

Liberty Insurance Vietnam (LIV), a leading non-life insurance company, a subsidiary of the Liberty Mutual Insurance, a group with over 100-year history in the general insurance industry in the United States and across the world. Inheriting from the group's expertise, LIV brings international standard products to the Vietnamese.

Liberty Mutual Insurance is the world-acclaimed group:

- The 3rd largest P&C insurer in the US and the 6th in the world.
- Ranked 75th in the Fortune 500 list.

In Vietnam, Liberty Insurance positions with a unique proposition in the non-life insurance market with **advanced technology**, easy and safe online insurance purchasing platform as well as fast and efficient claim process. At every Liberty Insurance office, anywhere in the world, customers are always served by a qualified, experienced and dedicated team.

Each and every Liberty's insurance product has been developed from thorough studies and diligently designed for the Vietnamese people. Liberty insurance products help ensure a better life, serving all lifestyle needs with a wide range of products such as comprehensive auto, home, medical, travel, property and liability insurance products...via traditional, direct and online channels at a reasonable premium. Liberty Insurance has always been highly recognised for our service quality and is the first choice for customers in seeking for practical insurance solutions to protect against unexpected risks and the joy of life.

Liberty Insurance is honoured to be awarded the **"Top 10 Most Reputable Non-Life Insurance Companies in Vietnam 2020"** accoladed in 2018, 2019, 2020 – a testament to the Liberty team efforts.



**THE TOP REPUTABLE
INSURER IN VIETNAM**
2018 | 2019 | 2020



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**LIBERTY MEDICARE
INSURANCE POLICY WORDING**

Global HealthCare Service, The Joy Of Life

MEDICARE
Bảo hiểm Sức khỏe



Liberty MediCare Insurance Policy Wording

*(Issued as the decision of Liberty Insurance Vietnam's CEO on 12/05/2015,
and became effective on 27/08/2015)*

Liberty Insurance gives you Freedom to Move



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LIBERTY MEDICARE INSURANCE POLICY WORDING

Based upon the Policyholder's application for insurance - through an Application Form and information provided therein as well as all other information provided to the Insurer in connection therewith – and due payment of the insurance premium in accordance with this Insurance Policy Wording, the Insurer agrees to insure the Insured against the covered bodily Injury, Sickness, Dental or being Pregnant (if applicable) during the Insured Period and within the Limits of Liability, subject to the terms and condition of the Insurance Policy.

PART A – GENERAL PROVISION

1. Interpretation

In this Insurance Policy Wording, the Benefit Plan, the Policy Schedule, the Certificate and the Endorsements, the following terms and phrases shall have the meaning set forth below:

Application Form

A duly executed application form for Liberty Medicare Insurance in the form as set forth by the Insurer from time to time.

Benefit Plan

The benefit plan issued by the Insurer. With respect to an Insured, the relevant benefit plan applicable to that Insured as provided in the Policy Schedule and the Certificate issued to such Insured.

Policy Schedule

The policy schedule issued by the Insurer to the Policyholder and/or the Insured.

Certificate

The certificate of insurance issued by the Insurer to the Insured in the form of a Liberty MediCare card.

Insurance Policy

The Insurance Policy as described in Article 2.

Group Policy

Insurance Policy for Group.

Limit of Liability

The maximum limit of the Insurer's accrued liability for each Insured, for the whole Insured Period, with respect to each section as set out in the Coverage of Insurance and the Benefit Plan

Insurer

Liberty Insurance Limited.

Insured Period

With respect to an Insured, the insured period as provided in the Policy Schedule and the Certificate issued to such Insured.

Usual Country of Residence

With respect to a person, the country in which such person is living at the date of commencement of cover under the Insurance Policy and which is declared in the Application Form.

Accident

Any sudden and unforeseen event occurring during the Insured Period resulting in bodily injury of the Insured by an external force.

Active Service

An employee will be considered in active service on any day if he or she is then performing his or her duties in order to complete his or her role as assigned to him or her to perform or being performed on the last day of the working schedule.

A member of a Sponsoring Organization will be considered in "Active Service" on any day if he or she is then able to perform all the normal activities of a member of such Sponsoring Organization, and is confined neither at home nor in a medical facility.

A Dependant will be considered in "Active Service" on any day if he or she is then able to perform all the normal activities of a person in good health of the same age and sex, and is confined neither at home nor in a medical facility.

AIDS/HIV

Cover for treatment of Human Immunodeficiency Virus (HIV) and related illnesses including Acquired Immune Deficiency Syndrome (AIDS), its complications and all illnesses/conditions caused thereby and/or related thereto, including the consequences of treatment arising thereof which occurs during the Insured Period, including the subsequent renewal year(s) and manifests itself after five years of

continuous coverage under the Policy from the first Effective Date.

This benefit is inclusive in the Limit of Liability for inpatient and subject to a sub-limit of 10% of the Limit of Liability for inpatient per Insured per lifetime.

Appliances

Devices and equipment when used as an integral part of a surgical procedure administered by a licensed medical facility.

Companion Bed

Hospital accommodation in respect of a parent or a legal guardian staying overnight with an Insured, who is under 18 years of age, and is admitted as an inpatient in a Hospital.

Chinese Herbalist/Bonesetter/Acupuncturist

Chinese Herbalist/Acupuncturist shall mean a physician or a medical practitioner who is licensed as Chinese Medicine Practitioner in accordance with the prevailing laws.

Herbal Medication shall mean herbal medications prescribed by a registered Chinese Medicine Practitioner in writing, directly related to the diagnosis being treated.

Bone-setting shall mean treatment of musculoskeletal system, joint and soft tissue resulting from accident for internal or external bodily injuries.

