អង្គរ ជេនេរ៉ាល់ អ៊ិនសួរេន ម.ក

ANGKOR GENERAL INSURANCE PLC.

ANGKOR CARE INSURANCE POLICY WORDING

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PART 1: DEFINITION

- Angkor Care Insurance: Insurance covers costs for injury, illness, or other expenses, such as long-term care costs for the insured who are physically harmed or have other illnesses.**Accident:** means a sudden, unexpected, unusual, specific event, which occurs at an identifiable time and place.

- **Age:** means the current age. A person is considered to be of his/her current age until his/her next birthday.

- **Advice:** refers to any consultation from a Medical Practitioner or Specialist including the issue of any prescriptions or repeat prescriptions.

- **Appliances:** shall mean devices and equipment when used as an integral part of a surgical procedure administered by a Medical Practitioner or Specialist.

- **Bodily Injury:** means identifiable physical injury, which is sustained by an Accident and occurs during the insurance period.

- **Chronic Condition:** is a disease or illness which has at least one of the following:
  - It needs ongoing or long-term monitoring through consultations, check-up and prescribed drugs.
  - It needs ongoing or long-term control or relief of symptoms.
  - It continues indefinitely.
  - It has no known cure.
  - It comes back or is likely to come back.
  - When the Insured Person receives medical treatment for the same disease or illness more than 5 times per policy period, it is also considered as chronic medical conditions.

- **Congenital Condition:** Congenital anomalies as well as neo-natal physical abnormalities developing within six (6) months of birth.

- **Commencement Date:** shall mean the date shown on the insurance schedule on which cover first become effective.

- **Complication of Pregnancy** are health problems, which are related to pregnancy. Complication of Pregnancy requires treatment of medical conditions, which arise during the antenatal stages of pregnancy or during childbirth, and those medical conditions required a recognized obstetric procedure.

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- **Critical Illness:** means an illness, sickness or a disease or a corrective measure as defined in Scope of Cover & Benefits section of this Policy.

- **Day-Patient** refers to treatments for the Insured Person who is admitted to a hospital or day-patient unit because of an emergency case (excluding Outpatient Treatment) but does not occupy a bed more than 6 hours as recommended by Medical Practitioner or Specialist.

- **Dependents** means one spouse or adult partner and/or unmarried children who are not more than 18 years old and residing with the Insured at the Commencement Date or any subsequent Renewal Date. The term partner shall mean husband, wife and civil partner. All Dependents must be named as Insured Persons in the Insurance Schedule.
  - Maximum age limit for spouse or adult partner is 70 years old at first year enrolment and renewal.
  - New-born child becomes eligible on the thirty (30) days following the date of birth.
  - A child dependent shall include stepchildren and adopted children.

- **Dental Practitioner** means a person who is licensed by the relevant licensing authority to practice dentistry in the country where the dental treatment is given.

- **Drugs and Dressings**: Drugs, medicines and dressings prescribed by a Medical Practitioner or Specialist.

- **Emergency** means a sudden, serious, and unforeseen acute medical condition or injury requiring immediate medical treatment, that without treatment commencing within 48 hours of the emergency event could result in death or serious impairment of bodily function.

- **Hospital:** A registered institution licensed by the Ministry of Heath for the care and treatment of persons who are injured or ill and which:
  - Provides organized facilities for diagnosis, treatment and major surgery;
  - Provides 24-hour nursing services by registered graduate nurse and under the supervision of one or more Physicians at all times;
  - Is not a mental hospital, a place for alcoholics or drug addicts, a nursing, rest or convalescent home or a home for the aged or similar establishment.

- **Inpatient treatment**: means treatments provided in a hospital where an Insured Person is admitted and, out of medical necessity occupies a bed for more than 6 hours as recommendation of Medical Practitioner or Specialist but period of confinement will not exceed number of days mentioned in Insurance Schedule. A patient shall not be considered as an inpatient if the patient dose not physically stay in the hospital for the whole period of confinement less than 6 hours.

- **Insured Person:** refer to a natural person or a legal entity that purchases an insurance policy, and in some cases an insured can be a policyholder as well as an insured person.

- **Insurance contract:** refers to a written agreement between the insurer and the Insured in which the insurer agrees to accept any specific risk, and in return receives premium paid by the Insured. insurance contract is an insurance policy that must be accompanied by an insurance certificate or a reference document that is a temporary replacement for a final insurance policy.**Insurance Policy**: Refers to a legally binding document issued by an insurance company, which sets out the essential terms and detailed conditions agreed upon between the insured or policyholder and the insurer under an insurance contract.
- **Certificate of Insurance**: Refers to a document issued by an insurance company to certify that the insured has purchased insurance coverage from the insurer.
- **Cover Note**: Refers to a temporary insurance contract issued by an insurance company or insurance intermediary in place of a formal insurance policy.
- **Jurisdiction**: Refers to the courts (at all levels) or any competent authority responsible for adjudicating disputes.
- **Arbitration Tribunal**: Refers to an arbitration forum constituted by one or more arbitrators.
- **Insurance Regulator of Cambodia**: Refers to the authority responsible for supervising and regulating insurance companies and insurance intermediaries within the Kingdom of Cambodia.
- Insurance Compensation: Refers to an indemnity made in cash or property or can be both to be paid by the insurance company.
- **Claims Fraud: Fraud against the insurer in the execution of an insurance product by obtaining wrongful payment.**
- **Maternity Care/Pregnancy** shall mean Childbirth costs, plus ante and post-natal check-ups costs for normal pregnancy and childbirth incurred.

