Liberty Mutual Insurance Group

#87	#8	45.000 +	A
Fortune Ranking Based on 2023 revenue	**Largest Property & Casualty Insurer globally** 2023 gross written premium	**Estimated employees worlwide**	**Financial Ratings** A.M. Best Co. - 'A' (Excellent) Moody's - 'A2' (Good) Standard & Poor's - 'A' (Strong)

Liberty Insurance Limited

Liberty Insurance Limited, as a member of the esteemed Liberty Mutual Group, stands proudly in Vietnam's non-life insurance market. We differentiate ourselves through our unique proposition, which includes advanced technology, a user-friendly and secure online insurance purchasing platform, and a fast and efficient claim process.

Each Liberty insurance product has been meticulously developed and tailored specifically for the people of Vietnam. We take great pride in our unwavering commitment to service excellence, which has earned us widespread recognition. Customers turn to Liberty Insurance as their first choice, seeking practical insurance solutions that provide protection against unforeseen risks while embracing the joys of life.

Embrace today, confidently pursue tomorrow

Liberty Insurance Limited takes great pride in being among leading non-life insurance companies in Vietnam. As one of the first foreign insurers who entered the Vietnam market in 2003, our commitment to excellence and dedication to our customers have been recognized through prestigious awards:

- "The only 100% foreign-owned enterprise achieving "Top 10 Most Reputable Non-Life Insurance Companies in Vietnam" accolades in 2018 - 2020 by Vietnam Report.
- The first non-life insurer in Vietnam achieving four Financial Services Awards by IDG Vietnam in three consecutive years from 2021 to 2023: Non-life Insurance Company with Outstanding Innovative Products and Services - Comprehensive Car Insurance Package (2021), Non-life Insurance Company with The Best Customer Digital Experience (2021), Non-life Insurance Company with Outstanding Innovative Products & Services (2022 - 2023).
- The first and the only non-life insurer in Vietnam winning for 4 consecutive years at the Insurance Asia Awards (2022 - 2025), with 7 awards including three International General Insurer of the Year - Vietnam awards, three Auto Insurance Initiative of the Year awards (2022 - 2023, 2025) and one Technology Excellence Initiative of the Year award (2025).

Liberty nationwide network

Head Office

18th floor, Vincom Office Building
45A Ly Tu Trong, District 1, Ho Chi Minh City
45A Ly Tu Trong, Sai Gon Ward, Ho Chi Minh City (due to merger)
Tel: (84-28) 38 125 125
Fax: (84-28) 38 125 018

Hanoi Branch

Floor 10, East Tower
Hanoi Lotte Center Building
54 Lieu Giai, Ba Dinh District, Hanoi
Tel: (84-24) 37 55 7 111
Fax: (84-24) 37 557 066

Other offices

Hai Phong Office

F3, Seabank Tower
No. 17, B1, Block 7B, Le Hong Phong
Ngo Quyen District, Hai Phong
Tel: (84-225) 3 999 366 225
Fax: (84-225) 3 999 368 225

Nghe An Office

F3, Nha Viet Building, 8 V.I Lenin
Vinh, Nghe An
Tel: (84-28) 38 125 125

Danang Office

F2, SAVICO
66 Vo Van Tan, Thanh Khe District, Danang
Tel: (84-236) 3 749 999; (84-236) 3 749 998;
(84-236) 3 749 997
Fax: (84-236) 3 749 996

Can Tho Office

C36, Road no. 1
Hung Phu, Cai Rang, Can Tho
Tel: (84-28) 38 125 125

Bien Hoa Office

101 Vu Hong Pho, Block 2, Binh Da
Bien Hoa, Dong Nai
Tel: (84-28) 38 125 125

Binh Duong Office

F1, Minh Sang Plaza, 888 Binh Duong Boulevard
Thuan Giao, Thuan An, Binh Duong
Tel: (84-28) 38 125 125

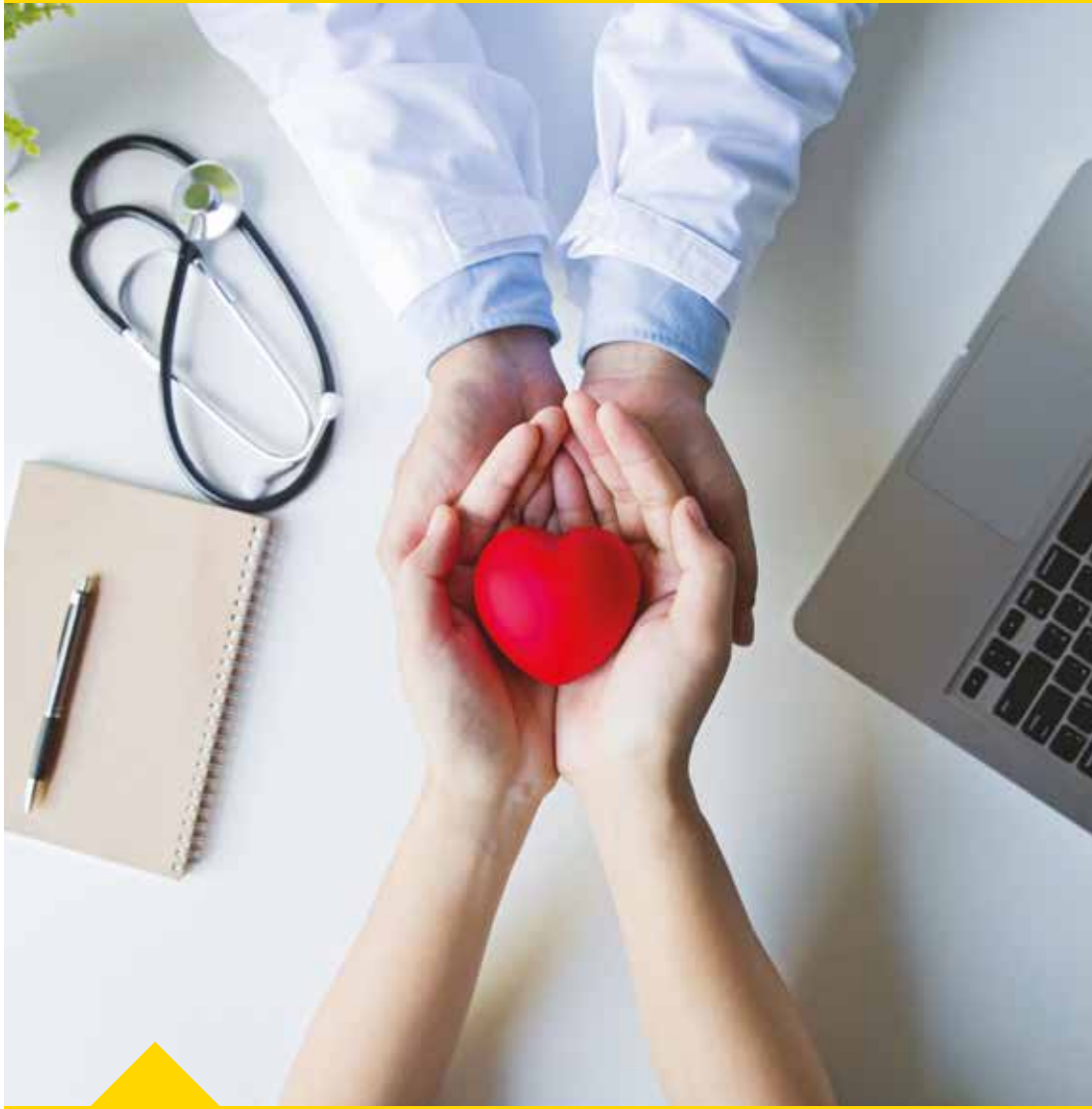
UW+HOA-W-001-02-E

* Office information is updated as of July 9, 2025.
Please refer to our website for the latest update www.libertyinsurance.com.vn/en/contact-us

24/7 Customer Service (toll-free)

1800 599 998 - 24/7, toll-free
Hotline@libertyinsurance.com.vn
www.libertyinsurance.com.vn

Liberty Insurance



LIBERTY HEALTHCARE INSURANCE POLICY WORDING

Global HealthCare Service, The Joy Of Life

HEALTHCARE
Bảo hiểm Sức khỏe

HEALTHCARE
Bảo hiểm Sức khỏe

Liberty HealthCare Insurance Policy Wording

(Issued as the decision of Liberty Insurance Vietnam's CEO on 01/8/2025, and became effective on 01/8/2025)

Global HealthCare Service, Enjoyment of Life

Liberty Insurance

TABLE OF CONTENT

LIBERTY HEALTHCARE
INSURANCE POLICY WORDING

Based on the Policyholder's application for insurance – through the Application Form and the information provided therein, as well as all other relevant information submitted to the Company in connection therewith – and subject to the timely payment of premiums under this Insurance Policy Wording, the Company agrees to insure the Insured against bodily injury, sickness/disease, dental care, or maternity care (if applicable) during the Insurance Period and within the applicable Limits of Liability, subject to the terms and conditions of this Insurance Policy.

PART I – GENERAL PROVISION

1. Definition

In this Insurance Policy Wording, the following terms and phrases shall have the meaning set forth below:

Application Form

A duly completed form presenting information relating to the insurance request, medical questionnaires, and other relevant data in the format prescribed by the Company from time to time, for the purpose of applying for Liberty HealthCare.

Benefit Plan/Plan Enrolled

The insurance plan issued by the Company. For each Insured, the relevant Benefit Plan shall apply as stated in the Policy Schedule and Certificate of Insurance issued to that Insured.