This benefit includes consultation fee and medicine for the treatment in a medical facility that provides Chinese Medicine/Bone-setting/Acupuncture treatment, subject to the Limit of Liability for Chinese Herbalist/Bonesetter/Acupuncturist as stated in the Benefit Plan.

Day Case Treatment/ Day-Patient

Treatment in a Hospital where the Insured is usually admitted to a Hospital bed but does not stay overnight.

Each hospital confinement must be for a minimum period of six (6) consecutive hours before any benefits hereunder are payable, except that no minimum period of hospital confinement is required if such confinement is in connection with a surgical operation, accidental emergency treatment.

If an Insured has undergone surgical treatment in an authorized medical facility or confined in a Hospital for less than 24 hours as a result of injury and disease, the Insurer shall pay the reasonable and customary charges, which is actually incurred by the Insured from the medical facility or Hospital, and subject to the relevant Limit of Liability as set forth in the Benefit Schedule.

Deductible/Co-insurance

The portion of costs for which the Insured is liable, as stated in the Policy Schedule.

Dependant

The legally married spouse and unmarried children (including natural children, step-children, foster children and legally adopted children) who are dependent on the Insured for support, Provided always that such children are not less than 15 days and less than 18 years old (or 23 provided that the dependent is in continuous full-time education).

Dental Services

Dental Service include:

Routine Oral Examination: Scaling and polishing is covered once a year per Insured.

Basic Dental Service: Extraction, amalgam, filling, x-rays, periodontal scaling is covered.

Major Dental Treatment: Removal of impacted, buried or unerupted teeth, root canal treatment, removal of solid odonomes, adpicectomy will be covered.

PROVIDED ALWAYS THAT these dental services must be performed by a registered dentist who is licensed by relevant licensing authority to practice dentistry in Vietnam where the dental treatment is given. The material being used for filling is limited to amalgam and porcelain and does not include precious metal/material.

The Dental Services are available when applying together with optional Outpatient and subject to 20% co-insurance.

Direct Settlement Network

Medical providers, details of which are listed separately and informed by the Insurer to the Policyholder, which agree to charge the Insurer directly for the treatment cost when the Insured present a valid designated Certificate. However, the Insured is responsible for repayment if such charges are not eligible under the Insurance Policy. Failure to re-pay by the Insured to the Direct Settlement Network, such ineligible expenses will result in the Insurer's right to suspend or cancel the Insurance Policy.

Effective Date

With respect to an Insured, the first date of the Insured Period of such Insured (either original or renewal, as the case maybe).

Elective Treatment

Elective treatment includes all non-emergency hospital/surgery treatment planned for in advance.

Employee

A person being more than 18 years old, having the ability to work in accordance with the labor contract, being paid and being subject to the management and control of the Employer.

Employer

A company, enterprise, organization or sponsoring organization having recruited and engaged employment in accordance with the labor contract and according to which the Group Policy is proposed, executed or performed and according to which the Group Policy is issued.

Emergency/Serious Conditions

Emergency/serious condition means a bona fide situation where there is a sudden change in an Insured's state of health, which requires urgent medical or surgical intervention within forty-eight hours of onset to avoid imminent danger to his/her life or health.

Emergency Dental Treatment following Accident

A Dental Treatment received within 30 days of incurring accidental damage caused to sound, natural teeth, except when the accidental damage has been caused through eating and/or drinking, when given by an Orthodontic Physician in an authorized medical facility.

Emergency Medical Evacuation

The medically necessary expense of emergency transportation and medical care en route to move an Insured with a Serious Medical Condition insured under the Insurance Policy, to the nearest Hospital within Vietnam, where appropriate medical care and facilities are available, as determined by the attending Medical Practitioner or Specialist in conjunction with the Insurer's medical advisors.

The Insured/legal representative of the Insured shall contact to the Insurer or the Medical Assistance Provider to obtain prior approval for any evacuation and to make the necessary transportation arrangements.

This benefit is also subject to the scope of coverage and exclusion specified in the Service Agreement between the Insurer and the Medical Assistance Provider, which

coverage and exclusion have been informed by the Insurer to the Policyholder, subject to any changes from time to time as informed by the Insurer to the Policyholder.

This benefit is not available for the Insured aged 70 or above.

Emergency Ward Treatment

Services performed in a Hospital casualty ward or emergency room for a period of not more than 24 hours Provided That these services are determined as serious conditions by the Medical attendance from Emergency Ward and Hospital, which require an emergency treatment.

Group

A group of Employees employed by one Employer and their Dependants; or a group of members of a Sponsoring Organization and their Dependants.

Sponsoring Organization

Trade Union or any other associations, organizations or institutions accepted by the Insurer to be a Policyholder of an Insurance Policy in which its members are insured.

Home Country

With respect to an Insured, the country of which the Insured holds a passport. Where the Insured holds more than one passport, the Home Country will be taken to mean the country which the Insured has declared on the Application Form.

Hospital/Clinic

Any medical facility which is a legally licensed as a medical examination or treatment facility in the country in which it is located.

Hospital Services

Medical services rendered to the Insured only when appropriate diagnostic procedures and/or treatments are not available as outpatient services and when admittance as a registered inpatient or day-patient to a Hospital. Hospital Services include reasonable and customary charges, in the area where treatment is provided, for Hospital accommodation, the cost of the room, meal charges, all Hospital medical facilities and all medical treatments and medical services prescribed by a Physician and Hospital/Clinic, including intensive care unit accommodation where this is medically necessary.

Bodily Injury

Injury which is sustained by the Insured on any part of his/her body during the Insured Period and is caused by an Accident.

Insured

A person satisfied all conditions for whom commencement of cover has been confirmed by the Insurer by issuing a Policy Schedule describing him/her as an Insured under such Insurance Policy.