- **Medical Check-up** is payable as a contribution towards the cost of routine health checks, but excluding vision test, hearing test and dental examination.

- **Medical Practitioner** shall mean a person who has attained primary degrees in medicine or surgery following attendance at a recognized medical school and who is licensed to practice medicine by the relevant authority in the country where the Treatment is given.

- **Medically Necessary** is treatment, which in the opinion of a qualified Medical Practitioner is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards could not have been omitted without adversely affecting the Insured Person's condition or the quality of medical care rendered. Such Treatment must be required for reasons other than the comfort or convenience of the patient or Medical Practitioner and provided only for an appropriate duration of time. As used in this definition, the term "appropriate" shall mean taking patient safety and cost effectiveness into consideration.

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- **Outpatient** is an Insured Person who receives treatment at a recognized medical facility agreed by the Company, but he/she is not admitted to a hospital bed as an inpatient.

- **Per Disability:** All medical conditions resulting from the same cause, including any and all complications arising therefrom or closely related thereto, except that after 30 days following the latest discharge from Hospital of Surgery, any subsequent Disability from the same cause shall be considered as a new Disability.

- **Policyholder:** refer to a natural person or a legal entity who has legal title to an insurance policy.

- **Pre-existing Medical Condition:** refers to any disease, illness or injury for which the Insured Person has received medication, Medical Advice or Treatment, or for which the Insured Person has experienced symptoms, within a period of twelve (12) months prior to the effective date of insurance for that Insured Person or before their Date of Entry.

- **Qualified Nurse:** A qualified resident or daily nurse whose name is currently on any register or roll of nurses maintained by any Statutory Nursing Registration Body within the country in which they are resident.

- **Rehabilitation:** refers to Medically Necessary Treatment aimed at restoring independent activities of daily living and the normal form and/or function of an Insured Person following a Medical Condition.

- **Related Condition:** means any disease, illness or injury that is caused by a Pre-existing Medical Condition or results from the same underlying cause as a Pre-existing Medical Condition.

- **Treatment:** Surgical, medical or other procedures the sole purpose of which is the cure or relief of a Medical Condition.

- **Waiting Period:** shall mean a period of time starting on the Insured's commencement date, during which the Insured Person is not entitled to cover for particular benefits. Insurance Schedule and policy wording will indicate which benefits are subject to waiting periods. It is applied only when the Insured Person is first covered. This shall not be applicable after the first year of cover. However, if there is a break in insurance, the waiting period will apply again.

- **We / Us / Our / Insurance Company** / Insurer **Refers to** ANGKOR GENERAL INSURANCE PLC.

- **You / Yourself / Your** Refers to the Policyholder and/or the Insured shown in the Policy Schedule.

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PART 2: INTEREST INSURED

The Company will insure to individuals between the ages of 18 and 70 and also their child or dependent with the aged 30 (thirty) days and under 18 years which under Insured's control.

PART 3: COVERAGE

SECTION A: BASIC COVERAGE (INPATIENT TREATMENT)

The Company agrees to pay compensation, up to maximum payable per plan and per insurance period, for medical treatment following accident and medical condition following illness limited to in-patient treatment and/or day-patient treatment. The Costs of treatment include:

1. **Accommodation, Recovery Room for Intensive care:** Where an Insured Member warded in the Intensive Care Unit of a Hospital, a benefit equals to the charges actually made by the Hospital shall be payable subject to a limit of days for Any One disability as set forth in the Insurance Schedule. Benefit payable in respect of confinement in an Intensive Care Unit shall be payable in place of expenses covered under above Daily Room and Board benefit

2. **Accommodation, Recovery Room for Ordinary care:** A benefit shall be payable when, upon recommendation of a Registered Medical Practitioner, an Insured Member is registered as an in-patient in a Hospital. The amount of benefit shall be equal to the actual room & board inclusive of meal charges made by the Hospital during the Insured Member's confinement; but in no event shall the benefit exceed for any one day the rate of Daily Room and Board benefit or the maximum number of days for Any One disability as set forth in the Insurance Schedule.

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3. **Surgical Benefits:** surgical benefit shall be payable in an amount equal to the Necessary and Reasonable Charges made for such operation, provided that the maximum payable per disability shall not exceed the limit per plan/policy period as mentioned in Insurance Schedule.

4. **In-Hospital Doctor's Visit:** Fees charged for daily bedside visits made by the attending Physician during the Insured Person's confinement in the Hospital. This benefit is limited to one visit per day and shall be payable up to the maximum daily limit specified in the Schedule of benefits.

5. **Pre-Hospitalization Diagnostic Test and Consultation:** Charges made by a legally licensed and duly qualified medical specialist for his opinion and advice sought diagnostic X-rays and laboratory examinations or tests which are recommended by a Registered Medical Practitioner for disability resulting from Illness or Bodily injury of the Insured Person within Ninety (90) days before Hospitalisation is payable as per Schedule of Benefits.