Policy Schedule/Renewal Policy Schedule

The insurance policy terms issued by the Company to the Policyholder and/or the Insured, specifying the Insurance Period, name of the Benefit Plan, premium and/or any other applicable details.

Certificate of Insurance

The certificate of insurance issued by the Company to the Insured in the form of a Liberty HealthCare card (either physical or digital).

Insurance Policy

The Insurance Policy as described in Article 2.

Group Policy

An Insurance Policy is issued to cover a group of members.

Limits of Liability

The maximum total liability of the Company for each Insured during the Insurance Period for each section as stated in the Benefit Plan.

Sub-Limit

The sub-limit of the Company's liability for each Insured, during the Insurance Period, is applicable to each benefit as stated in the scope of insurance of the Insurance Policy and the Benefit Plan.

Company

Liberty Insurance Limited.

Insurance Period

For an Insured, the Insurance Period is stated in the Policy Schedule and Certificate of Insurance issued to them.

If, at the beginning of the Insurance Period, the Insured has not entered Vietnam or is not eligible for coverage under this Insurance Policy, they shall not be considered to be insured. In such cases, the start date of the Insurance Period specified in the Policy Schedule/Certificate of Insurance will be adjusted to the later of the date the Insured enters Vietnam; or the date they meet the eligibility to be insured under this Insurance Policy, whichever is later.

Insurance Event

An objective event falling within the scope of insurance which, upon occurrence, entitles the claim payment by the Company to the Insured in accordance with the terms of this Insurance Policy.

Usual Country of Residence

For a person, the country in which they reside at the start of coverage under this Insurance Policy, as declared in the Application Form.

Foreigners residing in Vietnam on a tourist visa shall not be considered as having Vietnam as their Usual Country of Residence.

Accident

An unexpected event caused by an external and visible force acting upon the Insured's body occurring during the Insurance Period. This event must result in physical harm to the Insured, be unintentional, beyond the Insured's control, and be the direct cause of the Insured's Injury or Death.

Active Service

An employee shall be considered “Active Service” on any given day if they are carrying out, or can carry out, the duties of their assigned role, or were capable of doing so on their last scheduled workday.

A member of a Sponsoring Organization shall be deemed “Active Service” on any given day if they can perform all normal activities expected of a member of such organization and are not confined at home or in a Medical Facility for treatment.

A Dependant shall be considered “Active Service” on any given day if they are capable of engaging in the normal activities of a person in good health of the same age and gender and are not confined at home or in a Medical Facility for treatment.

Appliances

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

Deductible/Co-insurance

The portion of costs is stated as an absolute amount or percentage in the Policy Schedule, that the Insured must share and pay out-of-pocket for each and every Insurance Event falling into the scope of coverage.

Dependant

The legally married spouse of the Insured, or a partner living with the Insured as a spouse, and their unmarried children (including biological children, children born out of wedlock, stepchildren, and legally adopted children) who are financially dependant on the Insured, PROVIDED THAT such children are not less than 15 days old and not more than 18 years of age (or up to 23 years of age if continuously enrolled in full-time education). Unless otherwise approved by the Company.

Individuals aged over 18 and up to 23 must submit a valid student card or other documents as proof of active full-time enrollment to be eligible under this Insurance Policy.

Effective Date

For any Insured, the first day of the Insurance Period applicable to that Insured (whether under the original policy, a renewal, or an endorsement, as the case maybe).

Elective Treatment

Elective treatment refers to Medically Necessary treatment that is beneficial to the Insured’s health, including scheduled surgeries or procedures, and which is not deemed emergency treatment.

Employee

An individual aged 18 or older who is capable of working, employed by an Employer under an agreement, is compensated, and works under the Employer’s management, direction, and supervision.

Employer

A company, entity, organization, cooperative, or household that hires, employs workers under an agreement and, through such arrangement, proposes, signs, or executes a Group Insurance Policy under which the coverage is provided.

Emergency/Critical Conditions

Emergency or Critical Condition refers to a bona fide situation where there is a sudden change in the Insured’s health status requiring urgent medical or surgical intervention within 48 hours of onset to prevent serious threat to the Insured’s life or health.

Group

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

The Group must be established for purposes other than to obtain insurance.

Sponsoring Organization

A trade union or any association, organization, or entity which are accepted by the Company as the Policyholder of the Insurance Policy in which their members and Dependants are insured.

Home Country

For the Insured, the country of which they hold a passport. If the Insured holds more than one passport, Home Country is the one the Insured declared in the Application Form.

Medical Facility

Any hospital, clinic, dispensary, or healthcare institution that is licensed and operates legally to provide medical examination and/or treatment in the country in which it is incorporated.

Hospital Services

Medical services provided to the Insured when admitted to a Medical Facility for at least 24 hours or overnight for the treatment of a Sickness/Disease, Injury, or Maternity Care (if applicable), and only when appropriate diagnostic procedures and/or treatments are not available for Outpatient Services, requiring admission as a registered inpatient or Day Case Treatment patient at a Medical Facility. If the Medical Facility is unable to issue an admission/discharge letter, then medical records or invoices clearly indicating the treatment dates shall be accepted as alternative documentation. A hospitalization “day” is defined as a 24-hour period and is based on the room and board charges listed in the discharge letter or detailed medical billing documentation.

Hospital Services include Reasonable and Customary charges in the location where treatment is provided, including hospital accommodation, room and meal charges, use of medical equipment and facilities, and all treatments and medical services prescribed by a Physician and/or Medical Facility, including intensive care unit charges when medically necessary.

Injury

Any bodily harm sustained by the Insured during the Insurance Period that is caused by an Accident.

Insured

An eligible individual whose insurance coverage has been confirmed by the Company through the issuance of a Policy Schedule identifying them as an insured person under the Insurance Policy.

Medically Necessary

Any treatment, service, or procedure which, in the opinion of the attending Physician and/or Medical Facility, is appropriate and consistent with the diagnosis and accepted medical standards.

Specifically, medical services or treatments must: (a) align with medical diagnosis and standard treatment practice for the related disease or injury; and (b) commonly follow accepted medical standards; and (c) be necessary and performed in a Medical Facility; and (d) not be for testing, diagnosis, research, prevention, or screening purposes; and (e) involve a hospital stay that is reasonable in length and in line with standard medical practice for the related disease or injury. The Company reserves the right to apply and adjust the number of hospital admission days which are considered Medically Necessary from time to time.

Physician (Medical Practitioner)

A person legally licensed and recognized by the laws of the country of practice to engage in the diagnosis and treatment of medical conditions within the scope of their training and licensure.

Policyholder

An organization or individual that enters an Insurance Policy with the Company and pays the required premium.

Policy Year

The period starting from either (i) 00:01 a.m. on the first day of the Insurance Period or (ii) the time the Insurance Policy is issued by the Company (whichever is later), and ending at 11:59 p.m. on the last day of the Insurance Period, both times inclusive. All times are based on Vietnam standard time.

Pre-existing Condition

Any Sickness/Disease/Injury which:

(a) existed before the Effective Date with symptoms the Insured was aware of or reasonably should have been aware of; or

(b) for which the Insured received or sought treatment, medication, advice, or diagnosis within two (2) years prior to the start of the Insurance Policy; or

(c) was known to the Insured to exist prior to the Effective Date, regardless of whether treatment, medication, advice, or diagnosis was obtained by the Insured.

Congenital Disease

Any disease, malformation, birth defect, or abnormality formed during fetal development due to environmental influences on the fetus. These may be referred to various terms (with or without the word “congenital”), such as congenital diseases, birth defects, congenital abnormalities, or chromosomal disorders. Diagnosis must be made by a Physician or in accordance with applicable laws /health authorities. Congenital Diseases include Genetic Diseases.

Genetic Disease

Any disease occurring among blood relatives or inherited genetically from parents to children and/or passed from generation to generation among relatives. Diagnosis must be made by a Physician or in accordance with applicable laws/ health authorities.

Prescribed Drugs

Medication, pharmaceutical products that are legally dispensed and used only with a prescription from a Physician, in accordance with applicable laws. This does not include: (i) drugs purchased without a Physician’s prescription; and/or (ii) items not listed in the Ministry of Health’s approved treatment drug list (including but not limited to: functional foods, cosmeceuticals, cosmetics, minerals, tonics, vitamins).

Medical Assistance Provider

An emergency medical assistance organization or any similar provider as notified by the Company to the Policyholder from time to time.

Local Ambulance Services

Ground ambulance transportation to and from a local Medical Facility, provided that such transportation is Medically Necessary.

Serious Medical Condition

A medical condition which, in the opinion of the Medical Facility, constitutes a severe medical emergency requiring urgent treatment to avoid death or long-term serious health impairment or immediate health deterioration of the Insured.

Sickness/Disease

A deviation from the normal healthy state of the body.

Terrorist Act

Any act, including but not limited to the use and/or threat of force or violence, committed by any person or group acting alone or on behalf of, or in connection with, any organization(s) or government(s) for political, religious, ideological, or similar purposes, including to influence a government and/or in still fear in the public or a segment thereof.

Terrorist Act also includes any act declared as such by the (relevant) government authority.

AIDS/HIV

Coverage for the treatment of Human Immunodeficiency Virus (HIV) and related conditions including Acquired Immunodeficiency Syndrome (AIDS), its complications, and any illness/condition caused by or related to HIV. Coverage includes consequences of treatment incurred during the Insurance Period and subsequent renewal years, provided the condition manifests after five (05) consecutive years of uninterrupted coverage starting from the first Effective Date ("Waiting Period").

This benefit is included within the Insured's overall Limit of Liability and is subject to a Sub-Limit equal to 10% of the Limit of Liability as stated in the Insurance Policy in effect at the time of the first related claim. The limit applies for the lifetime of the Insured.