Laboratory and X-Ray Services

Laboratory testing, radiographic and nuclear medicine procedures used to diagnose and treat medical conditions. Any such laboratory and X-Ray Services must be prescribed by a Physician and the Hospital/Clinic.

Local Ambulance Services

The medically necessary road ambulance transportation services to and from a local Hospital.

Maternity Care

Pre-natal, childbirth, post-natal treatment and miscarriage, or abortion out of medical reason, or any complications arising from pregnancy for the Insured with respect to normal and complicated delivery and the after birth baby care incurred in the Hospital. The maximum coverage for general new-born baby care is 5 days immediate after birth; if there is inpatient treatment for disease manifests itself within 30 days following birth, the maximum coverage is 30 days following birth.

Where this benefit is included in the Insurance Policy for an Insured, it will apply to pregnancies which actual date of birth is at least 12 months after the date of enrolment of this benefit of the Insured, except that it is a premature termination of pregnancy due to miscarriage or abortion because of medical reasons. The Maternity Care benefits will be insured when such pregnancy commences after 90 days from the enrolment date of this benefit of the Insured.

Medically Necessary

Treatment, service or procedure which in the opinion of a qualified Medical Practitioner and the Hospital is appropriate and consistent with the diagnosis and which in accordance with generally accepted medical standards.

Medical Assistance Provider

The Medical Assistance Provider of the Insurer, which can be International SOS or any other similar providers as informed by the Insurer to the Policyholder from time to time.

New-Born Baby Care

A Maternity Care benefit extension for the general baby care, for the maximum of 5 days immediate after birth or inpatient treatment for disease manifests itself within 30 days following birth. The benefit is limited for a maximum of 30 days of hospitalization from the date of birth of the baby.

Nursing at Home/Home Nursing

The services of a legally Registered or Enrolled nurse in the Insured Member's abode when prescribed by a Hospital for medical as distinct from domestic reasons immediately after or instead of Inpatient or Day Case Treatment. Cover will be limited to a maximum period of 182 days in any one insurance period of 12 months.

Occupation Classification

Class I – Professionals and occupations involving non-manual administration or clerical work solely in offices or similar non-hazardous places.

Class II - Persons engaged in work of a supervisory nature and others not in Class I whose duties may involve occasional light manual work but not using tools or machinery or expose them to any special hazard (e.g., Clerk-of-Work, Supervisor), Persons who are required to travel outside office for business or professional purposes but no engaging in manual labour. (e.g., Salesman).

Class III – Persons engaged in manual work not of particularly hazardous nature but involving the use of tools or light machinery (e.g. toolmaker, delivery service).

Class IV – Persons engaged in hazardous occupations, e.g. heavy manual work involving the use of heavy tools and machinery (e.g. construction worker).

Oncology

Treatment given for cancer received as an In-Patient or Day-Patient of the Hospital.

If an Insured has undergone chemotherapy or radiotherapy for cancer treatment in a Hospital for less than 24 hours for such treatment, the Insurer will pay this Benefit for actual medical expenses charged by the Hospital up to the maximum amount as shown in the respective Benefit Plan.

Except the Group Policy and unless the Insurer agrees otherwise, treatment given for Oncology will only be insured if the first symptom of the Oncology occurs after 90 consecutive days as from the first Effective Date of the Insured in accordance with the certification of the Physician and the Hospital where the Insured is being treated. The medical expenses will be paid as follows:

| | |
|---|---|
| Time of occurrence of the first symptom (From the first Effective Date of the Insured) | Rate of compensation (% of the total medical expenses) |
|---|---|

| | |
|----------------|------|
| After 90 days | 70% |
| After 180 days | 100% |

Organ Transplant

The medical treatment costs incurred in respect of kidney, heart, liver and bone marrow transplants only up to the respective Benefit Plan’s sub-limits. The cost of acquisition of the organ and all costs incurred by the donor are not covered under the Insurance Policy.

Outpatient Services

Medical treatment provided to the Insured when the Insured is not a registered in-patient/day-patient in a Hospital, or in any other facility for medical care, Laboratory testing, radiographic and nuclear medicine procedures used to diagnose and treat medical conditions. Laboratory and x-ray services have to be prescribed by a Physician and Hospital/Clinic.

Outpatient Services also include medication, the sale and use of which is legally restricted to prescription by a Physician and Hospital/Clinic, and do not include items that may be purchased without a prescription of a Physician and the Hospital/ Clinic.

Physician

A legally licensed medical examination and treatment recognised by the law of the country where treatment is provided and who, in rendering such treatment, is practising of medical examination and treatment within the scope of his licensing and training.

Policyholder

The policyholder as stated in the Policy Schedule.

Unless clearly provided by an Endorsement to the Insurance Policy, the Insurer shall consider the Policyholder as the unique holder of the Insurance Policy and shall not be forced to recognize any compliant or claim or other legitimate benefits of the Insurance Policy.

Policy Year

The time starting from (whichever is later) (i) 00.01 a.m. on the first day of the Insured Period or (ii) the time of issuance of the Insurance Policy by the Insurer and 11:59 pm on the last day of the Insured Period, both inclusive. All times are calculated as according to Vietnam standard time.

Pre & Post Hospitalisation Treatment

Will be covered as defined under Outpatient Services for a maximum period of 30 days immediately prior to hospitalisation and 90 days immediately following discharge from Hospital for the same medical condition per person. This benefit will be paid following the inpatient treatment or surgery. Reimbursement will be according to the date of the expenses incurred.

“Pre-existing conditions” means any **Sickness/Illness/Injury**:

- (a) which existed before the Effective Date in respect of an Insured, which presented signs or symptoms of which the Insured was aware or should reasonably have been aware; or
- (b) for which treatment, or medication, or advice, or diagnosis has been sought or received during the two (2) years prior to the Effective Date by the Insured; or
- (c) which was known by the Insured to exist prior to the Effective Date whether or not treatment, or medication, or advice, or diagnosis was sought or received.