   No Benefits shall be payable if the Specialist's consultation diagnostic X-rays and laboratory examinations or test does not lead to Hospitalisation or surgical treatment within the Period of Insurance.

6. **Hospital General Fees:** In case, the Insured Person is registered as an inpatient and day-patient in a hospital, and benefit of Accommodation and Recovery Room is payable to the Insured Person. The Company shall pay hospital miscellaneous services in respect of the Necessary and Reasonable Charges which are normally given by Hospital.

   Hospital General Fees, which are covered under this Policy, include:
   - Use of Operating Room and Surgical Appliances;
   - Anesthesia and Oxygen and its administration;
   - X-ray, Electrocardiograms, Basal Metabolism Test and other Laboratory Examinations and Tests;
   - Administration and the cost of Blood or Blood Plasma;
   - Medicines, Drugs, Dressings, Ordinary splints, Plaster Casts, and Intravenous Infusions.

7. **Post Hospital Benefits within 90 days following discharge:** Charges incurred for follow-up treatment by the same attending Physician received immediately after discharge from a Hospital or Day Surgery, provided the treatment is for the same medical condition for which the Inpatient treatment or Surgery was required. The treatment must be received within ninety (90) days immediately following discharge from hospital as per Schedule of Benefits.

8. **Cash Allowance for Treatment Covered by NSSF'S Panel Hospital:** When eligible medical expenses are not claimed from this Policy, the Company will pay hospital cash allowance to the Insured Person. Provided that payable of hospital cash

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allowance will not exceed limit and number of days stated in the Insurance Schedule for any one disability. The Insured Person shall be applicable to this benefit only if the Insured Person is registered as an inpatient in a hospital.

9. **Funeral/Burial/Cremation Cost:** When the Insured Person dies because of covered medical conditions, the Company will arrange and pay up to amount specified in the Insurance Schedule for the funeral/burial/cremation cost.

10. **Allowance for Food/Meal Allowance for Non-feeding government Hospital:** A daily cash allowance per each day of confinement at a government hospital provided the insured person is confined in a ward that is lower than the insured person's benefit limit, subject to the maximum stated in the Schedule of Benefit during any one period of disability.

11. **Road Ambulance Transportation: The Company will pay fee of emergency road** ambulance transportation to Hospitals or when it is considered as Medically Necessary by a Medical Practitioner or Specialist.

12. **Reconstructive Surgery:** In addition to the above benefit, surgical benefit shall be payable in an amount equal to the Necessary and Reasonable Charges made for such operation, provided that the maximum payable per disability shall not exceed **30% of maximum payable per plan/policy period** as mentioned in Insurance Schedule.

13. **Surgical Implants:** In addition to the above benefit, surgical benefit shall be payable in an amount equal to the Necessary and Reasonable Charges made for such operation, provided that the maximum payable per disability shall not exceed **30% of maximum payable per plan/policy period** as mentioned in Insurance Schedule.

14. **Companion Accommodation:** This benefit included companion accommodation, new born accommodation and ambulance.

Note:

- New born accommodation is applicable to the insured mother's benefit for children who is less than sixteen (16) weeks old to stay in the hospital with insured mother while she is receiving treatment at hospital.

15. **Accidental Damage to Natural Teeth** It is hereby declared and agreed that the policy is extended to cover accidental damage to teeth. The limit shown for the insured member's plan includes the cost of treatment to teeth damage by accident only such as examination, extraction, filling, sealant, bridgework, and crowns.

16. **Overall Payable Limit for Chronic Conditions:** This Policy covers only 14 chronic conditions as mentioned below. It is subject to 12 months waiting period, and this waiting period will apply to first year of insurance only. Overall payable limit for

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following chronic conditions is subject of maximum payable per plan/policy period which is mentioned in Insurance Schedule only.

- Cardiac Failure;
- Cardiomyopathy;
- Chronic Hepatitis B;
- Chronic Hepatitis C;
- Chronic renal disease;
- Liver Cirrhosis;
- Coronary artery Disease;
- Diabetes mellitus Type 1 & 2;
- Dysrhythmias;
- Multiple Sclerosis;
- Schizophrenia;
- Systemic Lupus Erythe matous;
- Hypertension,
- Thalassemia.

17. **Complications of Pregnancy or Miscarriage due to Accident:** The company extends a benefit to cover only complication of pregnancy or a miscarriage due to accidental which is medically necessary up to limit as stated in the policy schedule per employee female per policy period. The company shall not pay the costs associated with normal pregnancy and childbirth.

18. **Supplemental Accident Expense (within 24 Hours after the accident):** All medical charges including diagnostic, tests and medicines, plus the fees for Specialist treatment and consultation for emergency treatment caused by accidental bodily injury.

SECTION B: OPTIONAL COVERAGE:

The following optional coverages are solely valid as stated in the List of Benefits in the Policy Schedule with Additional Premium Payment. Otherwise, other terms and conditions shall refer to the Policy Wording

1. **Outpatient Care:** It is hereby declared and agreed that the policy is extended to cover out-patient treatment at the panel and non-panel hospitals in the geographical limit as stated on the policy schedule. Co-payment and benefits scale as stated in the policy benefits as per attached.

