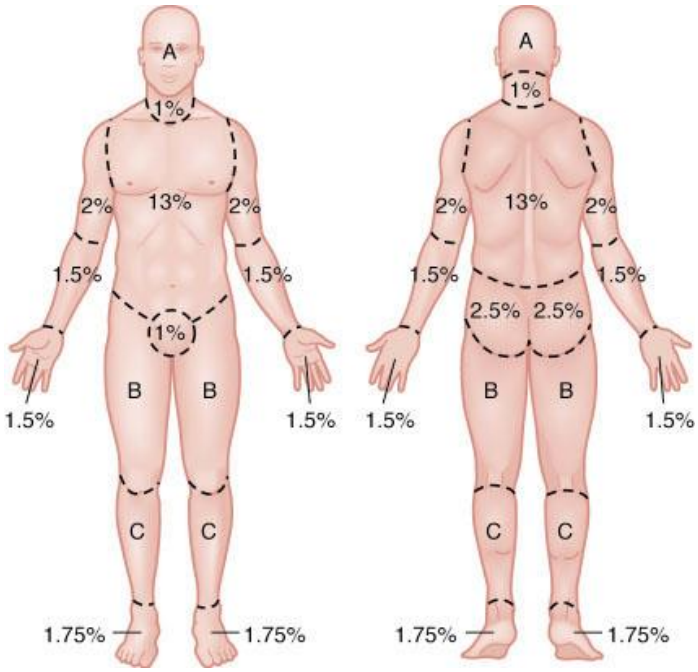
7. The Company reserves the right to alter the terms of this Policy in such a way as the Company deems appropriate in the event of any change in the law or in the basis of taxation levy applicable to the Company or this Policy.

8. The insurance provided in this Policy and the benefits payable are not assignable.

9. This Policy is written in English and Khmer languages. Should there be any controversies or conflict between the two versions, the Khmer version shall prevail.

APPENDIX I – LUND BROWDER CHART

Percentage of Burns will be determined by the following Lund Browder chart:



Area	Percentage of Burns
A = half of head	3.5% - 9.5%
B = half of one thigh	2.75% - 4.75%
C = half of one lower leg	2.5% - 3.5%

The Lund Browder chart for calculating the percentage of total body surface area burnt varies by attained age as recognised internationally.

APPENDIX II – CRITICAL ILLNESS TABLE

1. Group 1 Illness/Surgery

No	Critical Illness Category	Critical Illness Events
1.	Cancer	**Carcinoma in situ** Carcinoma in situ (CIS) means the focal autonomous new growth of carcinomatous cells confined to the cells in which it originated and has not yet resulted in the invasion and/or destruction of surrounding tissues. 'Invasion' means an infiltration and/or active destruction of normal tissue beyond the basement membrane. The Diagnosis of the Carcinoma in situ must always be supported by a histopathological report. Furthermore, the Diagnosis of Carcinoma in situ must always be positively Diagnosed upon the basis of a microscopic examination of the fixed tissue, supported by a biopsy result. Clinical Diagnosis does not meet this standard. In the case of the cervix uteri, Pap smear alone is not acceptable and should be accompanied with cone biopsy or colposcopy with cervical biopsy. Clinical Diagnosis or Cervical Intraepithelial Neoplasia (CIN) classification which reports CIN I, CIN II and CIN III (severe dysplasia without carcinoma in situ) does not meet the required definition and are specifically excluded. Non-melanoma CIS is also specifically excluded. This coverage is available to the first occurrence of CIS only; or **Early Prostate Cancer** Prostate Cancer that is histologically described using the TNM Classification as T1a or T1b or T1c or Prostate cancers described using another equivalent classification; or **Early Thyroid Cancer** Thyroid Cancer that is histologically described using the TNM Classification as T1N0M0 Papillary microcarcinoma of thyroid where the tumor is less than 1cm in diameter; or **Early Bladder Cancer** Bladder Cancer that is histologically described using the TNM Classification as T1N0M0 including Papillary carcinoma of Bladder (TaN0M0); or **Early Chronic Lymphocytic Leukaemia** Chronic Lymphocytic Leukaemia (CLL) RAI Stage 1 or 2. CLL RAI stage 0 or lower is excluded.