Annual Medical Examination

Outpatient Services including tests/screenings performed by a Medical Facility when: (i) there is no clinical symptoms; and/or (ii) there is no final medical diagnosis; and/or (iii) no prescription is issued. These tests may include, depending on appropriate age intervals for early detection of Sickness/Disease:

- Vital signs (blood pressure, cholesterol, pulse, respiration, temperature, other vital screenings)
- Cardiovascular examination
- Neurological examination
- Cancer screening
- Pediatric developmental check-ups (for children up to age 6)

This benefit also includes vaccinations and medical examinations which are required for work permits.

Companion Bed

Accommodation in a Medical Facility for parents or legal guardian to stay with an Insured under 18 years of age during the hospitalization in a Medical Facility. Only father/mother or guardian is covered per night per hospitalization of the Insured.

Compassionate Visit

A relative or a friend of the Insured to visit the Insured who, when travelling alone, is hospitalised outside the Home Country or the Usual Country of Residence for a period exceeding 7 consecutive days, subject to a prior approval of the Company's Medical Assistance Provider and only when judged necessary by the Company's Medical Assistance Provider on reasonable medical and compassionate grounds.

Chinese Herbalist

A Chinese Herbalist means a Physician or medical practitioner licensed in chinese medicine in accordance with the laws of the country in which they practice.

This benefit includes consultation fees and medication expenses in a Medical Facility that provides chinese medicine, bone-setting, acupuncture, physiotherapy, herbal medication, and other traditional chinese treatments performed by a Chinese Herbalist, subject to the Limits of Liability stated in the Benefit Plan.

Herbal Medication refers to herbal medications prescribed in writing by a registered Chinese Herbalist and directly related to the diagnosis being treated.

Bone-setting refers to the treatment of the musculoskeletal system, joints, and soft tissue injuries sustained either internally or externally due to an accident.

Day Case Treatment

Medically Necessary treatment, including non-Emergency outpatient surgery due to Accident and Sickness/Disease, carried out in a Medical Facility where the Insured is admitted for at least six (6) consecutive hours and incurs room and board charges, but does not exceed twenty-four (24) consecutive hours and does not stay overnight.

The consecutive six-hour minimum stay is not required for Emergency outpatient surgery resulting from Accident and Sickness/Disease.

If the Insured undergoes surgical treatment due to Accident and Sickness/Disease for less than twenty-four (24) hours, the Company shall reimburse the Reasonable and Customary charges actually incurred, subject to the applicable Limits of Liability as specified in the Insurance Policy.

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 after the Insured has been insured by the Company covering Dental Services for at least **nine consecutive months**.

Crown, bridges and dentures will be covered after the Insured has been insured by the Company covering Dental Services for at least **twelve consecutive months**.

PROVIDED ALWAYS THAT these dental services are applied for sound natural teeth only and must be performed by an Orthodontic Physician in an authorized medical facility who is licensed by relevant licensing authority to practice dentistry in the country where the dental treatment is given. The material being used for filling/crown/ denture is limited to amalgam and porcelain and does not include precious metal/ material.

Direct Settlement Network

Medical providers, the details of which are listed separately and informed by the Company to the Policyholder/Insured, agree to charge the Company directly for treatment costs when the Insured presents a valid and active Certificate of Insurance. However, the Policyholder/ Insured shall be liable to reimburse the Company if such charges are not eligible under the Insurance Policy.

Emergency Dental Treatment following Accident

Dental treatment provided within thirty (30) days of an accident for damage to sound, natural teeth, excluding the damage caused while eating, and when performed by a licensed orthodontic Physician in a Medical Facility.

Emergency Medical Evacuation

Medically necessary expenses related to emergency transportation and en-route medical care for an Insured suffering from a Critical Condition covered under the Insurance Policy, to the nearest Medical Facility with appropriate medical capability, as determined by the attending Physician or specialist in conjunction with the Company's medical advisors.

The Insured/their legal representative must contact the Company or Medical Assistance Provider for prior approval and to arrange necessary transportation.

The Company will pay for the cost of a round-trip economy class airfare for a companion to accompany the Insured under 18 years old during emergency evacuation, if such accompaniment is deemed medically necessary by the Company.

This benefit is subject to the scope of coverage and exclusions under the service agreement between the Company and the Medical Assistance Provider, as updated from time to time and notified to the Policyholder.

This benefit does not apply for the Insured aged 70 years or above.

Emergency Ward Treatment

Services performed in a Medical Facility's 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 Medical Facility, which require an emergency treatment provided that arising room and board and having confirmation in writing of Medical Facility that it is an emergency treatment. For the purpose of clarification, in case of treatment in emergency ward or emergency room due to out of working hours of the Medical Facility, such treatments will be treated as Outpatient Services.

Hormone Replacement Therapy

Hormone Replacement Therapy shall mean any consultation services and medication provided by a Medical Facility for the treatment of hormonal imbalance in respect of pre and post-menopausal symptoms only.

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 endorsed by the Medical Facility.

Maternity Care

Pre-natal, childbirth, post-natal treatment, miscarriage, or medically necessary abortion, and any pregnancy-related complications for the normal or caesarean delivery and newborn baby care incurred in a Medical Facility.

Where this benefit is included in the Insurance Policy for an Insured, it only applies to pregnancies for which the actual date of birth occurs at least 12 months after the enrolment date of this Maternity Care benefit, except in the case of miscarriage or medically required abortion. The pregnancy must commence at least 90 days after the enrolment date of Maternity Care benefit.

The Maternity Care benefit limit is applied per pregnancy, even if the Insurance Event spans across two (2) consecutive calendar years.

New-Born Baby Care

This is an extension of the Maternity Care benefit for general newborn baby care up to 5 days immediately after birth or inpatient treatment for medical conditions manifesting within 30 days after birth. This benefit is limited to treatment provided within 30 days from the date of birth of the baby.

An additional benefit limit is applied to inpatient services for acute medical conditions and any associated costs presenting at birth or Sickness/Disease manifesting within 30 days after birth when the Maternity Care benefit limit has been exhausted.

Nursing at Home/Home Nursing

The services of a legally registered or enrolled nurse provided at the Insured's residence when prescribed by a Physician and/or Medical Facility due to the medical necessity of the case, immediately after or instead of Inpatient or Day Case Treatment.

Coverage is limited to a maximum 182 days per Insured during 12-month Insurance Period.

Occupation Classification

Class I – Professionals and occupations involving intellectual or administrative tasks performed in office settings or similarly non-hazardous environments.

Class II – Individuals in supervisory roles or other occupations not classified under Class I, whose duties may occasionally involve light manual work, but without the use of tools or machinery or exposure to specific hazards. This includes those who frequently travel for business or professional purposes but do not engage in manual labor (e.g., sales representatives).

Class III – Individuals involved in light manual labor under non-hazardous conditions, which includes the use of light tools or machinery (e.g., delivery personnel).

Class IV – Individuals working in hazardous occupations that involve manual labor beyond light manual work, such as trades requiring the use of tools or machinery (e.g., construction workers).

Oncology

Regardless of any other provisions in the Insurance Policy, oncology treatment is classified as inpatient services as specified in the Benefit Plan.

Except for Group Insurance Policy and unless agreed otherwise by the Company, oncology treatment will only be covered if the first symptom occurs after 90 consecutive days from the Insured's first Insurance policy's Effective Date, confirmed by the Physician and/or Medical Facility where the Insured is receiving treatments. 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 not registered as an inpatient or Day Case Treatment patient in a Medical Facility. Laboratory testing, radiographic and nuclear medicine procedures are to diagnose and treat medical conditions. Laboratory and x-ray services have to be prescribed by a Physician and/or Medical Facility.

Outpatient Services also include prescribed medication, the sale and use of which medication must be prescribed by a Medical Facility. Over-the-counter medication is not covered.

Inpatient Services

Coverage for Sickness/Disease/Injury, including emergency treatment of pregnancy complications caused by an Accident occurring during the Insurance Period that requires the Insured to admit into a Medical Facility for inpatient treatment and/or inpatient surgery. Inpatient medical expenses include all hospital services, such as daily room and board, intensive care unit fees, oncology treatment, day case treatment, local ambulance services, organ transplant expenses, pre and post-hospitalization costs, emergency ward treatment, nursing care at home, psychiatric treatment, emergency dental treatment, AIDS/HIV treatment, emergency medical evacuation/ repatriation, repatriation of mortal remains, medical/legal information and assistance, compassionate visit benefit, Return of Minor Child, Dependant living support due to the Insured's cancer-related death, Dependant living support due to the Insured's Accidental death, coverage for Pre-existing Conditions, and emergency treatment outside the selected coverage area.

Doctor's Visit/Visit

Means a single visit during which the Insured is clinically examined by a Physician, undergoes tests, imaging, or other diagnostic procedures, and/or receives prescribed medication from the Physician in the same Medical Facility for the purpose of diagnosing and treating Sickness/Disease/Injury. Each visit concludes with a final diagnosis documented in the Physician's prescription.

If multiple specialized Physicians consult on the same Insured according to the Medical Facility's regulations, it is counted as one Doctor's Visit.

If the Insured visits the same specialty multiple times in one day, it is counted as one Doctor's Visit.

If the Insured visits different specialties within the same Medical Facility on the same day, regardless of Physician referrals, it is still counted as one Doctor's Visit.

Pre & Post Hospitalisation Treatment

Covered as defined under Outpatient Services for a maximum of 30 days immediately before hospitalisation and 90 days immediately after discharge from the Medical Facility, for the same medical condition per Insured. This benefit is payable following the inpatient services or surgery. Reimbursement is based on the date the expenses incurred.