2. **Maternity Care:** The company extends a benefit to cover routine pregnancy and childbirth. The company shall pay the costs associated with normal pregnancy and childbirth and any related condition incurred where the date of conception is after the first 280 days from the commencement date of this benefit or the date of entry, whichever is the later. Benefits are limited to childbirth, check-ups (pre-natal and immediately post-natal) and delivery costs. All costs relating to complication of

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pregnancy and/or childbirth following assisted conception will be limited to this benefit.

3. **Medical Check-up:** It is hereby declared and agreed that the policy is extended to cover medical checkup fees subject to the available of this benefit and the amount shown for the insured member's plan. The limit shown for the insured member's plan includes the cost of any eligible consultation needed as part of the screening process.

4. **Vaccinations:** This benefit covers medical test or medical service which is linked to episode of treatment and vaccination given at a medically appropriate.

5. **COVID-19 Medical Treatment:** The company extends a benefit to cover Medical Expenses, Hospital room and board in Hospital inclusive of meal charges for treatment of COVID-19 illness up to ninety (90) days. For daily Intensive Care Unit maximum is limited twenty (20) days and for daily Ordinary care Unit is seventy (70) days, coverage includes special nursing services and all medical equipment supplies used while Insured Person is warded.

Conditions for all Sections:

i. Insured Person is diagnosed with COVID-19 and hospitalized as in-patient in a hospital.
ii. Healthcare worker, frontline workers are Excluded from purchasing this covid extension.

6. Critical illness

Insurer hereby agrees subject to the terms, conditions and exclusions herein contained or otherwise expressed to the **Insured** to pay the following benefits in the manner, for the period and to the extent of the Sum Insured as specified. For the purposes of this Section and the determination of **Insurer's** liability under it, the **Insured** Event in relation to the **Insured**, shall mean any illness, medical event or surgical procedure as specifically defined below whose signs, symptoms & diagnosis occurs for the first time after 90 days after the commencement of Period of Insurance and shall only include –

A. First diagnosis of the below-mentioned Illnesses more specifically described below:

i) **Cancers:** A malignant tumor characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma & sarcoma.

Special Exclusions:

- Tumors showing the malignant changes of carcinoma-insitu & tumors which are histologically described as pre-malignant or non-invasive, including, but not

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limited to: Carcinoma-in-situ of the breasts, Cervical dysplasia: CIN-1, CIN-2 and CIN-3;
- Any skin cancer other than invasive malignant melanoma
- All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
- Papillary micro-carcinoma of the thyroid less than 1 cm in diameter
- Chronic lymphocytic leukaemia less than RAI stage 3
- Microcarcinoma of the bladder
- All tumors in the presence of HIV infection.

ii) **Kidney Failure (End Stage Renal Failure):** End stage disease presented as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

iii) **Multiple Sclerosis:** The definite occurrence of multiple sclerosis with the diagnosis support by all of the following:

- investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis
- there must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and

Well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least one month apart. Other causes of neurological damage such as SLE and HIV are excluded.

B. Undergoing for the first time of the following surgical procedures, more specifically described below:

i) **Major Organ Transplant :**The actual undergoing of a transplant of: One of the following human organs: heart, lung, liver, kidney, pancreas that resulted from irreversible end-stage failure of the relevant organ, or Human bone marrow using haematopoietic stem cells The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

Exclusions: Other stem-cell transplants or Where only islets of langerhans are transplanted

ii) **Stroke:** Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intra-cranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has

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to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

Exclusions: Transient ischemic attacks (TIA), Traumatic injury of the brain or Vascular disease affecting only the eye or optic nerve or vestibular functions.

iii) **Coma:** A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- No response to external stimuli continuously for at least 96 hours;
- Life-support measures being necessary to sustain life; and
- Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

The condition has to be confirmed by a specialist medical practitioner.

Exclusions: Coma resulting directly from alcohol or drug abuse is excluded.

iv) **Total blindness:** Total, permanent and irreversible loss of all sight in both eyes as a result of sickness or accident. Diagnosis has to be confirmed by a specialist (best by an ophthalmologist) and evidenced by specific test results.

v) **Paralysis:** Total and irreversible loss of use of two or more limbs as a result of Injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than three months.

Conditions for all Sections:

Only one **Critical Illness** claim can be allowed by us during the lifetime of the **Insured**. Without prejudice to the provisions relating to the termination of the Policy mentioned elsewhere, the **Critical Illness Insurance** Policy terminates immediately on the payment of first **Critical Illness** benefit under the Policy.