Prescribed Drugs

Medication, the sale and use of which is legally restricted to prescription by a Physician and Hospital/Clinic, and not including items that may be purchased without a prescription of Physician and/or Hospital/Clinic.

Physiotherapy or Chiropractic Treatment

If while this coverage is in force, on account of accident or disease contracted during the term of the Insurance Policy, the Insured shall require treatment by a Physiotherapy or Chiropractic Treatment upon recommendation by attending Physician (Medical Technician) in writing, the Insurer will pay the actual, reasonable and customary expenses incurred and such payment shall not exceed the Limit of Liability and subject to the maximum number of visits per Policy Year stated in the Benefit Plan.

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Reasonable and Customary

No benefit shall be paid for charges which are in excess of the general level of charges being made by other providers of similar standing in the locality where the charges are incurred, when providing like or comparable treatment, services or supplies for a similar Injury or Sickness. The Insurer will determine such charging scale by its own experience in similar cases and the quotations we can receive from similar standard medical facilities within the region.

Repatriation

The Medical Assistance Provider will arrange for the return of the Insured who is dying or dead to a place within Vietnam (at the choice of the representative of the Insured) by air and/or surface transportation following an Emergency Medical Evacuation for in-hospital treatment. The Insurer shall pay for the Reasonable and Customary expenses incurred in the services so arranged by the service provider. The service provider reserves the right to decide the means or method by which such repatriation will be carried out having regard to all the assessed facts and circumstances. The Insured/The representative of the Insured must contact to the Insurer or the Medical Assistance Provider in advance for the approval and arrangement of transportation.

This benefit is also subject to the scope of coverage and exclusion specified in the Service Agreement between the Insurer and the Medical Assistance Provider, which coverage and exclusion have been informed by the Insurer to the Policyholder, subject to any changes from time to time as informed by the Insurer to the Policyholder.

This benefit is not available for the Insured aged 70 or above.

Serious Medical Condition

The medical condition which in the opinion of the Hospital where the Insured receives treatment determined a serious medical emergency requiring urgent remedial treatment to avoid death or serious impairment to the Insured's immediate or long-term health prospects.

Disease

A physical condition marked by a pathological deviation from the normal healthy state.

Standard Private Room

Single occupancy accommodation in a Hospital. If the hospital sub-divides Private Room into several levels, reimbursement will be based on the actual charge for the standard private room or the norm of the charges for Private Room of that particular hospital, whichever is lower.

Terrorist Act

Any act, including the use of force or violence and/or the threat thereof, of any persons or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

Terrorist Act shall also include any act, which is verified or recognized by the (relevant) government as an act of terrorism.

2. Insurance Policy

This Insurance Policy Wording, the Benefit Plan, the Policy Schedule, the Certificate and any Endorsements thereon constitute the entire agreement ("**Insurance Policy**") between the Insurer, the Policyholder and the Insured. These documents shall be applied in the following order of priority:

- (a) The Endorsements;
- (ii) the Certificate;
- (iii) the Ins Policy Schedule;
- (iv) this Liberty MediCare Insurance Policy Wording; and
- (v) the Benefit Plan.

No agent is authorized to alter or amend the Insurance Policy, or to waive any of its provisions. All changes of this Insurance Policy Wording must be accepted in advance by the Insurer.

3. Insurance Effectiveness

Subject to the terms and condition of this Insurance Policy, the Insurer's liability to an Insured under this Insurance Policy shall become effective from the commencement of the Insured Period with respect to such Insured, and will remain effective until

the end of the Insured Period of such Insured unless otherwise terminated in accordance with this Insurance Policy.

4. Termination of Benefits

4.1 For individual Insurance Policy

The insurance under the Insurance Policy for an Insured shall be terminated at such time as the benefits applicable to such Insured shall have been exhausted or at midnight on the last day of the Insured Period with respect to such Insured. In the case where, at the time of termination, an Insured is confined in a Hospital for a disease or injury covered under the Insurance Policy, then the time of termination shall be extended to the time (A) he/she no longer requires confinement for said Disease or Injury or (B) the time his/her benefits for said Disease or Injury is exhausted, whichever shall occur first. For the purpose of this part, "confinement" means a continuous period of not less than 18 hours as a registered bed patient in a Hospital.

4.2 For the Group Policy

The insurance under the Insurance Policy for an Insured shall be terminated at such time as the benefits applicable to such Insured shall have been exhausted.

The insurance under the Insurance Policy for an Insured, who is an Employee, shall also be automatically terminated on the earliest of the following dates:

- (a) the date on which the Employee ceases to be eligible for insurance;
- (b) the date the Group Policy terminates;
- (c) the date of an Employee's termination of employment;
- (d) the date of expiration of the period for which the last premium payment must be made in respect of the Employee's insurance;
- (e) the Employee resides in USA/Canada for a period in excess of twelve consecutive weeks.

In the cases of (a), (c) or (e) above, the Policyholder shall be entitled to a return of premium with respect to that Insured, less the amount due to the Insurer for the period during which the Policy had been in force for such Insured, computed on the pro-rata basis for the period during which the Policy had been in force. Provided Always that there is no claim with respect of such Insured and there is no violation under the Insurance Policy at that time.

The insurance under the Insurance Policy for an Insured, who is a Dependent, shall automatically terminate on the earliest of the following dates:

- (a) the date the Dependant ceases to be eligible as a Dependant as defined hereunder Definition of Dependant;
- (b) the date the Group Policy terminates;
- (c) the date the relevant Insured (on which the Dependent depend)'s benefits under the Group Policy terminate;
- (d) the date of expiration of the period for which the last premium payment is made in respect of the Dependent's insurance;
- (e) the Dependent resides in USA/Canada for a period in excess of twelve consecutive weeks.