Psychiatric Treatment

Treatment in a psychiatric unit of a Medical Facility, limited to 30 days per policy year, and only available after 24 consecutive months of coverage. The treatment must be pre-authorized by the Company.

Physiotherapy or Chiropractic Treatment

Preventative treatment and/or therapy using natural or artificial physical agents such as: water, air, temperature, climate, altitude, electricity, X-rays, ultraviolet rays, infrared rays, ultrasound, radioisotopes, and massage. Such treatment must be prescribed in writing by the attending Physician, and shall not include expenses for relaxation, massage, spa services, or posture correction.

If during the Insurance Period, the Insured contracts a covered Sickness/Disease or Injury and requires Physiotherapy or Chiropractic Treatment based on written recommendation from the attending Physician, the Company shall pay the actual, Reasonable and Customary charges incurred, not exceeding the Limits of Liability, and subject to the maximum number of Doctor's Visit per Policy Year as stated in the Benefit Plan.

Reasonable and Customary

No benefit shall be paid for charges exceeding the general level of charges made by other providers of similar standing in the locality where the charges are incurred, for comparable treatment, services or supplies for similar Injury or Sickness/Disease. The Company will determine such charges based on its own experience in handling similar cases and quotations received from similar standard Medical Facilities within the region.

Repatriation

The Medical Assistance Provider will arrange for the return, by air and/or sea transportation, of the Insured's body or ashes who is dying or deceased in a place outside the Insured's Home Country or Usual Country of Residence to the Home Country or Usual Country of Residence or another country (at the choice of the representative of the Insured) following an Emergency Medical Evacuation where the Insured has been medically evacuated to a place outside the Home Country or Usual Country of Residence for inpatient treatment. The Medical Assistance Provider reserves the full right to determine the means and method of repatriation based on the assessment of all relevant facts and circumstances. The Company will cover the necessary and unavoidable costs incurred for such services arranged by the Medical Assistance Provider PROVIDED THAT, if the Insured is repatriated to a country other than the Home Country or Usual Country of Residence, the Company's liability will not exceed VND 100,000,000 per Insured. The Insured or their representative must contact the Company or the Medical Assistance Provider in advance for approval and arrangement of transportation.

Unless the above benefit applies, the Medical Assistance Provider will (i) arrange for the return, by air and/or sea, of the Insured's body or ashes if the Insured dies in a place outside the Home Country or Usual Country of Residence, with the right to determine the appropriate method of repatriation after reviewing all circumstances; or (ii) at the request of the Insured's representative, arrange for the preparation of the Insured's remains for burial or cremation in the place of death. The Company will cover the incurred expenses for services arranged by the Medical Assistance Provider up to a maximum of VND 200,000,000 per Insured. The Medical Assistance Provider must be contacted in advance for necessary arrangements.

This benefit is also subject to the scope of services and exclusions specified in the service agreement between the Company and the Medical Assistance Provider. These details have been communicated to the Policyholder and may be updated or amended from time to time by the Company with prior notice.

This benefit does not apply for the Insured aged 70 or above.

Return of Minor Child

The return of a minor child to the Home Country or Usual Country of Residence if he/she is left unattended as a result of the accompanying adult Insured's Emergency Medical Evacuation. The Insured or their representative must contact the Company or the Medical Assistance Provider in advance for approval and transportation arrangements.

Covering for Pre-existing Conditions (after one (1) year of coverage)

The Company agrees to cover Pre-existing Conditions after one (1) year of continuous coverage from the Effective Date of the first insurance policy, provided that such Pre-existing Conditions have been:

(i) declared by the Insured to the Company in the most recent Application Form and prior to the Effective Date of the first insurance policy; and/or

(ii) notified by the Insured to the Company prior to the Effective Date of the first insurance policy; and/or

(iii) acknowledged by the Company to the Insured as a Pre-existing Condition in the first insurance policy.

Minor Child

A person under 18 years of age who is unmarried.

Standard Private Room

A Standard Private Room is a single-occupancy room with the lowest cost in the Medical Facility or as limited by the Benefit Plan. It does not include requested rooms, VIP rooms, or all-inclusive/private suites. If the Medical Facility categorizes Private Rooms into different levels, reimbursement shall be based on the actual charge for the standard private room or the norm of the charges for Private Room of that particular Medical Facility, whichever is lower.

Working Day

The day on which the Company operates in accordance with Vietnamese law.

Age

A person's Age is determined as of their most recent past birthday. It is verified using one of the following documents: birth notification, birth certificate, national ID, citizenship card, household registration book, or passport.

Dependant Living Support due to Accidental Death of the Insured

This benefit covers up to the Limits of Liability as specified in the Benefit Plan to the Dependant designated as Beneficiary under the Insurance Policy, provided that the Insured dies due to an Accident and only if the Insurance Policy has been continuously in effect for 12 months from the Effective Date of the first insurance policy. If multiple Beneficiaries are designated, the maximum Sum Insured as stated in the Benefit Plan will be evenly divided among them. In the absence of a designated Beneficiary, the Company will pay the Sum Insured in accordance with applicable laws in effect at the time of payment.

Dependant Living Support due to Cancer Death of the Insured

This benefit covers up to the Limits of Liability as specified in the Benefit Plan to the Dependant designated as Beneficiary under the Insurance Policy, provided that the Insured dies due to Cancer and only if the Insurance Policy has been continuously in effect for 12 months from the Effective Date of the first insurance policy. If multiple Beneficiaries are designated, the maximum Sum Insured as stated in the Benefit Plan will be evenly divided among them. In the absence of a designated Beneficiary, the Company will pay the Sum Insured in accordance with applicable laws in effect at the time of payment.

Emergency Pregnancy Complication due to Accident

This benefit covers all medical expenses arising from medically necessary emergency inpatient treatment related to miscarriage due to an Accident occurring within the Insurance Period, provided by a Physician at a Medical Facility. For the purpose of this provision, "pregnancy complication" refers to medical conditions occurring during the prenatal stage, and "miscarriage" (also referred to as "spontaneous abortion" in medical terminology) refers to the termination of pregnancy resulting in the loss and expulsion of the embryo or fetus from the womb before it is capable of independent survival.

Emergency Medical Treatment Outside Coverage Area

This benefit applies for maximum one (1) time per Insured per Policy Year, and covers emergency medical treatment subject to the following conditions: (a) Treatment must be provided within twenty-four (24) hours from the occurrence of the Insurance Event; (b) Not applicable for dental care/treatment or maternity care; (c) Not applicable for Pre-existing Conditions or ongoing treatment of sickness/disease/injury; (d) The condition must be certified as an emergency medical conditions/diseases; (e) The event must occur outside the selected coverage area; (f) Maximum of thirty (30) aggregate days per Policy Year.

External Prosthesis

Artificial body parts fitted externally to the body as part of the treatment for a covered Sickness, Disease, or Injury, as prescribed by a Physician. This includes upper limbs, lower limbs, nose, ears, and eyes.

2. Insurance Policy

The Insurance Policy is an agreement between the Policyholder/Insured and the Company, whereby the Policyholder must pay the premium, and the Company must pay claims as agreed in the Insurance Policy.

The Insurance Policy includes this Insurance Policy Wording, the Certificate of Insurance, the Benefit Plan, the Policy Schedule, the Application Form, and any Endorsements which collectively form the entire agreement ("Insurance Policy") between the Company, the Policyholder, and the Insured. These documents shall be applied in the following order of priority:

(i) the Application Form / Quotation / Renewal Notice / Renewal Quotation

(ii) the Endorsements

(iii) the Certificate and/or the Policy Schedule

(iv) the Benefit Plan; and

(v) this Insurance Policy Wording.

No agent or third party is authorized to alter or amend the Insurance Policy, or to waive any of its provisions. All changes to the Insurance Policy must be accepted in advance in writing by the Company.

3. Commencement of Insurance

Subject to the terms and conditions of the Insurance Policy, the Company's liability for the Insured under the Insurance Policy shall commence from the beginning of the Insurance Period applicable to the Insured and remain valid until the end of such Insurance Period unless terminated under the terms of the Insurance Policy.

4. Termination of Benefits

4.1 For individual insurance policy

4.1.1. The insurance for an Insured under this Insurance Policy shall automatically terminate on the earliest of the following dates (unless otherwise agreed by the Company):

(a) The date the Insured is no longer eligible for insurance under the Insurance Policy;

(b) The date following the end of the Payment Period if the premium related to the Insured is not fully and/or timely paid to the Company;

(c) The date the Insured resides outside the territory of Vietnam for more than one hundred and eighty (180) consecutive days without prior notice to and/or approval from the Company for continuous coverage;

(d) The date the Insured fails to notify the Company of any information or changes that may increase the risk or the Company's liability, including but not limited to a change of occupation or any Sickness/Disease/Injury arising during the Insurance Period;

(e) The date on which all applicable insurance benefits for the Insured have been exhausted;

(f) The date of expiration of the Insurance Period for the Insured.

If the insurance under this Insurance Policy for an Insured automatically terminates under item (e) or (f) of Article 4.1.1 above, and at the time of termination, the Insured is hospitalized for a continuous period of not less than eighteen (18) hours for treatment of a covered Sickness, Disease, or Injury in a Medical Facility, the termination of coverage shall be extended until (a) the Insured is discharged after completing such treatment or (b) the Insured's benefits for the said Sickness/Disease or Injury are fully exhausted, whichever comes first.