PART 4: POLICY BENEFITS

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SECTION A: BASIC COVERAGE (INPATIENT TREATMENT)

In respect of each and every In-patient, we will pay up to the amounts specified in the Benefit Plan specified in the Schedule for the Reasonable Charges as follow:

No.	Schedule of Benefit	Magic (USD)	Bright (USD)	Bliss (USD)	Vita (USD)	Innova (USD)
Maximum payable per plan/ policy Contract		**50,000**	**25,000**	**15,000**	**10,000**	**5,000**
1	Accommodation, Recovery Room for Intensive Care (Max 30 days)	200	200	200	200	200
2	Accommodation, Recovery Room for Ordinary Care (Max 90 days)	90	70	60	50	40
3	Surgical Benefits	6,000	5,000	3,000	2,000	1,500
4	In-Hospital Doctor Visit per day (Max 90 Days)	40	30	25	20	15
5	Pre-Hospital Diagnostic and Consultations	120	100	80	70	60
6	Hospital General Fees	1,400	1,200	1,000	800	600
7	Post-Hospital Benefits (within 90 days following discharge)	105	95	85	75	65
8	NSSF Supplementary Daily Hospital Cash Allowance (Daily limit, max up to 20 nights per disability)	60	45	35	30	25
9	Funeral / Burial / Cremation Cost	500	500	500	500	500
10	Allowance for Food / Meals in Non-Feeding government Hospitals per day	25	20	15	10	8
11	Road Ambulance Transport	500	400	300	250	150
12	Reconstructive Surgery	1800	1500	Not Covered	Not Covered	Not Covered
13	Surgical Implant	1800	1500	Not Covered	Not Covered	Not Covered
14	Companion Accommodation	40	35	30	25	20

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15	Accidental Damage to Natural Teeth per Plan / Policy Period	500	400	300	200	100
16	Chronic Conditions	Full Cover				
17	Complications of Pregnancy or Miscarriage due to Accident	300	250	200	150	100
18	Supplemental Accident Expense (within 24 Hours after the accident)	Up to Maximum Pay able Limit				

PART 5: PREMIUM PAYMENT

Premium payment is yearly basis, and pro-rata premium charge/refund in case of add/delete during the period of insurance.
Premium warranty is fundamental and absolute special condition of this contract of Insurance that the premium due must be paid and received by The Company within thirty (30) days from the inception date of this Policy/ Endorsement/ Renewal Certificate.
If this condition is not complied with then this contract is automatically cancelled and The Company shall be entitled to the pro-rata premium for the period they have been on risk. Where the premium payable pursuant to this warranty is received by an authorized agent of The Company, the payment shall be deemed to be received by The Company for the purposes of this warranty and the onus of proving that the premium payable was received by a person, including an insurance agent, who was not authorized to receive such premium shall lie on The Company. Subject otherwise to the terms and conditions of this Policy.
Insured could pay premium within scenarios such as: cash, cheque, any app, and/or doing bank transfer to **ANGKOR GENERAL INSURANCE PLC** 's account.

PART 6: EXCLUSION

A. SPECIAL EXCLUSION APPLICABLE TO SECTION A BASIC COVERAGE

The Company will not pay for:

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I. Treatment which is provided:

i) At a Cabinet unless an Emergency
ii) Which is not Medically Necessary
iii) For dialysis, obesity, or complications from excluded or restricted conditions.
iv) in respect of puberty or menopause;
v) for deafness caused by ageing;

II. Costs and expenses incurred in respect of:

i) Treatment if confined to a hospital for less than 6 consecutive hours;
ii) preventive Treatment, vaccinations or routine health/eye examinations;

III. The use of:

i) Medications which are not prescribed to cure the Medical Condition;
ii) Herbal or dietary supplements, vitamins;
iii) Spa cures or alternative medicine cures.

IV. Services in connection with:

i) Physical therapy or rehabilitation
ii) Medical tests or check-ups which are not performed as a result of an insured person showing signs or symptoms of a Medical Condition

B. SPECIAL EXCLUSION APPLICABLE TO SECTION B OPTIONAL COVERAGE

The Company will not pay for:

I. COVID-19:

i) COVID-19 illness treated as outpatient or treatment sought outside of Hospital facility or at home.
ii) COVID-19 is known and detected at policy inception date.
iii) Any treatment not related to COVID-19
iv) Insured Person is infected with COVID-19 for the fourth time during policy year,
v) Non-compliance to government rules, quarantine order and movement control order including large group gatherings, cross-district and cross-border movements.

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II. Critical Illness:

No benefit shall be paid for the following circumstances, for the following conditions/ tests/ treatments and/or any **Critical Illness** directly or indirectly arising thereof or there from:

i) Benefits will not be available for any **Pre-Existing conditions** or related condition(s) or any complications arising thereof for which **Insured** has been diagnosed, received medical treatment, had signs and / or symptoms, prior to inception of **Insured's** first Policy, unless such a condition is stated in the Proposal form and specifically accepted by the **Company** and endorsed thereon.

ii) Company shall not be liable to make any payment under this Policy in connection with or in respect of any Insured Event during the Waiting Period as defined under the Policy.

iii) Any Covered Critical Illness arising from Treatment by a family member and self-medication or any treatment that is NOT scientifically recognized and any complications arising thereof / there from.