No	Critical Illness Category	Critical Illness Events
2.	Heart and Vascular System Disease	**Cardiac Pacemaker or Defibrillator Insertion** Insertion of a permanent cardiac pacemaker or defibrillator that is required as a result of serious cardiac arrhythmia which cannot be treated via other means. The surgical procedure must be certified as absolutely necessary by a Registered Medical Practitioner who is a cardiologist. **Coronary Angioplasty** Means the actual undergoing for the first time of Coronary Artery Balloon Angioplasty, artherectomy, laser treatment, or the insertion of a stent to re-vascularise a narrowing or blockage of one or more coronary arteries as shown by angiographic evidence. Intra-arterial investigation procedures are not included. **Minimally Invasive Surgery to Thoracic or Abdominal Aorta** The actual undergoing of Surgery via minimally invasive or intra arterial techniques to repair or correct an aortic aneurysm, an obstruction of the aorta or a dissection of the aorta, as evidenced by an appropriate diagnostic test and confirmed by a specialist. For the purpose of this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. Intra-arterial investigative procedures are not included.
3.	Brain Disease	**Cerebral Shunt Insertion** The actual undergoing of surgical implantation of a shunt from the ventricles of the brain to relieve raised pressure in the cerebrospinal fluid. The need of a shunt must be certified to be absolutely necessary by a Registered Medical Practitioner who is a neurologist.
4.	Lung Disease	**Surgical Removal of a Lung** Complete surgical removal of the entire right or left lung as a result of an illness or an Accident of the Insured. Partial removal of a lung is not included in this benefit.
5.	Liver Disease	**Partial Surgical Removal of the Liver** Partial hepatectomy of at least one (1) entire lobe of the liver that has been found necessary as a result of illness or Accident as suffered by the Insured. Liver Surgery secondary to alcohol or drug abuse and liver donation are all excluded.
6.	Kidney Disease	**Surgical Removal of a Kidney** The actual undergoing of a complete surgical removal of one (1) kidney as a result of an illness or an Accident. The need for the surgical removal of the kidney must be certified to be absolutely necessary by a specialist in the relevant field. Partial removal of

No	Critical Illness Category	Critical Illness Events
		a kidney and kidney donation is excluded.
7.	Organ Transplantation	**Small Bowel Transplant** The receipt of a transplant of at least one (1) meter of small bowel with its own blood supply via a laparotomy resulting from intestinal failure.

2. Group 2 Illness/Surgery

No	Critical Illness Category	Critical Illness Events
1.	Cancer	**Cancer - of specified severity and does not cover very early cancers** Any malignant tumour positively diagnosed with histological confirmation and characterised by the uncontrolled growth of malignant cells and invasion of tissue. The term malignant tumour includes leukaemia, lymphoma and sarcoma. For the above definition, the following are not covered: (i) All cancers which are histologically classified as any of the following: - pre-malignant - non-invasive - Carcinoma in situ - having borderline malignancy - having malignant potential (ii) All tumours of the prostate histologically classified as T1N0M0 (TNM classification); (iii) All tumours of the thyroid histologically classified as T1N0M0 (TNM classification); (iv) All tumours of the urinary bladder histologically classified as T1N0M0 (TNM classification); (v) Chronic Lymphocytic Leukaemia less than RAI Stage 3; (vi) All cancers in the presence of HIV; (vii) Any skin cancer other than malignant melanoma.
2.	Heart and Vascular System Disease	**Heart Attack – of specified severity** Death of heart muscle, due to inadequate blood supply, that has resulted in all of the following evidence of acute myocardial infarction: (i) history of typical chest pain; and (ii) characteristic electrocardiographic changes; with the development of any of the following: ST elevation or depression, T wave inversion, pathological Q waves or left bundle branch block; and