The Policyholder shall be entitled to a refund of premium with respect to that Insured, less the pro-rated amount corresponding to the period the Insurance Policy was in effect for that Insured, PROVIDED ALWAYS that no claims have been made by that Insured and there is no breach of the Insurance Policy at any time.

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

(a) The date the Dependant ceases to be eligible as a Dependant, as defined under the definition of Dependant;

(b) The date the Insurance Policy terminates;

(c) The date the insurance benefits of the relevant Insured (on whom the Dependant relies) under the Insurance Policy are terminated;

(d) The date after the expiration of the Payment Period if the premium relating to the Dependant is not fully and/or timely paid to the Company;

(e) The date the Dependant resides outside the territory of Vietnam for more than one hundred and eighty (180) consecutive days without prior notice to and/or approval from the Company for continuous coverage;

(f) The date on which the benefits applicable to such Dependant have been exhausted;

(g) The date of expiration of the Insurance Period for the Dependant;

(h) The date the Policyholder/Insured/Dependant fails to notify the Company immediately of any change in circumstances that may increase the insurable risks, including but not limited tofailure to comply with Reasonable Precautions and Material Changes provisions under Article 7, Part V of this Insurance Policy Wording; occurrence of any Sickness/Disease/Injury during the Insurance Period; or changes to factors used to calculate premiums which result in increasing insurable risks.

If the insurance under the Insurance Policy for an Insured automatically terminates under items (f) or (g) of Article 4.1.2 above, and at the time of termination, the Insured is hospitalized for a continuous period of not less than eighteen (18) hours for treatment of a covered Sickness, Disease, or Injury in a Medical Facility, the termination of coverage shall be extended until (a) the Insured is discharged after completing such treatment or (b) the Insured's benefits for the said Sickness/Disease or Injury are fully exhausted, whichever comes first.

In the event of termination under items (a), (c), or (e) of Article 4.1.2 above, the Policyholder shall be entitled to a refund of the premium paid for the Insured, minus the pro-rated premium for the period during which the Insurance Policy was in force for that Insured, PROVIDED ALWAYS that no claim has been made and there is no breach of the Insurance Policy at that time.

4.2 For Group Policy

4.2.1. The insurance under the Insurance Policy for an Employee shall automatically terminate on the earliest of the following dates:

(a) The date the Employee ceases to be eligible for insurance;

(b) The date the Group Insurance Policy is terminated;

(c) The date the Employee's employment with the Employer ends;

(d) The date following the end of the Payment Period if the insurance premium for the Employee has not been fully and timely paid to the Company;

(e) The date the Employee resides outside the territory of Vietnam for more than one hundred and eighty (180) consecutive days without prior notice to and/or approval from the Company for continuous coverage;

(f) The date the employee fails to notify the Company immediately of any change in circumstances that may increase the insurable risks, including but not limited to failure to comply with Reasonable Precautions and Material Changes provisions under Article 7, Part V of this Insurance Policy Wording; changes of occupation or occurrence of any Sickness/Disease/Injury during the Insurance Period; or changes to factors used to calculate premiums which result in increasing insurable risks;

(g) The date on which the benefits applicable to that Employee have been fully exhausted;

(h) The date of expiration of the Insurance Period for the Employee.

If the insurance under the Insurance Policy for an Insured automatically terminates pursuant to (g) or (h) of Article 4.2.1 above, and at the time of such termination, the Insured is hospitalized for a continuous period of not less than eighteen (18) hours for treatment of a covered Sickness, Disease, or Injury in a Medical Facility, the termination of coverage shall be extended until (a) the Insured is discharged after completing such treatment or (b) the Insured's benefits for the said Sickness/Disease or Injury are fully exhausted, whichever comes first.

In the case of (a), (c), or (e) of Article 4.2.1 above, the Policyholder shall be entitled to a refund of the premium paid for the Insured, minus the pro-rated premium for the period during which the Insurance Policy was in force for that Insured, PROVIDED ALWAYS that no claim has been made and there is no breach of the Insurance Policy at that time.

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

(a) The date the Insured ceases to meet the eligibility requirements as a member of the Sponsoring Organization;

(b) The date the Insured no longer satisfies any of the eligibility conditions for insurance under the Insurance Policy as stated in the Policy Schedule;

(c) The date the Group Insurance Policy is terminated;

(d) The date following the end of the Payment Period if the premium for the Insured has not been fully and timely paid to the Company;

(e) The date the Insured resides outside the territory of Vietnam for more than one hundred and eighty (180) consecutive days without prior notice to and/or approval from the Company for continuous coverage;

(f) The date the Insured fails to notify the Company immediately of any change in circumstances that may increase the insurable risks, including but not limited to failure to comply with Reasonable Precautions and Material Changes provisions under Article 7, Part V of this Insurance Policy Wording; changes of occupation or occurrence of any Sickness/Disease/Injury during the Insurance Period; or changes to factors used to calculate premiums which result in increasing insurable risks;

(g) The date the benefits applicable to that Insured have been fully exhausted;

(h) The date of expiration of the Insurance Period for the Insured.

If the insurance under the Insurance Policy for an Insured automatically terminates under Item (g) or (h) of Article 4.2.2 above, and at the time of such termination, the Insured is hospitalized for a continuous period of not less than eighteen (18) hours for treatment of a covered Sickness, Disease, or Injury in a Medical Facility, the termination of coverage shall be extended until (a) the Insured is discharged after completing such treatment or (b) the Insured's benefits for the said Sickness/Disease or Injury are fully exhausted, whichever comes first.

In the case of (a), (b), or (e) of Article 4.2.2 above, the Policyholder shall be entitled to a refund of the premium paid for the Insured, minus the pro-rated premium for the period during which the Insurance Policy was in force for that Insured, PROVIDED ALWAYS that no claim has been made and there is no breach of the Insurance Policy at that time.

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

(a) The date the Dependant ceases to be eligible as a Dependant as defined in the Definition of Dependant;

(b) The date the Group Insurance Policy is terminated;

(c) The date the relevant Insured's benefits (on whom the Dependant relies) under the Group Insurance Policy terminate;

(d) The date following expiration of the Payment Period if the premium payment related to the Dependant's insurance has not been fully and timely paid to the Company;

(e) The date the Dependant resides outside Vietnam for a continuous period exceeding one hundred and eighty (180) consecutive days without prior notice to and/or approval from the Company for continuous coverage;

(f) The date on which the benefits applicable to such Dependant have been exhausted;

(g) The date of expiration of the Insurance Period of the Dependant;

(h) The date the Policyholder/Insured/Dependant fails to notify the Company immediately of any change in circumstances that may increase the insurable risks, including but not limited to failure to comply with Reasonable Precautions and Material Changes provisions under Article 7, Part V of this Insurance Policy Wording; changes of occupation or occurrence of any Sickness/Disease/Injury during the Insurance Period; or changes to factors used to calculate premiums which result in increasing insurable risks;

If the insurance under the Insurance Policy for an Insured automatically terminates pursuant to (f) or (g) of Article 4.2.3 above, and at the time of termination, the Insured is hospitalized for a continuous period of not less than eighteen (18) hours for treatment of a covered Sickness, Disease, or Injury in a Medical Facility, the termination of coverage shall be extended until (a) the Insured is discharged after completing such treatment or (b) the Insured's benefits for the said Sickness/Disease or Injury are fully exhausted, whichever comes first.

In the case of (a), (c), or (e) of Article 4.2.3 above, the Policyholder shall be entitled to a refund of the premium paid for the Insured, minus the pro-rated premium for the period during which the Insurance Policy was in force for that Insured, PROVIDED ALWAYS that no claim has been made and there is no breach of the Insurance Policy at that time.

5. Termination of Insurance Policy

A. The Insurance Policy terminates in the following cases:

5.1. When the benefits applicable to all Insureds under the Insurance Policy have been terminated.

5.2. Upon mutual agreement between the Policyholder and the Company.

5.3. Cancellation of the Insurance Policy:

(a) When entering into the Insurance Policy, the Company shall be responsible for providing full and accurate information related to the Insurance Policy and explaining all policy terms and conditions to the Policyholder. The Policyholder is responsible for providing full and truthful information related to the matter of insurance to the Company.

(b) Where the Policyholder deliberately provides insufficient or false information with the intention of (i) entering into the Insurance Policy; and/or (ii) claiming indemnity or insurance payment, the Company shall have the right to cancel the Insurance Policy. In such case, the Company shall not be liable for any insurance indemnity or payment and shall refund the premium to the Policyholder after deducting the expenses specified under Point B, Article 5, Part I of this Insurance Policy Wording. At the same time, the Policyholder must compensate the Company for all losses incurred, including any paid claims and other resulting losses (if any). The Company has the right to deduct such losses from the premium before issuing a refund (if any remains).

(c) Where the Company intentionally fails to fulfill its duty of information disclosure or provides false information with the intention to conclude the Insurance Policy, the Policyholder shall have the right to cancel the Insurance Policy and receive a full refund of the premiums paid.

(d) The Company reserves the right to cancel the Insurance Policy if any Conditions Precedent specified in the Policy are not fulfilled or complied with.

(e) The Insurance Policy shall be cancelled pursuant to the provisions set out in Part VII of this Insurance Policy Wording.

5.4. Unilateral Termination of the Insurance Policy:

5.4.1. Whenever there is any change in the factors used to calculate premiums that results in a reduction of insurable risks, the Policyholder shall have the right to request the Company to perform one of the following:

(a) Reduce the premium for the remaining period of the Insurance Policy;

(b) Increase the sum insured for the remaining period of the Insurance Policy;

(c) Extend the Insurance Period;

(d) Broaden the scope of insurance coverage for the remaining period of the Insurance Policy.