C. GENERAL EXCLUSION

1. Supplying or fitting physical aids and devices such as hearing aids, spectacles, contact lenses, crutches and walking sticks.
2. All types of sleep disorder including snoring.
3. All treatments related to all types of tumors and cancers are not covered under this Policy, unless option critical illness is selected.
4. AIDS/HIV or any related diseases.
5. Artificial heart implantation.
6. Birth injuries or Congenital Anomalies unless option critical illness is selected.
7. Chronic medical condition which are not stated in the Basic cover **number 16.**
8. End-stage kidney failure unless option critical illness is selected.
9. Consequential loss of any kinds arising from the provision of, or any delay in providing, the services to which this Policy relates, unless negligence on our part can be demonstrated.
10. Cosmetic Treatment whether or not for psychological purposes.
11. Costs of providing or fitting any external prostheses or appliance.
12. Corrective surgery for sight defects not incurred as a result of an accident.
13. Costs incurred in connection with locating a replacement organ or any costs for removal of the organ from the donor, transportation costs of same and all associated administration costs.
14. Dangerous Sport: Preparation for or participation in speed races with motor vehicles, motor boats or bicycles, amateur flying, delta flying, hang-gilding and the like, equestrian competitions, deep sea diving under 40m deep, all combat and

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self-defence sports and rugby. If a sport or activity is not in this list the Company will decide if it is a dangerous sport or activity.

15. Double consultation any second or subsequent medical opinions from a Medical Practitioner or Specialist for the same condition unless it has been authorized by us in writing.
16. Evacuation or Repatriation is excluded from this policy.
17. Experimental or unproven Treatment.
18. Ear or body piercing and tattooing including any Death or Permanent Disablement or Treatment needed as a result of any of these.
19. Fraud: If a claim is in any respect fraudulent, or if any false declaration is made or used in support thereof, or if any fraudulent means or devices are used by the Insured or anyone acting on his behalf to obtain any benefit under this Policy, all benefits under this Policy shall be forfeited.
20. Glasses/Sunglasses of any kinds including doctor's prescription, Normal eye tests, provision of visual aids, normal hearing tests, provision of hearing aids.
21. Genetic tests, nor for any counselling made necessary following genetic tests, even when those tests are undertaken to establish whether or not the Insured Person may be genetically disposed to the development of a Medical Condition in future. This is because such tests are carried out for purposes of establishing whether a Medical Condition might develop and not for the Treatment of a Medical Condition.
22. Home Nursing is excluded from this Policy.
23. Illegal and Criminal Activities: The Company will not indemnify the Insured in respect of any liability or injury arising out of illegal or criminal activities or dishonest acts alleged or otherwise committed by or at the direction of or with the knowledge and consent of the Insured.
24. Intoxication: The Company will not indemnify the Insured in respect of claims made or contributed to directly or indirectly under the use of alcoholic beverages, intoxicants, stimulants or similar substances (also including hard and soft drugs).
25. Maternity Care/Childbirth/ Normal pregnancy, childbirth pregnancy including abortion. Any routine ante and post-natal examination and delivery costs incurred unless it is stated in policy schedule.
26. Medical treatment associated with cryopreservation, implantation or reimplantation of living cells or living tissue whether autologous or provided by a donor.
27. Medical treatment for mental or nervous disorders, psychiatric treatment and the costs of a psychotherapist, psychologist, family therapist or bereavement counsellor (other than 30 days in-patient stay).
28. The treatment directly or indirectly arising form or required as a result of chemical contamination or contamination by radioactivity from any unclear material whatsoever or from the combustion of nuclear fuel, asbestos or any related condition.
29. Out-Patient drugs or dressings, Test, CT scan, MRI, PET or Gait Scan, unless it is following accident or release from hospitals or Out – Patient option is selected.

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30. Obesity (Body Mass Index or BMI equal to 30 and above) or any Medical Condition which arises from, or is related to, obesity in any way including but not limited to the use of gastric banding or stapling, the removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons, weight reduction or improvement program.
31. Personal comfort and convenience items including but not limited to, television, private rooms, housekeeping services, guest meals and accommodations, special diets, telephone charges, take home supplies, travel expenses, ambulance services (other than those provided by this Policy), and all other services, including private duty nursing and supplies that are not Medically Necessary and do not form a part of Accommodation charges as covered under the Policy.
32. Personal care items which are purchased during Hospitalization are not covered under this Policy.
33. No benefit shall be payable under the Policy and supplementary contracts for **Pre-**existing Medical Conditions and Related Conditions unless the Insured Person or Dependent (if applicable) has been continuously insured under the Policy or the insured's Healthcare insurance for at least twelve (12) months with the previous insurer.
34. Routine physical examination by a Medical Practitioner, including gynaecological investigations and tests, inoculations, vaccinations and other preventative medicines, unless it is stated in the policy schedule.
35. Rehabilitation unless it forms an integral part of treatment received as an In-Patient and is under the control or supervision of a Specialist and is undertaken in a recognized rehabilitation unit.
36. Routine or restorative dental Treatment, whether or not performed by a Medical or Dental Practitioner or a Specialist or an Oral and Maxillofacial surgeon unless otherwise it is stated in the policy schedule.
37. Treatment for alopecia, all forms of acnes.
38. Treatment for Coronavirus (Covid-19) / Pandemics / Epidemics, unless it is stated in the policy schedule.
39. Treatment for Pandemics or Epidemics.
40. Treatment directly or indirectly arising from or required in connection with male and female birth control, infertility, contraception, sterilization, abortion and any form of assisted reproduction.
41. Treatment directly or indirectly associated with a sex change**.**
42. Treatment for learning difficulties in children (Autism).
43. Treatment for alcoholism, drug or substance abuse or any addictive condition of any kind and any injury or illness arising directly or indirectly from such abuse or addiction.
44. Suicide or attempted suicide, wilfully self-inflicted bodily injury or illness or injury sustained as a result of a felony.
45. War, Sabotage and Terrorism: Unless more specifically insured under war option. The Company shall not indemnify the Insured for any treatment received directly or indirectly arising from or required as a consequence of: war, invasion, acts of foreign enemy hostilities (whether or not war is declared), civil war, rebellion,

revolution, insurrection or military or usurped power, mutiny, riot, strike, material law or state of siege or attempted overthrow of government or any acts of terrorism, unless the insured person sustains bodily injury whilst an innocent bystander.