No	Critical Illness Category	Critical Illness Events
		(iii) Elevation of the cardiac biomarkers, inclusive of CPK-MB above the generally accepted normal laboratory levels or Troponins recorded at the following levels or higher: - Cardiac Troponin T or Cardiac Troponin I > / = 0.5 ng/ml; and the evidence must show the occurrence of a definite acute myocardial infarction which should be confirmed by a cardiologist or Physician. For the above definition, the following are not covered: - occurrence of an acute coronary syndrome including but not limited to unstable angina. - a rise in cardiac biomarkers resulting from a percutaneous procedure for coronary artery disease. **Coronary Artery By-Pass Surgery** Refers to the actual undergoing of open-chest Surgery to correct or treat Coronary Artery Disease (CAD) by way of coronary artery by-pass grafting. For the above definition, the following are not covered: (i) angioplasty; (ii) other intra-arterial or catheter-based techniques; (iii) keyhole procedures; (iv) laser procedures. **Thoracic or Abdominal Aorta Surgery** The actual undergoing of Surgery via a thoracotomy or laparotomy (surgical opening of thorax or abdomen) to repair or correct an aortic aneurysm, an obstruction of the aorta or a dissection of the aorta. For this definition, aorta shall mean the thoracic and abdominal aorta but not its branches. For the above definition, the following are not covered: (i) angioplasty (ii) other intra-arterial or catheter-based techniques (iii) other keyhole procedures (iv) laser procedures
3.	Brain Disease	**Stroke – resulting in Permanent neurological deficit with persisting clinical symptoms** Death of brain tissue due to inadequate blood supply, bleeding within the skull or embolisation from an extra cranial source

No	Critical Illness Category	Critical Illness Events
		resulting in Permanent neurological deficit with persisting clinical symptoms. The Diagnosis must be based on changes seen in a CT scan or MRI and certified by a Registered Medical Practitioner who is a neurologist. A minimum Assessment Period of three (3) months applies. For the above definition, the following are not covered: (i) Transient ischemic attacks; (ii) Cerebral symptoms due to migraine; (iii) Traumatic Injury to brain tissue or blood vessels; (iv) Vascular disease affecting the eye or optic nerve or vestibular functions.
4.	Lung Disease	**Late-Stage Lung Failure** Late-stage lung disease causing chronic respiratory failure. All of the following criteria must be met: (i) The need for regular oxygen treatment on a permanent basis; (ii) Permanent impairment of lung function with a consistent Forced Expiratory Volume (FEV) of less than 1 litre during the first second; (iii) Shortness of breath at rest; and (iv) Baseline Arterial Blood Gas analysis with partial oxygen pressures of 55mmHg or less.
5.	Liver Disease	**Late-Stage Liver Failure** Late-stage liver failure as evidenced by all of the following: **(i)** Permanent jaundice; **(ii)** Ascites (excessive fluid in peritoneal cavity); and **(iii)** Hepatic encephalopathy. Liver failure secondary to alcohol or drug abuse is not covered.
6.	Kidney Disease	**Late-Stage Kidney Failure** Late-stage kidney failure presenting as chronic irreversible failure of both kidneys to function, as a result of which regular dialysis is initiated or kidney transplantation is carried out.
7.	Organ Transplantation	**Heart Transplantation** The receipt of a transplant of heart that resulted from irreversible end failure of heart. Stem cell transplants, islet cell transplants and transplants of part of the heart are excluded. **Lung Transplantation** The receipt of a transplant of lung that resulted from irreversible end failure of lung.

No	Critical Illness Category	Critical Illness Events
		Stem cell transplants, islet cell transplants and transplants of part of the lung are excluded. **Liver Transplantation** The receipt of a transplant of liver that resulted from irreversible end failure of liver. Stem cell transplants, islet cell transplants and transplants of part of the liver are excluded. **Kidney Transplantation** The receipt of a transplant of kidney that resulted from irreversible end failure of kidney. Stem cell transplants, islet cell transplants and transplants of part of the kidney are excluded. **Pancreas Transplantation** The receipt of a transplant of pancreas that resulted from irreversible end failure of pancreas. Stem cell transplants, islet cell transplants and transplants of part of the pancreas are excluded.