5.4.2. If the Company does not accept the Policyholder's request under Article 5.4.1 of Part I of this Insurance Policy Wording, the Policyholder has the right to unilaterally terminate the Insurance Policy, provided that written notice is immediately given to the Company.

5.4.3. If there is any change in the factors used to calculate premiums that increases the insurable risks (including the Policyholder's/Insured's failure to comply with the Reasonable Precautions or the Material Changes requirements set out in Article 7, Part V of this Insurance Policy Wording; changes in occupation; or any new Sickness/Disease/Injury arising during the Insurance Period; and other changes to risk-related factors), the Company may take one of the following actions:

(a) Re-calculate the premium for the remaining period of the Insurance Policy;

(b) Reduce the sum insured for the remaining period of the Insurance Policy;

(c) Shorten the Insurance Period;

(d) Restrict the scope of insurance coverage for the remaining period of the Insurance Policy.

5.4.4. Where the Policyholder refuses to accept the request specified in Article 5.4.3, Part I of this Insurance Policy Wording, the Company shall have the right to unilaterally terminate the Insurance Policy by giving prior written notice to the Policyholder before termination.

5.4.5. The Company reserves the right to unilaterally terminate the Insurance Policy if the Policyholder fails to pay the premium or does not pay the full premium by the agreed due date or within the extended payment period (if any).

5.5. The Policyholder or the Insured passes away or no longer satisfies the conditions/requirements to qualify as a Policyholder or Insured as stipulated in Part II of this Insurance Policy Wording and/or under applicable law.

If the Insurance Policy covers more than one Insured, the Insurance Policy shall only terminate in relation to the Insured who no longer satisfies the eligibility requirements as set forth in Part II of this Insurance Policy Wording and/or under applicable law.

5.6 Other cases as prescribed by law.

B. In all cases where the Insurance Policy is terminated and the Company refunds premiums to the Policyholder (whether on a pro-rata basis for the remaining period of the Insurance Policy or calculated otherwise, subject to the Company's discretion), the Company reserves the right to retain (deduct) a handling fee of VND 2,000,000 plus tax (if applicable) per Insurance Policy before refunding any premium.

If, at the request of the Policyholder, the refund is made by bank transfer, the Company shall bear any bank charges incurred if the transfer is made to a local bank account or paid through identity verification at a bank designated by the Company ("the Company's standard payment method"), unless otherwise requested by the Policyholder.

In the event the refund is transferred to a foreign bank account or made through a method other than the Company's standard payment method, any transfer or transaction fees shall be borne by the Policyholder.

C. Notwithstanding the premium refund provisions above or any other provision under the Insurance Policy (if applicable), the Company reserves the right not to refund any premium where the Insurance Policy is terminated in respect of an Insured for whom the Company has already paid any claim.

6. Co-ordination of Benefits / Overlapping Insurance / Other Insurance

All Insureds who are covered under any other medical or accident insurance policies must notify the Company of such participation and provide the Company with a copy of the relevant insurance policy and a summary of benefits under such insurance policies.

In the event that medical expenses related to the same Injury or Sickness/Disease covered under this Insurance Policy are also claimable under other types of insurance or insurance policies, the Company shall only be liable for the amount exceeding the compensation received from such other insurance or in proportion to the insured amount of this Insurance Policy compared to the total limits of liability under all insurance policies. Accordingly, if the Company pays the Insured or the Beneficiary an amount greater than the actual liability, the Insured/Beneficiary shall be obliged to reimburse the excess amount to the Company.

In the event that an Injury to the Insured arises from the act or negligence of a third party, the Policyholder and/or the Insured shall use their best efforts to claim full compensation for the loss from such third party. The Policyholder and/or the Insured must promptly notify the Company in any case where a claim against a third party is possible. At the request and expense of the Company, the Policyholder/Insured/ Beneficiary shall take all reasonable actions to assist the Company in recovering the compensation from such third party, to which the Company is legally entitled under applicable laws.

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.

Any dispute or conflict arising under or in connection with this Insurance Policy shall first be resolved by the parties through negotiation and amicable conciliation. If no amicable settlement is reached within thirty (30) days from the date one party notifies the other of such dispute, the parties agree to submit the dispute to the exclusive venue and jurisdiction of the competent courts of the Socialist Republic of Vietnam for resolution.

8. Prevailing Language

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

PART II – INSURED OBJECTIVES

1. The Insured Objective is the health of the Insured within the scope of insurance of the Insurance Policy.
2. The Policyholder (i) is an organization legally established and licensed to operate in Vietnam, or an individual residing in Vietnam aged 18 and above with full civil capacity at the time of concluding the Insurance Policy; (ii) meets the conditions to purchase the insurance under the Insurance Policy; and (iii) must have an insurable interest with respect to the Insured as prescribed by law.
3. The Insured is the person whose health is covered under the Insurance Policy; a Vietnamese citizen or foreigner residing in Vietnam, aged from 15 days old to 64 years old, and extendable to 74 years old for renewal policies (if any). The Company will only accept coverage for a Minor Child if he/she is included under the same Insurance Policy as his/her father/mother.
4. Citizens of countries subject to sanctions by the United Nations, the United States of America, the European Union and the United Kingdom shall not be eligible to be the Policyholder/ the Insured under this Insurance Policy.
5. The Beneficiary is the person designated by the Policyholder to receive insurance benefits under an Individual Insurance Policy, or the person designated by the Insured under a Group Insurance Policy. Any appointment or change of beneficiary must comply with applicable laws.

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 Company will pay the Insured for the expenses necessarily and reasonably incurred by the Insured as a direct result of the Insured suffering bodily injury, Sickness/Disease or dental or being pregnant (if applicable), during the Insurance Period for all benefits listed in the Benefit Plans, PROVIDED ALWAYS THAT (i) such expenses are actual and limited to usual, Reasonable and Customary charges in the country and area where treatment is provided and (ii) Conditions Precedent as specified in the Insurance Policy is always met/complied.

2. Territorial Scope

The coverage of insurance is subject to the geographical area as listed on the Policy Schedule and for which the appropriate zone premium has been paid. For Zone 1, treatment in USA/Canada is subject to a deductible of covered medical expenses incurred, unless additional premium has been paid to remove the Deductible.

3. Consideration for Insurance for Pre-existing Conditions

If a pre-existing condition shall have been disclosed to the Company, the Company may agree to cover such Pre-existing Conditions under the Insurance Policy after one year's continuous membership from the inception date of the Insurance Policy (first one).

PART IV - EXCLUSIONS

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

(1) Treatments of mental illness, behavioural, psychiatric disorders including depression, eating disorders, sleeping disorders, insomnia, neurasthenia, stress or illnesses/diseases related thereto, or any neuroses and their psychological or neurological manifestations, except pre-authorized hospitalisation treatment, and other mental illnesses, Alzheimer.

(2) Services or treatments at any institution that is mainly a long-term care facility, nursing home, or similar facilities, hydrotherapy clinics, sanatorium, naturopathy spa, or massage.

(3) Tests and treatments relating to Congenital Diseases, Genetic Diseases, birth defects, genetic deformities, and all complications and all illnesses/conditions caused thereby and/or related thereto, resulting from such diseases, including surgeries for those diseases occurring prior to the inception date of the Insurance Policy; such as congenital heart defects, psoriasis, Down syndrome, cleft lip and palate, hydrocephalus, anal stenosis, phimosis, congenital septal deviation, autism spectrum disorders, attention deficit disorders, attention deficit hyperactivity disorder, and other defects/congenital diseases. Treatment of learning problem or speech defects of a dependent child. Foetal surgery while still being in the womb.

(4) Tests and treatments relating to infertility, contraception, sterilisation, family planning measures, artificial insemination, abortion, and other treatments resulting from such procedures.

Family planning measures include contraceptive methods such as sterilisation, intrauterine devices, injectable contraception, contraceptive implants, condoms, oral contraceptives, and other contraceptive methods.

(5) Tests and/or treatments not undertaken by or on the recommendation of a Medical Facility, including indication of a Physician or Medical Facility to purchase medicines or tests, treatment in clinics, hospitals, legal pharmacies, or Medical Facilities, or treatments which is reasonably considered by the Company's medical advisor as not Medically Necessary, as well as examinations or treatments at home which is not prescribed by a Physician (except Home Nursing benefit as specified in the Benefit Plans).

(6) All dental/orthodontic treatments, unless explicitly stated on the Policy Schedule.

(7) Routine eye and ear examinations, visual acuity test/vision test, spectacles, contact lenses, vision correction or eye refraction including myopia, astigmatism, hyperopia, presbyopia, amblyopia, diplopia, cataracts, color blindness and other eye refractive errors; eye degenerations, retinal tears/detachment, regular hearing tests(*), aging, degeneration, treatment of natural degeneration not due to pathological causes of hearing or vision loss, and any corrective surgery for degenerative hearing and visual defects.

(*) Regular hearing tests are excluded (not covered) if the Insured undergoes a hearing examination without any prior symptoms and the Physician's conclusion does not conclude for any Injury, Sickness/Disease related to hearing.

(8) Treatments arising from the use, abuse, or addiction to narcotics, prohibited substances, stimulants, alcoholic beverages, beer, and any Injuries, Sicknesses/Diseases directly or indirectly resulting from such use, abuse, or addiction.

(9) Treatments for self-inflicted injury or suicide, deliberate acts of the Insured or the Policyholder or legal heir/Beneficiary of the Insured or the Policyholder.

(10) Routine medical examinations and preventive treatment (including vaccinations or inoculations, preventive medicines and tests, health screening, physical condition screening, malnutrition, rickets, anorexia, retarded development), unless otherwise explicitly provided and endorsed on the Policy Schedule.