PART 7: GEOGRAPHICAL LIMIT

The Company will cover the geographical limits following the below Options:

1. Cambodia, Vietnam, Laos and Thailand.
2. Asian Countries and Asia Pacific
3. Worldwide (Excluded Canada and USA)
4. Worldwide

PART 8: QUALIFICATION OF CLAIMANTS

In this policy, the beneficiary or the claimant must be the party to the policyholder as stated in the policy schedule or the legitimate beneficiary of the policyholder/The Insured person in case the policy owner/the Insured Person accidental to death.

PART 9: AMENDMENT

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Any amendment or additional to any condition on the original policy requires both parties to notify us in writing of such amendment or additional via electronic communication or by sending a written notice to the requesting party. There are amendments or additions to this. All amendments or additions will be valid only with the written consent of The Company and the underwriter/ insurer and stated in the endorsement.

In case of failure to notify the amendment as mentioned above, the terms of the original insurance contract will apply and the claim for damages arising from the amendment may be rejected.

PART 10: RENEWAL POLICY

This Policy is renewable at our option or not invited for a renewal which we will send to the Insured for a renewal notification 30 days before the renewal expiry, subject to underwriting requirements being fulfilled and at the premium rates determined at that time by Us.

Where a request is made to hold cover at renewal, the maximum period that cover can be held will be thirty (30) days. If at the end of this period, the Policy is cancelled or lapses for any reason whatsoever, you must pay us a premium for the number of days the cover was held which will be calculated on pro-rata basis at the renewal premium.

PART 11: TERMINATION

A 10-days' notice shall be given to The Company in advance if the insured wishes to terminate the insurance before expiry date. Based on reasonable grounds, the insurance Company will refund the insured ninety percent (90%) of the remaining premium.

In case of requesting to terminate the insurance after the risk occurred and The Company has already paid the claim, the insurance Company shall not refund the insurance premium for the remaining period.

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PART 12: CANCELLATION

The Company also has reserved the rights to cancel this policy by sending thirty (30) days noticed inform you as the following causes:

- Unpaid insurance premium after 30 (thirty) days after the insurance contract is valid.
- We find cases of concealment, fraud and/ or misrepresentation by the policyholder or the insured.

PART 13: CLAIM

When a claim is made, the Insured Person and/or the legal representative shall notify Us in writing as soon as possible after discharge from hospital by filling up the claim form as We have provided and related documents to The Company is the personal expense of the policyholder.

A. QUALIFICATION OF CLAIMS PROPOSER

In this insurance contract, the applicant must be a policyholder as stated in the insurance certificate, Insured Person as stated in the policy, or may be a relative of the Insured Person with legal documents certifying the recognition from the relevant authorities in case the Insured Person death.

B. CLAIMS PROCESSING

Treatment received at both panel and non-panel hospitals/ clinics will have to follow below claim notification:

1. Panel Hospitals/ Clinics

When the Insured Person admits to our panel hospitals/ clinics, our panel hospitals/ clinic will notice to our Company to confirm the limit of cover.

2. Non-Panel Hospitals/ Clinics

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For treatment received at non-panel hospitals/ clinics, when the Insured Person and/or the legal representative reports to our Company about the claims occurred, the Insured Person and/or the legal representative must submit all required documents to our Company within **ninety (90) days** from date of accident/ treatment.

If the Insured Person and/or the legal representative fails to follow period of claim notification and period of submission of required documents for claim settlement as mentioned in this claim procedures, our Company may decline Your claim, or subject to Your claim **Co-payment** as our Company may deem fit at our Company's sole discretion.

For your assistant or any issue regarding to claim procedure, please contact to The Company's 24/7 hotline number or broker.

C. REQUIRED I/NFORMATION AND DOCUMENTS

1. Required Information

In case of claim, You need to provide Us the below information to receive treatment at both Panel and Non-Panel Hospitals/ Clinics:

- Policy Number
- Name of Policyholder
- Name of Insured Person (Patient)
- Date of Admission
- Brief Circumstances of Illness/Accident
- Contact Person and Telephone Number.

2. Required Documents

In order to make claim, You need to provide required documents as following:

a) Panel Hospitals/ Clinics

When the Insured Person admits to our panel hospitals/ clinics, the Insured Person just shows our membership card to the hospitals/ clinics. Our panel hospitals/ clinics will contact our Company to confirm the cover and can assist to fill in claim form and guide the Insured Person what to do. The Insured Person follow the instruction of our panel hospitals/ clinics to fill in claim form and attached with ANGKOR Insurance Membership Card and National ID card/ Passport of the patient.

b) Non-Panel Hospitals/ Clinics

When the Insured Person admits to non-panel hospitals/ clinics, the Insured Person must pay all bills in advance and send required documents as following to our Company for claim reimbursement:

- A completed Healthcare claim form

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រាជធានីភ្នំពេញ ព្រះរាជាណាចក្រកម្ពុជា
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KHAN 7 MAKARA, PHNOM PENH, KINGDOM OF CAMBODIA.