In the cases of (a), (c) or (e) above, the Policyholder shall be entitled to a return of premium with respect to that Insured, less the amount due to the Insurer for the period during which the Policy had been in force for such Insured, computed on the pro-rata basis for the period during which the Policy had been in force. Provided Always that there is no claim with respect of such Insured and there is no violation under the Insurance Policy at that time.

The insurance under the Insurance Policy for an Insured, who is a member of a Sponsoring Organization, shall also be automatically terminated on the earliest of the following dates:

- (a) the date such Insured ceases to be eligible as member of such Sponsoring Organization;
- (b) the date such Insured ceases to meet any conditions to be eligible for the insurance under the Insurance Policy as set forth in the Policy Schedule;
- (c) the date the Group Policy terminates;
- (d) the date of expiration of the period for which the last premium payment is made in respect of the such Insured's insurance;
- (e) the Insured resides in USA/Canada for a period in excess of twelve consecutive weeks.

In the cases of (a), (b), or (e) above, the Policyholder shall be entitled to a return of premium with respect to that Insured, less the amount due to the Insurer for the period during which the Policy had been in force for such Insured, computed on the pro-rata basis for the period during which the Policy had been in force. Provided Always that there is no claim with respect of such Insured and there is no violation under the Insurance Policy at that time.

Provided that, for all cases, if an Insured is hospitalised for a covered Disease or Injury at the time of such termination then the time of termination shall be extended to the time he or she is discharged from hospital after having completed the medical treatment for the said Disease or Injury or the time his benefits for said Disease or Injury shall have been exhausted, whichever shall occur first.

For the purpose of this part, Hospitalisation means a continuous period of not less than 18 hours as a registered bed patient in a Hospital.

5. Termination

The Insurer may terminate the Insurance Policy at any time by giving 30 days' notice by registered letter to the Policyholder at his last known address and in such even the Insurer will return to the Policyholder the premium paid less pro-rata portion thereof for the period during which the Policy Insurance had been in force.

The Insurance Policy may be terminated by the Policyholder at any time by giving written notice to the Insurer. If no claim has been submitted to the Insurer during the period during which the Insurance Policy had been in force, the Policyholder shall be entitled to a return of premium, less the amount due to the Insurer for the period during which the Policy had been in force, computed on the pro-rata basis Provided Always there is no violation under the Insurance Policy at that time.

The Policyholder shall return to the Insurer the current policy document, schedule and medical card on or before the date of termination.

The Insurance Policy shall also be terminated upon termination of benefits of all Insureds under the Insurance Policy.

6. Co-ordination of Benefits/Other Insurance

All persons insured by any other medical or accident insurance policy shall be informed to the Insurer and a copy of that policy including the benefit schedules shall be provided to the Insurer.

In the event of Injury involving the actions or negligence of a third party, the Policyholder and the Insured shall use their best endeavours to claim from such third party for the full amount of the loss.

7. Governing Law

The parties hereto agree that the Law of the Socialist Republic of Vietnam shall govern and control in the event of any conflict or dispute between the parties with regard to the Insurance Policy.

In the event of any dispute or conflict arises under or in connection with this Policy, the parties shall resolve the dispute in question first by negotiation and amicable conciliation. If no resolution of the dispute or conflict could be reached within thirty (30) days from the date on which one party notifies the other party of the dispute arisen, the parties agree to submit themselves to the exclusive venue and jurisdiction of the competent courts of the Socialist Republic of Vietnam for the resolution.

8. Prevailing Language

This Insurance Policy Wording is drafted and issued in Vietnamese, and may be translated into foreign languages for reference purpose. In case of discrepancy between Vietnamese version and the foreign language version, the Vietnamese version shall prevail.

PART II - INSURED OBJECTIVES

Companies, enterprises, entities and sponsoring organizations legally licensed to operate in Vietnam. Insured is Vietnamese citizen and foreigners residing in Vietnam having the age from 15 days old to 64 years old, and being extended to 74 yearsto renewal members. The Insurer will only accept to insure child when he/she joins the Insurance Policy with his/her Father/Mother.

Citizens of countries being subject to sanctions in accordance with the resolution of the United Nation, the United States of America, the European Union and the United Kingdom will not be objectives insured by the Insurance Policy.

PART III - SCOPE OF INSURANCE

1. Coverage of Insurance

Subject to the terms and conditions of this Insurance Policy, and the applicable Limits of Liability, the Insurer will pay the Insured for the expenses necessarily and reasonably incurred by the Insured as a direct result of the Insured suffering bodily injury, disease or dental or being pregnant (if applicable), during the Insured Period for all benefits listed in the Benefit Plans, PROVIDED ALWAYS THAT such expenses are actual and limited to usual, customary and reasonable charges in Vietnam where treatment is provided.

2. Territorial Scope

The coverage of insurance is subject to the geographical area of Vietnam. Hospitalization, treatments and consultations outside of Vietnam is not covered.

3. Representative/Inheritance

The legal representative or heir of an Insured shall have the right to act for that Insured if the Insured is incapacitated or deceased. Benefits will be paid to the Insured or his/her legal representative or heir (if applicable) or to the Direct Settlement Network providers (if applicable).

4. Consideration for Insurance for Pre-existing conditions

Unless otherwise agreed by the Insurer in the Policy Schedule, all pre-existing conditions are not covered under the Insurance Policy.

Notwithstanding the foregoing, if a pre-existing condition shall have been disclosed to the Insurer, the Insurer may agree to cover such pre-existing conditions under the Insurance Policy after two years' continuous membership from the disclosure.