(11) Tests and medical expenses not incident to treatment or diagnosis of a covered Sickness/Disease or Injury; or any treatment which is not Medically Necessary according to professional advice of a Physician engaged by the Company for such advice.

(12) Treatments provided by a family member.

(13) Treatments provided by the Policyholder/Insured as a Physician treats themselves.

(14) Treatments provided by the Policyholder to the Insured.

(15) Treatments provided by the Policyholder/Insured to the Dependants.

(16) Prostheses, rehabilitation devices, and medical devices, as well as artificial heart implantation, mono or bi-ventricular assist devices, except standard surgical implants. Costs for procurement or use of mobility aids or other devices.

For the purpose of the above sentences:

- Rehabilitation devices are equipment and machinery that assist treatment to help the Insured recover bodily functions impaired by Accident, Congenital Diseases, or other causes. Different individuals require different treatment therapies and different corresponding supportive equipment and machinery.
- Medical devices are instruments and medical equipment used as part of a treatment process, including surgeries, performed by a Physician and/or Medical Facility, deemed Medically Necessary and prescribed for the Insured, including cranial helmets/cranial protective helmets, nebulizers, ventilator and oxygen masks, hearing aids, splint, insulin pumps, infusion pumps, blood glucose monitors and test strips, orthosis/braces and orthopedic supports, voice prosthesis, rubber prosthetic feet, orthotic footbeds, diabetic test strips, colostomy bags, and other medical devices used by Physicians.
- Mobility aids are the following items and their accessories deemed Medically Necessary and prescribed by a Physician to the Insured following surgical treatment due to Accident and/or Disease: crutches, canes, rollators, manual wheelchairs.
- Other devices are not Rehabilitation devices, Medical devices, or Mobility aids.

(17) Cosmetic or plastic surgery for aesthetic reasons. Treatments related to or arising from weight control, removal of fat or surplus tissue for weight loss or gain, obesity, malnutrition, rickets, or other treatments performed for cosmetic or psychological reasons, including treatment of hair loss, premature greying of hairs, baldness, freckles, hyperpigmentation, or hypopigmentation.

(18) Maternity care. No benefit shall be payable unless otherwise explicitly provided and endorsed in the Policy Schedule.

(19) Hospitalization primarily for diagnosis, X-ray examinations, or physical therapy, unless recommended by a legally qualified physician or surgeon.

(20) Tests, visits and treatments of sexually transmitted diseases and treatment of impotence (including but not limited to syphilis, gnorrhea/gonococcal infection, genital/ sexual dysfunction or sexual physiology treatment, erectile dysfunction, loss of libido, premature ejaculation) or any related condition of gender transition, precocious puberty, delayed puberty.

(21) All organ transplantation except as defined in the Benefit Plan.

(22) Acquisition of the organ itself and all expenses incurred by the donor, costs of transportation, preservation of body organs and other related costs.

(23) Tests and treatments for 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 Waiting Period has been fulfilled and subject to the sub limit as stated in the Schedule.

(24) Pre-existing Conditions or any related, associated or consequential disabilities, unless disclosed to and accepted in writing by the Company.

(25) Charges exceeding the Reasonable and Customary range as defined.

(26) Non-approved Elective Treatment.

(27) 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.

(28) Experimental medical treatments, surgical treatments, other experimental treatments or yet to be scientifically proven medical treatment.

(29) Treatments for Injury or Sickness/Disease incurred while participating in military training exercises, participation in combat of police or military forces and/or serving as a member of military or police or as a result of performing Class III or IV occupation (unless otherwise agreed in advance by the Company).

(30) Treatments for injuries or diseases sustained while participating in (practice or conditioning program to participate in) contest or sport competition; participation in contest or sport competition; 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 Company or deliberate exposure to exceptional danger (except in an effort to save human life);

(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, vitamins, minerals, supplements, foods for medical purposes, natural organic compounds supporting nutritional regime or diet program purposes, weight gain, weight loss, cosmeceuticals.

(33) Non-medical services, including the issue of medical certificates and attestations and examinations as to suitability for travel.

(34) Treatments for Injury or Sickness/Disease resulting from war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), terrorism, riots, usurpation, civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power, military acts or actions of any leader of any organization aimed at overthrowing, threatening government, controlling by forces, terrorist or violent acts.

(35) Treatments for Injury or Sickness resulting from Terrorist Act.

(36) Exposure to nuclear energy, ionizing radiation or radioactive contamination of any kind.

(37) Participation in an illegal act including resultant imprisonment or incompliance with all statutory obligations.

(38) Examination and treatments of Sickness/Disease/Injury sustained or 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, etc.

(39) Stem Cell Therapy except bone marrow transplant.

(40) All Emergency Medical Evacuation/Repatriation/Return of Mortal Remains is not approved in advance by the Company or its Medical Assistance Provider.

(41) Any other exclusion on Medical Evacuation/Repatriation/Return of Mortal Remains Benefits specifically stated in the Service Agreement with the Medical Assistance Provider, as amended from time to time and informed to the Insured.

(42) The Company 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 Company to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or United States of America, Vietnamese law.

(43) No coverage for persons with mental illnesses.

(44) No coverage for persons with permanent disablement at the time of application or at the inception of the Insurance Policy.

For the purposes of the above sentences, “permanent disablement” means the percentage of bodily injury or health damage from 50% and above in accordance with law/managing government in forensic examination, forensic psychiatric examination (or other similar regulations issued by or managing government of health) effective (i) at the time of insurance application or inception of the Insurance Policy; or (ii) in case of continuous insurance policies over multiple years, at the time of the first insurance application or inception of the first Insurance Policy.

(45) Expenses and/or events arising from or relating to or consequences of natural disasters such as earthquakes, volcanoes, tsunamis; radioactive contamination, pandemics as declared by competent authorities (including SARS, H5N1, Ebola, other pandemics as declared by competent authorities).

(46) The Insured participates in fights (other than an attempt to save human life).

(47) Any illness that is declared or assessed as a pandemic by the World Health Organization (WHO) and/or any other competent authority. The insurance benefits under this Insurance Policy shall immediately cease from the date of such announcement and will be reinstated once the pandemic status is officially lifted by the World Health Organization (WHO) or any other competent authority.

(48) 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 RELATION TO THE INSURANCE POLICY

1. Conditions Precedent to Liability

(a) Any liability of the Company towards the Insured shall arise only if the following conditions precedent are fully satisfied:

(i) The Company must be provided with all required statements and declarations made by the Policyholder and/or the Insured (or the parent or legally appointed guardian if the Insured is a Minor Child) through the Application Form and any accompanying documents; and all such statements and declarations must be entirely accurate, truthful, and complete. If the Policyholder/Insured provides information on behalf of a Dependant, that information must also be accurate, truthful, and complete.

(ii) The conditions precedent as specified in Article 8, Part V of this Insurance Policy Wording.

(iii) The conditions precedent as specified in Article 1, Part VIII of this Insurance Policy Wording.

(b) If any of the above conditions precedent are not fulfilled, the Company shall bear no liability towards the Insured. The Company reserves the right to deny claim payment and/or terminate the Insurance Policy in accordance with its termination provisions.

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.

Elective Treatment outside the Usual Country of Residence is also subject to the following requirements:

(1) quotations for such Elective Treatment from the elected Medical Facility must be obtained and submitted to the Company for pre-authorization at least 5 working days before the treatment is provided; and

(2) such Elective Treatment has been accepted by the Company.

3. Data Required

The Policyholder must provide, in writing (or in any other form as required by the Company), all information and documents that the Company may request regarding any matters related to the Insurance Policy. All documents or information provided by the Insured to the Policyholder in relation to the insurance, as well as any related records, must be made available for the Company's inspection at any reasonable time.

If the age, date of birth, or any other relevant information of an Insured is found to be misstated, and such misstatement affects the coverage, benefits, or any other terms and conditions of the Insurance Policy, or the Company's decision to insure that individual, then, at the Company's sole discretion, (a) the correct age and accurate information shall be used to determine whether coverage is applicable under the Policy and in what amount, and an adjustment to the premium may be made accordingly; or (b) the insurance benefits may be terminated in accordance with the termination of benefits clause.

4. Eligibility

1. For Individual insurance policy:

The maximum age for enrollment is 64 years, extended to 74 years (in case of renewal). The Policyholder, the Insured, and their Dependants (excluding newborn baby) of all nationalities are eligible for coverage, except citizens of countries sanctioned by the United Nations and the United States, as amended from time to time.

Coverage for Dependants must be under the same Benefit Plan as the principal Insured and is subject to the prior approval of the Company. The Minor Child are not eligible for individual insurance under the Benefit Plan.

The newborn baby shall be eligible for coverage from 15 days after birth or 15 days after discharge from the hospital where the birth occurred, whichever is later, subject to submission of an application and satisfactory evidence of good health and prior approval by the Company.

The Insurance Policy applies only to individuals employed in Class I and Class II occupations, unless otherwise agreed in writing by the Company. The Insured must notify the Company immediately upon a change of occupation to Class III or IV. Failure to do so may entitle the Company to reject or deny any claim and/or terminate the Insurance Policy.

2. For Group insurance policy:

Employees and members of the Sponsoring Organization, along with their Dependants, must be in Active Services from the inception date to be eligible for insurance coverage, except in cases of authorized paid leave.

Newborn baby shall be eligible for coverage 15 days after birth or 15 days after discharge from the hospital where the birth occurred, whichever is later, upon submission by the Policyholder of an Application Form, subject to satisfactory proof of good health and the Company's acceptance.