- National ID Card/ Passport (Copy)
- ANGKOR Insurance Membership Card (Copy)
- Proof of hospitalization
- Medical detail report
- Original medical bill/receipt
- Other relevant documents if necessary.

In case of death of the Insured Person, the beneficiary or the legal representative also needs to provide us death certificate and/or other related documents.

D. CLAIMS PAYMENT TERM

Claim Payment should be made through:

1. Panel Hospitals/ Clinics

All eligible bills will be settled directly between our Company and hospitals/clinics.

For any payment which The Company has paid to the Panel Hospitals/ Clinics but that payment is not covered under ANGKOR Care Insurance policy, Insured should reimburse that payment to The Company within 1 (one) month from the date that The Company request to reimburse back to The Company. In case Insured is not follow this term, so your insurance policy will be ceased unless the payment have been settled.

2. Non-Panel Hospitals/ Clinics

All necessary documents, information and proof required must be submitted to claim department as soon as possible after discharged. Please kindly note that only eligible bills will be paid. We endeavor to process your claim within 7 (seven) working days for the claim amount under USD 50,000, and within 14 (fourteen) working days for the claim amount USD50,000 and above, after a completed claim form and all necessary documentation have been received by us. If we need additional information, a written request will be sent to You within 7 (seven) working days.

Claims Payment will be made by cheque or bank transfer from ANGKOR INSURANCE PLC ‘s bank account.

In respect of any costs or expenses our Company has paid out on the Insured Person’s behalf which are not covered under this Policy, the Insured Person will be required to reimburse to our Company within one month of our request to the Insured Person. If this condition is not complied by the Insured Person, the Insured Person’s Plan will be suspended until all relevant payments have been settled in full.

In the event that there is no cooperation from the policyholder and / or insufficient documents related to the compensation process, Our Company will not be responsible for settling the claim.

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PART 14: CONFIDENTIALITY

All information provided to the Company must be kept confidential and no personal information shall be disclosed to any third party without prior consent unless it is required or authorized by the applicable laws and regulations.

PART 15: DISPUTE RESOLUTION

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

PART 16: LAW AND JURISDICTION

The Policy shall be governed by and interpreted in accordance with the Law of the Kingdom of Cambodia. The jurisdiction is the competent court in the Kingdom of Cambodia. This insurance policy shall be interpreted in accordance with the law and shall apply under the jurisdiction of the Kingdom of Cambodia.

PART 17: CONDITIONS APPLICABLE TO ALL SECTIONS

A. BASIC OF CONTRACT

This Policy shall form the basis of understanding and agreement between You and Us. Therefore, observation and fulfilment of the terms by you shall be condition precedent to any liability for Us to make any payment under this Policy.

B. MISPRESENTATION/ FRAUD

24/7
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Our Company reserves the absolute rights to refuse or refuse to renew or cancel or vary the terms of the Policy if:

1. There is or has been any fraud, hiding of facts or untrue statements made,
2. The insured breached the terms of this contract. In such instance, the Insured must reimburse any benefits Our Company may have already paid.

C. DUTY OF DISCLOSURE

If You fail to disclose to Us fully and faithfully, all the facts which You know or ought to know, or if You misrepresented any facts to Us before the Policy was entered into, We may avoid this Policy.

You must observe and fulfil the Terms, Conditions, Endorsements, Clauses or Warranties of the Policy.

PART 18: COMPLAINT PROCEDURE

Applicable to All Sections

Our commitment is to provide an excellent service. If you have a complaint, we will try to resolve it straight away but if we are unable to we will confirm we have received your complaint within forty-eight hours (48 hours) and do our best to resolve the problem within four weeks. If we cannot, we will let you know when an answer may be expected.

If you have a complaint, please contact us at:

CUSTOMER SATISFACTION TEAM

HEAD OFFICEANGKOR GENERAL INSURANCE PLC.

Khan 7 Makara, Phnom Penh, Cambodia

Tel: XXXXXXX

Email: XXXXX

If we have not resolved the problem within twelve (12) weeks, You have the right to refer your complaint to:

INSURANCE REGULATOR OF CAMBODIA
MINISTRY OF ECONOMY AND FINANCE

Building # 168 F (6th Floor), Street 598
Sangkat Chraing Chamres 1, Khan Russey
Keo Phnom Penh, Kingdom of Cambodia

PART 19: CONTACT INFORMATION

Please contact us at:

ANGKOR GENERAL INSURANCE PLC.
Khan 7 Makara, Phnom Penh, Cambodia
Telephone: xxxxxx
Email: xxxxxx

CUSTOMER SERVICE
Telephone: XXXXX
Email: XXXXX

UNDERWRITING DEPARTMENT
Telephone: XXXXX
Email: XXXXX

CLAIMS DEPARTMENT
Telephone: XXXXXX
Hotline: XXXXXX
Email: XXXXXX