PART IV - EXCLUSIONS

The following treatments, conditions, activities, items and their related expenses are excluded from the insurance and the Insurer shall not be liable for:

1. Treatments of mental illness, behavioural, psychiatric disorders including but not limited to depression, eating disorder, sleeping disorders or any neuroses and their physiological or psychosomatic manifestations and other mental illnesses.
2. Rest cures or sanatoria care.
3. Tests and treatments relating to birth defects and congenital illnesses. Birth defects are deemed to include hereditary conditions. Treatment for learning problems or speech defects of a child. Foetal surgery when still being in the womb.
4. Test and Treatment relating to infertility, contraception, sterilization, including pregnancy or any abortion, and other treatment due to the consequences of above listed treatments.
5. Hospitalization primarily for diagnosis, X-ray examinations, or physical therapy, unless recommended by a legally qualified physician or surgeon.
6. Any dental treatment or surgery/ orthodontic treatment except dental operation resulting from an injury sustained by the insured member in an accident, unless otherwise explicitly provided and endorsed in the Policy Schedule.

7. Routine eye and ear examination. Fitting of glasses, contact lenses or correction of eye visions or eye refraction error including but not limited to myopia, hyperopia and presbyopia,
8. Drugs addiction or alcoholism.
9. Injuries due to insanity or self-infliction or suicide.
10. Routine medical examinations and preventive treatment (including vaccinations or inoculations, preventative medicine and test), unless otherwise explicitly provided and endorsed on the Schedule.
11. Tests and treatment of Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS) and all diseases caused by and/or related to the virus HIV positive unless the qualified period has been fulfilled and subject to the sub limit as stated in the Schedule.
12. Pre-existing conditions or any related, associated or consequential disabilities, unless disclosed to and accepted in writing by the Insurer.
13. Room, board, general nursing care or special hospital services not in accordance with the diagnosis and treatment of the condition for which the hospital confinement is required.
14. Prostheses, corrective devices and medical appliances. Charges for the procurement or use of special braces, appliances, hearing and/or visual aids, crutches, wheelchairs or other equipment.
15. Cosmetic surgery for purposes of beautification or plastic surgery. Treatment related to or arising from the removal of healthy, surplus or fat issue including but not limited to treatment of obesity or and diet program to weight loss or other treatment undergone for cosmetic or psychological reasons, including but not limited to hair loss treatment, freckle, hyperpigmentation.
16. Plastic surgery for pre-existing infirmity/defects.
17. Injury or disease arising directly or indirectly from war, declared or undeclared, strike, riot, revolution, or any warlike operation.
18. Treatment by any person other than a licensed Medical Practitioner.
19. Injury sustained or disease contracted as a direct result of participation in

illegal acts; such acts include but are not limited to burglary, robbery, failure to obey an order given by an officer of the law, drug abuse, use of explosives or incendiary devices (unless permit has been issued), assault and battery.

20. Vaccination and any preventive treatment.
21. Treatments for injuries or diseases sustained while participating in (including any practice or conditioning program for) contest or competition including but not limited to the following activities: Racing of any form other than on foot including but not limited to auto or car racing, professional sport, contact sport, motorcycle racing, powerboat racing, and dressage competition; skydiving, parasailing, hang-gliding, flying (other than as a fare-paying passenger on a duly licensed commercial aircraft), caving, rock or mountain climbing (with or without the use of ropes or other equipment), bun gee jumping, scuba-diving, polo, steeple chasing, martial arts, ballooning, and any organized sports undertaken on a sponsored basis or any other hazardous activity, unless declared to and accepted by the Insurer or deliberate exposure to exceptional danger (except in an effort to save human life);
22. Non-medical services, including the issue of medical certificates and attestations and examinations as to suitability for employment.
23. Tests primarily not incident to treatment or diagnosis of a covered Disease or Injury; or any treatment which is not medically necessary. Treatment of an optional nature. Treatment by a family member. In addition, the Policyholder/ Insured as doctor/nurse treats themselves or dependants in the hospitals/ clinics/medical establishments where they are working.
24. Maternity Care. No benefit shall be payable, unless otherwise explicitly provided and endorsed in the Schedule.
25. Tests and Treatment of sexually transmitted diseases and treatment of impotence or any related conditions.
26. All Emergency medical evacuation not approved in advance by the Medical Assistance Provider.
27. Exposure to nuclear energy, ionizing radiation or radioactive contamination of any kind.

28. Participation in an illegal act including resultant imprisonment or Incompliance with all statutory obligations.
29. Treatment for Injury or Disease incurred while serving as a member of police or military forces or as a result of performing Class IV Occupation.
30. All transportation costs incurred for trips specifically made for the purpose of obtaining medical treatment, if not part of an Emergency Medical Evacuation and except as defined under Local Ambulance Services.
31. Tests and treatments for sleep-related breathing disorders, including snoring, fatigue, jet lag, sonasthenia or work-related stress or any related condition.
32. Dietary supplements and substances which are available naturally and that can be purchased without prescription, including but not limited to vitamins, minerals, supplements, food for medical purposes,
33. Stem cells replacement therapy except bone marrow transplantation
34. The Insurer shall not provide cover and 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 Insurer 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 State of America.
35. Other exclusions as agreed with the Insured and as set forth in the Policy Schedule.

PART V - LIABILITIES OF THE INSURED AND THE POLICYHOLDER IN RELATING TO THE INSURANCE POLICY

1. Conditions Precedent to Liability

Any liability of the Insurer to the Insured under the Insurance Policy shall be subject to the satisfaction of all the following conditions precedent:

- (a) the Insurer being furnished with all the required statements and declarations to be provided by the Policyholder and/or the Insured (parent or duly appointed guardian if the Insured is a minor) on an Application Form and the complete truth of all such statements and declarations.