Citizens of any country sanctioned by the United Nations or the United States, as amended from time to time, are not eligible for insurance under this Insurance Policy.

The maximum age for enrollment is 64 years, extended to 74 years (in case of renewal).

The Insurance Policy applies only to persons employed in Class I and Class II occupations, unless otherwise agreed in writing by the Company. The Insured must inform the Company promptly any change to a Class III or IV occupation. Failure to do so may entitle the Company to deny claims or terminate coverage.

5. Examination

The Company, through its appointed medical representative, shall have the right and opportunity to examine any Insured at any time and as often as reasonably required before the Insurance Policy is issued and/or during any claim process. The Company also reserves the right to request an autopsy in the event of death, where not prohibited by law or religious belief.

6. Medical Evaluation

The Company reserves the right to request additional tests and/or evaluations if it determines that a claimed condition may be directly or indirectly related to an excluded condition. The Company shall bear the cost of such tests or evaluations.

7. Reasonable Precautions and Material Changes

The Policyholder and/or the Insured shall take all reasonable precautions to prevent or minimize any Accident, Injury, Sickness/Disease, or expenses.

The Policyholder and/or the Insured are responsible for notifying the Company of any material information or changes that may increase the risk or give rise to additional liability for the Company. The Company shall have the right to continue coverage under revised terms, conditions, and premiums that it deems appropriate for such changes, and/or unilaterally terminate the Policy if the Insured does not accept the proposed terms. Any claims arising from or related to such changes will not be payable unless and until the Company has been informed of the changes and has agreed to continue the coverage.

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

For citizens of the United States or Canada who return to their Home Country, and for citizens of other countries who intend to reside in the United States/Canada for more than one hundred and eighty (180) consecutive days, the coverage will be automatically terminated. The Insured must notify the Company within thirty (30) days of the return or change of Usual Country of Residence. Any paid premium will be refunded according to the Termination of Insurance Policy article.

For changes of residence to countries other than the United States or Canada during the Policy Year, coverage shall be subject to the Company's consideration based on Reasonable and Customary costs in such country, or the premium will be refunded in accordance with the Termination of Insurance Policy article.

A condition precedent to liability under this Insurance Policy is that the Company must be notified in writing of any change in the Usual Country of Residence of the Policyholder or any Insured. A change in the Usual Country of Residence is defined as ceasing to reside in the previously declared country or intending to reside in another country for more than one hundred and eighty (180) consecutive days. Failure to notify the Company may entitle the Company to reject or deny claims, terminate the Policy, or negotiate to revise terms and conditions with the Policyholder/Insured.

The Company must be notified of the location of any Dependants whose Usual Country of Residence differs from that declared in the Application Form by the Policyholder/ Insured. The Company reserves the right to decline coverage for such Dependants under the Insurance Policy.

The Company reserves the right to decline renewal of coverage for any Insured who has changed their Usual Country of Residence 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 Company 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 Company. 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 Company a claim dossier including:

- the Claim Form fully completed and signed by the claimant;
- the original copy of medical records;
- the medical reports;
- Test results, biopsy, screening;
- The prescription;
- Invoices and receipts.
- Other documents upon the Company's requests.

Photocopies are acceptable, except when the Company requests original copies. The claim dossier must be fully submitted to the Company within the time limit as provided 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 incurred.

For treatments in Medical Facility, surgery and Day Case Treatment, please refer to "Elective Treatment – Pre-authorization requirement".

If the reimbursement is received by the Insured by bank transfer as requested by the Insured, all bank charges are payable by the Company if transferring to local banks or through identification documents at banks appointed by the Company ("the standard payment of the Company"), unless the Insured requests otherwise.

In case of transferring to a foreign bank account or payment methods other than the standard payment method of the Company, all transfer charges or arising payment fees shall be borne by the Policyholder/Insured.

Option 2 – Direct Billing Service

Direct Billing Service is a cashless service provided by the Company that allows the Insured to receive Outpatient Services and Inpatient Services at the Company's appointed healthcare providers.

The Insured is not allowed to use Direct Billing Services if the premium has not been paid or fully paid according to the Payment Period as agreed in the Insurance Policy.

For elective treatments in Medical Facility, the Insured must follow the "Elective Treatment – Pre-authorization requirement".

The Company will issue a Letter of Guarantee for Payment if the medical condition is covered by the Insurance Policy.

The Insured must present his/her Insurance Certificate along with identification documents for verification.

In any event, any pre-authorized payment and/or amount paid by the Company for a claim not covered under the Insurance Policy or exceeding the Limits of Liability shall be reimbursed by the Insured and/or the Policyholder to the Company within 31 days from the date the Company issues a repayment notice.

PARTY VII – FRAUD AND HANDLING METHODS

1. For Individual insurance policy:

If any claim is in any way false or fraudulent, or if fraudulent means or devices are used by the Insured or anyone acting on his/her behalf to obtain benefits under this Insurance Policy, the Policy shall be immediately terminated, all benefits shall be forfeited, and the Company shall have the right to retain (deduct) an amount of VND 2,000,000 plus tax (if applicable) per Insurance Policy or Endorsement before refunding any premium.

2. For Group insurance policy

If any claim is in any way false or fraudulent, or if fraudulent means or devices are used by the Policyholder or anyone acting on their behalf to obtain benefits under this Group Insurance Policy, the Group Insurance Policy shall be immediately terminated, all benefits shall be forfeited, and the Company shall have the right to retain (deduct) an amount of VND 2,000,000 plus tax (if applicable) per Insurance Policy or Endorsement before refunding any premium.

In the event an Insured submits a false or fraudulent claim, his/her insurance shall be immediately terminated and all benefits forfeited. The Policyholder/Insured shall be liable to compensate the Company in the amount of VND 2,000,000, which the Company shall deduct from the premium prior any refund. This provision shall not affect the validity of the Group Insurance Policy which shall remain in force.

PART VIII - PREMIUM PAYMENT TERM

1. It is hereby declared and agreed that it is a condition precedent to liability under the Insurance Policy, that any premium due must be paid and duly received in full by the Company (or by any party being authorized to collect the premium pursuant to that party's agreement with the Company):

   (a) Unless the below Item (b) is applicable, with respect to the Insurance Policy, within thirty (30) days from the Inception date of the Insurance Policy; if the Insurance Period is less than 30 days, the payment period is prior or equal to the start of the Insurance Period.

   (b) With respect to the Insurance Policy, where the Company has allowed payment of the policy premium in installments, within thirty (30) days from the Inception date of the Insurance Policy for the first installment and thereafter from the agreed dates on which the subsequent installments are due; if the Insurance Period is less than 30 days, the payment period is prior or equal to the start of the Insurance Period.

   (c) With respect to Endorsement arising additional premium, within thirty (30) days from the Inception date of each corresponding Endorsement, if the Insurance Period is less than 30 days, the payment period is prior or equal to the start of the Insurance Period.

2. In the event the Insurance Policy and Endorsement's premium(s) are not paid in full to the Company (or by any party being authorized to collect the premium pursuant to that party's agreement with the Company) as specified in Article 1 above, and within the timeframe stipulated above (the "Payment Period"), the cover under the Insurance Policy/Endorsement(s) shall be deemed to have terminated automatically from the adjacent date right after the expiry date of the Payment Period and the Company shall be discharged from all liability therefrom. Accordingly:

   (a) No premium payment required from the inception date of the Insurance Period to the termination date of the Insurance Policy if the Policyholder is an individual and no claim has been made during this period of insurance.

   (b) The premium payment should be made from the inception date of the Insurance Period to the termination date of the Insurance Policy/Endorsement(s) according to the number of pro-rated days in which the Insurance Policy/Endorsement(s) takes effect over the Insurance Period prior to termination ("pro-rata basis"), regardless of whether any claim has been made.

(c) The Policyholder is responsible to pay the premium and entitled to receive the corresponding claim payment if any insurance event arises during the period from the inception date of the Insurance Policy to the termination date of the Insurance Policy/Endorsement. Accordingly, for each Insured:

- Premium is calculated on a pro-rata basis;
- The maximum claim payment the Insured may receive will not exceed zero point one percent (0.1%) of:

(i) The Limits of Liability of each benefit as specified for each Sickness/ Disease/Injury in the Benefit Plan; or

(ii) The Sum Insured as specified in the Policy Schedule and/or Endorsement for any claim relating to inpatient services, outpatient services, dental, maternity care (and/or other documents in the Insurance Policy/Renewal Insurance Policy, if applicable), whichever is lower.

The Company reserves the right to deduct the premium before making claim payment.

3. Reinstatement of Insurance Policy/Endorsement

After the Insurance Policy/Endorsement is terminated according to Article 2, Part VIII of this Insurance Policy Wording, if the Policyholder requests reinstatement and subject to the Company's decision, the Policyholder and the Company may agree on the applicable premium, terms, and conditions for the period during which the Insurance Policy/Endorsement is reinstated (as specified in the relevant Endorsement(s)).

PART IX - TRANSFERRING GROUP INSURANCE POLICY TO INDIVIDUAL POLICY

The Policyholder/Insured under the Group Insurance Policy has the right to request the Company to transfer the coverage to an Individual Insurance Policy after being insured under the Group Insurance Policy for at least one (1) year. Accordingly, the Company reserves the right to require the Policyholder/Insured to provide additional information/documents and decide the applicable terms and conditions for the Individual Insurance Policy in accordance with the request. Any changes to benefits or policy terms and conditions (if any) will be notified in writing to the Policyholder/ Insured. The Company reserves the right to decline the request for transition to an Individual Insurance Policy if the transition is not in line with the provisions of the current Insurance Policy, the Company's insurance products, or at the sole discretion of the Company.