INSURANCE POLICY
AIA MedCare RIDER

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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. **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.
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. **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.
16. **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.
17. **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.
18. **Illness:** a physical or mental defect marked by a pathological deviation from the normal healthy or normal state.
19. **Illness Annual Limit:** the maximum amount payable per Policy Year for each Insured Member for the medical expenses incurred for Treatments caused by Illness.
20. **In-Patient:** an Insured Member who is Medically Necessary to have a Treatment at Hospital for more than 06 (six) consecutive hours.
21. **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.
22. **Medical Condition**: Any injury, Illness or disease covered under this Rider.
23. **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.

24. **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.

25. **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.

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

27. **Overall Lifetime Limit:** the maximum amount payable per Insured Member throughout the lifetime of the policy.

28. **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.

29. **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.

30. **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.

31. **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.

32. **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.

33. **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.

34. **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.

35. **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.

36. **Waiting Period:** A period of time, expressed in number of days or months and starting from the Policy 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 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 07 (seven) days take 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 and radiotherapy 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. **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.

7. **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.

8. **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.

9. **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.

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.

10. **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.

11. **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.

12. **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.

13. **Optional Out-patient Care Benefit** reimburses consultations, prescribed drugs, 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.

14. **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.

15. **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.

16. **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.

17. **Optional Mental Care Benefit** reimburses in-patient charges for the Insured Member's hospitalisation in a mental or psychiatric Hospital, or the mental or psychiatric unit or department of a Hospital, for psychiatric care and Treatment recommended by a specialist in psychiatry, and out-patient charges for tests and consultations with psychiatrists or psychologists incurred 90 (ninety) days before hospitalisation and 90 (ninety) days after discharge. The amount payable per Policy Year is up to the limit shown in the Benefits Schedule.

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

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 daily limit stated in the Benefits Schedule
2	In-patient Treatment Benefit	Up to annual limit stated in the Benefits Schedule
3	Out-patient Cancer Treatment Benefit	Up to annual limit stated in the Benefits Schedule
4	Out-patient Dialysis Benefit	Up to annual limit stated in the Benefits Schedule
5	Out-patient Surgical Procedure Benefit	Up to annual limit stated in the Benefits Schedule
6	Pre and Post Hospitalisation Out-patient Treatment Benefit	Up to per hospitalisation limit stated in the Benefits Schedule
7	Emergency Ground Ambulance Transport Benefit	Up to per hospitalisation limit stated in the Benefits Schedule
8	Accidental Emergency Care Benefit	Up to per hospitalisation limit stated in the Benefits Schedule

9	Secondary Claim Benefit	Up to daily limit stated in the Benefits Schedule
	Optional Benefit	
10	Optional Hospital Companion Benefit	Up to annual limit stated in the Benefits Schedule
11	Optional Durable Medical Equipment Benefit	Up to annual limit stated in the Benefits Schedule
12	Optional Preventive Care Benefit	Up to annual limit stated in the Benefits Schedule
13	Optional Out-patient Care Benefit	Up to annual limit stated in the Benefits Schedule
14	Optional Dental Care Benefit	Up to annual limit stated in the Benefits Schedule
15	Optional Vision Care Benefit	Up to annual limit stated in the Benefits Schedule
16	Optional Hospice Care Benefit	Up to annual limit stated in the Benefits Schedule
17	Optional Mental Care Benefit	Up to annual limit stated in the Benefits Schedule
18	Optional Maternity Delivery Benefit	Up to annual 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; 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 Policy 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. Costs that are not usual, Reasonable and Customary in the area where Treatment is received; or
12. Treatment against obesity such as, but not limited to, gastric banding or surgery, removal of surplus issue and fat; or
13. Treatment that is not Medical Necessary; or

14. Treatment that is customarily done as an out-patient including drugs and dressings, consultations and investigations, including pre- and post-natal 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
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 other than initial vaccination for new-borns covered under the maternity delivery benefit if Optional Maternity Care 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.

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

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.

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.