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- (b) the complete truth and accuracy of all statements and declarations made in respect to any claim made against the Insurer by the Policyholder or any Insured under this Insurance Policy.
- (c) the due and fully compliance with all the terms and conditions of this Insurance Policy insofar as they relate to anything to be done, restrained from doing or to be complied with by the Policyholder and/or any Insured.

2. Pre-Authorization Requirement

The coverage of insurance is subject to the pre-notification or pre-authorization as follows:

All Elective Treatment must be supported by a full quotation and submitted to the Insurer 5 working days before treatment for assessment.

3. Data Required

The Policyholder shall furnish in writing to the Insurer, all information as the Insurer may require with regard to any matters pertaining to this Insurance Policy. All documents or information furnished to the Policyholder by an Insured in connection with insurance, together with such records as may have a bearing on the Policy, shall be opened for inspection by the Insurer at all reasonable times.

Clerical error in keeping the records shall not invalidate insurance otherwise validly in force nor continue insurance otherwise validly terminated. If the age or date of birth or other relevant facts relating to an Insured shall be found to have been misstated, and if such misstatement affects the scale of benefits or has anything to do with the terms and conditions of the Insurance Policy or the Insurer's decision to insure such Insured, at the Insurer's sole discretion, (A) the true age and facts shall be used in determining whether benefits are secured under the terms of the Insurance Policy, and in what amounts, and an equitable adjustment of premiums shall be made, or (B) his or her insurance shall be void and the Insurer shall limit the return of premiums in respect of such Insured.

4. Eligibility

4.1 For Individual policy:

The maximum age for enrolment is 64. Policyholder and Insured of all nationalities and their Dependants (other than newborn children) are eligible to join except for citizens of any of the UN and US. sanctioned countries, as amended from time to time.

Dependant's cover must be under the same Benefit Plan as the Insured on which he/she depends, and subject to prior acceptance by the Insurer. Minor child(ren) cannot independently insure under the Benefit Plan.

New-born children shall be eligible for insurance 15 days after the date of birth or 15 days after discharge from Hospital where the birth takes place, whichever is the later, upon submission by the Policyholder of an application for insurance, subject to satisfactory evidence of good health and prior acceptance by the Insurer.

The coverage under this Insurance Policy is only applicable for those holding Class I and II occupations, unless otherwise agreed by the Insurer (with or without additional conditions/requirements). The Insured is required to inform the Insurer as soon as the occupation changes to Class III or IV. Failure to inform may result in a claim being denied or benefits terminated by the Insurer.

4.2 For Group policy:

The Employee and member of Sponsoring Organizations and the Dependant must be in Active Service at the inception date in order for eligible for this Insurance Policy, except for reasons of authorised routine paid leave-of-absence.

New-born children shall be eligible for insurance 15 days after the date of birth or 15 days after discharge from Hospital where the birth takes place, whichever is the later, upon submission of an application for insurance, subject to satisfactory evidence of good health and acceptance by the Insurer.

Citizens of any of the UN and US. sanctioned countries, as amended from time to time, are not eligible for the insurance under this Insurance Policy.

The maximum age for enrolment is 64.

The coverage under this Insurance Policy is only applicable for those holding Class I and II occupations, unless otherwise agreed by the Insurer (with or without additional conditions/requirements). The Insured is required to inform the Insurer as soon as the occupation changes to Class III or IV. Failure to inform may result in a claim being denied or benefits terminated by the Insurer.

5. Examination

The Insurer shall have the right and opportunity through his medical representative to examine any Insured Member whenever and as often as may be reasonably required within the duration of any claim. In addition the Insurer shall have the right

to require an autopsy in the case of death, where this is not forbidden by law or religious belief.

6. Medical Evaluation

The Insurer reserve the right to request further tests and/or evaluation where the Insurer decide that a condition being claimed for may be directly or indirectly related to an excluded condition and the Insurer will pay the expenses of such tests and/or evaluation.

1. Reasonable Precautions and Important Changes

Insured Members shall take all reasonable precautions to prevent and minimize any Accident, Injury, Sickness or expense and the Insurer must be informed immediately in writing of any material information or change of circumstances which may increase the possibility or likely magnitude of a claim under this Policy.

The Insurer shall have the right to continue coverage on terms and conditions it considers appropriate to such changes in material information or circumstances which may increase the possibility or likely magnitude of a claim under this Policy] or to decline to continue coverage under this Policy. No claim arising from or related to such changes shall be met until and unless the Insurer has been informed of such changes, and has agreed to continue the coverage.

2. Return to Home Country/Change of Usual Country of Residence

For citizens of the USA or Canada who return to their Home Country and for citizens of other countries who plan to reside in USA/Canada for a period in excess of 12 weeks, the Plan will be terminated automatically. The Insured Member shall notify the Insurer of the date of his return to the Home Country or change of Usual Country of Residence to USA/Canada within thirty days of the date of such return/change. Premium paid will be refunded according to the Termination Article.

For changes of residence other than the USA or Canada during the Policy Year, the Insurer will cover upon the consideration of normal and reasonable expenses at such country or refund the premium in accordance with the Termination Article.

As a condition precedent to liability under this Policy, the Insurer must be informed immediately in writing of any change in the Usual Country of Residence of the Policyholder or any Insured Member. A change in the Usual Country of Residence shall be deemed to mean the Insured Member ceasing to reside in his Usual Country

of Residence, or intending to be relocating in another country for a period in excess of 12 weeks.

The Insurer must be informed of the location of any Dependants whose Usual Country of Residence is different from that declared for the Policyholder in the Application Form, and the Insurer reserves the right to decline to cover such Dependants under this Policy.

The Insurer reserves the right to decline to offer renewal to any member whose Usual Country of Residence has changed during the policy year.

PART VI - CLAIMS PROCEDURE

The Insured has the right to use the insured medical services by either of the followings:

Option 1 – Self-Paid

If the Insured choose the self-paid option, the Insured shall notify in writing to the Insurer of the insured event within 90 days from the first day of treatment as a result of the insured event or, in case of maternity, the date of delivery for which the claim is made, unless otherwise agreed by the Insurer. Except the case with legitimate reason which prevents the Insured from notifying, failure to notify the insured event within the time limit as required in this the Policy, the following penalty will be applied, calculated on the percentage of total claim value:

- Notifying of the insured event from the 91st day to the 180th day: 10%
- Notifying of the insured event from the 181st day to the 270th day: 20%
- Notifying of the insured event from the 271st day to the 365th day: 30%

Claim dossier: the Insured shall provide the Insurer a claim dossier including:

- the Claim Form fully completed and signed by the claimant;
- The original copy of medical records;
- The medical reports;
- The test results;
- The prescription;
- The supporting invoices and receipts.

Photocopies are not acceptable. The claim dossier must be fully submitted to the Insurer within the time limit as provided for by law.

Reimbursement: Any claim made by an Insured for the incurred actual expenses shall be reimbursed in Vietnam Dong subject to the prevailing regulations of Vietnamese government on foreign exchange management at the time the expenses was incurred.

For hospital, surgery and day-care treatment please refer to “Pre-authorization requirement”.

If the reimbursement is to be received by the Insured by bank transfer as requested by the Insured, all bank charges are payable by the Insurer, unless otherwise requested by the Insured.

Option 2 – Direct Billing Service

Direct Billing Service is a cashless service provided by the Insurer that allows Insured to receive General Outpatient Services and Hospital treatment at the Insurer’s appointed healthcare providers. For elective hospital treatment, Insured has to follow the “Elective Treatment-Pre-authorization requirement”. The Insurer will issue a Letter of Guarantee for Payment if the medical condition is covered by the Insurance Policy.

Insured is required to present his/her Medical Card with other identity document for verification. In any event, authorization of payment and/or payment that shall have been made by the Insurer for a claim which is not covered under the Insurance Policy or when the limit of liability is exceeded, the Insured and/or the Policyholder will be responsible for repayment to the Insurer the costs of ineligible treatment within 31 days from the date the Insurer issues the repayment notice.

PART VII - FRAUD AND HANDLING METHODS

1. For individual policy

If any claim shall in any respect be false or fraudulent or if fraudulent means or devices are used by the Insureds or anyone acting on his/her behalf to obtain benefits hereunder then the Insurance Policy shall be immediately terminated and all benefits and return premiums will be forfeited.

2. For group policy

If any claim shall in any respect be false or fraudulent or if fraudulent means or devices are used by the Policyholder or anyone acting on the Policyholder’s behalf to obtain benefits hereunder then the Group Policy shall be immediately cancelled and all benefits and premiums will be forfeited.

In the event of a false or fraudulent claim by an Insured then his or her insurance shall be cancelled immediately and all benefits and premium will be forfeited. This shall not prejudice the Group Policy which shall remain in force.

PART VIII - PREMIUM WARRANTY

1. It is hereby declared and agreed that it is a condition precedent to liability under the Schedule, the Renewal Schedule and Endorsement(s) that any premium due must be paid and duly received in full by the Insurer, the registered broker or registered agent through whom this Policy was effected:
 - (a) unless the below Item (b) is applicable, with respect to the Schedule and the Renewal Schedule,
 - (i) within fifteen (15) days from the INCEPTION date of the cover under the Schedule or the Renewal Schedule; or
 - (ii) where the Insured Person requests, the Insurer may accept to extend the period of payment by issuing the Endorsement and sending to the Insured, within fifteen (15) days from the INCEPTION date of the Schedule or the Renewal Schedule with the extended period of payment as stipulated in the Endorsement, subject that total period of payment including extended period will not more than thirty (30) days from the INCEPTION date of the Schedule or the Renewal Schedule; or
 - (b) with respect to the Schedule or the Renewal Schedule, where the Insurer has allowed payment of the policy premium in installments:
 - (i) within fifteen (15) days from the INCEPTION date of the cover under the Schedule or the Renewal Schedule for the first installment and thereafter from the agreed dates on which the subsequent installments are due; or
 - (c) with respect to the Endorsement(s) which may increase premium:
 - (i) unless the below item (ii) , (iii) and (iv) is applicable, within fifteen (15) days from the INCEPTION date(s) of the Endorsement(s);
 - (ii) unless item (iii) is applicable, where the Insured requests, the Insurer may accept to extend the period of payment by issuing

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the Endorsement and sending to the Insured, within fifteen (15) days from the INCEPTION date of the Endorsement with the extended period of payment as stipulated in the Endorsement, subject that total period of payment including extended period will not more than thirty (30) days from the INCEPTION date of the Schedule or the Renewal Schedule; or

- (iii) if the period of payment under item (i) or (ii) above extend past the due date of the latest installments of the Schedule (for policies on a premium installment plan), the premium must be paid no later than the due date of the latest installment of the Schedule.
- (iv) unless above item (i), (ii) and (iii) is applicable, the premium will be paid immediately to the Insurer when the period of insurance is less than thirty (30) days.

2. In the event the policy and endorsement premium(s) are not paid in full to the Insurer, registered broker or registered agent as described in section 1 and within the timeframe stipulated above (the "premium warranty period"), the cover under the Schedule, the Renewal Schedule and Endorsement(s) shall be deemed to have terminated automatically from the expiry of the "premium warranty period" and the Insurer shall be discharged from all liability therefrom but without prejudice to any liability incurred before that date and the Insurer shall be entitled to a pro-rata time on risk premium.
3. In the event the accumulated claim amounts of the Schedule or the Renewal Schedule and Endorsements exceed the outstanding premiums, all the outstanding premiums will be paid immediately to the Insurer.