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Liberty HealthCare
Insurance Policy Wording

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

PART I – GENERAL PROVISION

1. Definition

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

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

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

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

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

Insurance Policy
The Insurance Policy as described in Article 2.

Group Policy
Insurance Policy for Group.

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

Insurer
Liberty Insurance Limited.

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

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

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

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

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

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

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 for which the Insured is liable in accordance with the Policy Schedule.

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

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

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

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

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

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

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

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

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

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

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

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

Insured
A person satisfied all conditions to whom the commencement of the insurance has been confirmed by the Insurer by issuing a Policy Schedule to clearly indicate that such person is the insured under the Insurance Policy.

Medically Necessary
Treatment, service or procedure which in the opinion of the Medical Practitioner and the medical facility where the Medical Practitioner is working is appropriate and consistent with the diagnosis and the generally accepted medical standards.

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

Policyholder
The policyholder as stated in the Policy Schedule.

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

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

"Pre-existing Conditions" means any Sickness/Illness/Injury:

(a) which existed before the Effective Date in respect of an Insured, which presented signs or symptoms of which the Insured was aware or should reasonably have been aware; or

(b) for which treatment, or medication, or advice, or diagnosis has been sought or received during the two (2) years prior to the Effective Date by the Insured; or

(c) which was known by the Insured to exist prior to the Effective Date whether or not treatment, or medication, or advice, or diagnosis was sought or received.

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

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

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

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

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

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

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

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

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

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

Annual Medical Examination
Are tests/screenings that are undertaken by an authorized medical facility without any clinical symptoms being present. Such tests include the following examinations performed, at an appropriate age interval, for the early detection of illness or disease:

- Vital signs (blood pressure, cholesterol, pulse, respiration, temperature etc.)
- Cardiovascular exam
- Neurological exam
- Cancer screening
- Well child test (for children up to the age of 6 years)

This benefit is also applied for Vaccination and Work Permit Medical Check-up.

Companion Bed

Hospital accommodation in respect of a parent or a legal guardian staying with an Insured, who is under 18 years of age, and is admitted as an inpatient in a Hospital. This is limited to only one parent/guardian each night when the child is receiving covered hospital inpatient treatment for which the child is insured under the Insurance Policy.

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 Insurer's Medical Assistance Provider and only when judged necessary by the Insurer's Medical Assistance Provider on reasonable medical and compassionate grounds.

Chinese Herbalist/Bonesetter/Acupuncturist
Chinese Herbalist/Acupuncturist shall mean a physician or a medical practitioner who is licensed as Chinese Medicine practitioner in accordance with the laws in the country of his practice to render treatment.

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

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

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

Day Case Treatment/ Day-Patient
Treatment in a Hospital where the Insured is usually admitted to a Hospital bed but does not stay overnight.

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

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

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 Insurer covering Dental Services for at least **nine consecutive months**.
Crown, bridges and dentures will be covered after the Insured has been insured by the Insurer 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, details of which are listed separately and informed by the Insurer to the Policyholder, which agree to charge the Insurer directly for the treatment cost when the Insured present a valid designated Certificate. However, the Insured is responsible for repayment if such charges are not eligible under the Insurance Policy. Failure to re-pay by the Insured to the Direct Settlement Network, such ineligible expenses will result in the Insurer's right to suspend or cancel the Insurance Policy.

Emergency Dental Treatment following Accident
Dental treatment provided within 30 days from the accident for accidental damage caused to sound, natural teeth, except when the accidental damage has been caused through eating, when given by an Orthodontic Physician in an authorized medical facility.

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

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

The Insurer will pay the cost of one Economy Class Return Airfare accompanying the Insured aged 18 years old or below during evacuation, when this is deemed necessary for medical reasons by the Insurer.

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

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

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

Hormone Replacement Therapy
Hormone Replacement Therapy shall mean any consultation services and medication provided by an authorized 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 Hospital.

Maternity Care
Pre-natal, childbirth, post-natal treatment and miscarriage, or abortion out of medical reason, or any complications arising from pregnancy for the Insured with respect to normal and complicated delivery and the after birth baby care incurred in the Hospital.

Where this benefit is included in the Insurance Policy for an Insured, it will apply to pregnancies which actual date of birth is at least 12 months after the date of enrolment of this benefit of the Insured, except

that it is a premature termination of pregnancy due to medical reasons but such pregnancy commences after 90 days from the enrolment date of this benefit of the Insured.

New-Born Baby Care
A Maternity Care benefit extension for the general baby care, for the maximum of 5 days immediate after birth or inpatient treatment for sickness manifests itself within 30 days following birth. This benefit is limited to the treatment provided within 30 days from the date of birth of the baby.

An additional limit for new-born baby care is applied for inpatient treatment of an acute medical condition and any associated cost which presents symptoms at birth or which manifests itself within 30 days following birth when the Limits of Liability for Maternity is exhausted.

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

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

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

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

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

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

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

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

Time of occurrence of the first symptom (From the first Effective Date of the Insured)	Rate of compensation (% of the total medical expenses)
After 90 days	70%
After 180 days	100%

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

Outpatient Services

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

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

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

Psychiatric Treatment
Treatment in a psychiatric unit of a Hospital, limited to 30 days per policy year after 24 month cover. Treatments must be pre-authorized by the Insurer.

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

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

Repatriation
The Medical Assistance Provider will arrange for the return, by air and/or surface transportation, of the Insured's body or ashes who is dying or dead in a place outside the Home Country or Usual Country of Residence to the Home Country, the Usual Country of Residence or another country (at the choice of the representative of the Insured) following an Emergency Medical Evacuation where the Insured is evacuated to a place outside the Home Country or Usual Country of Residence for in-hospital treatment. The Medical Assistance Provider reserves the right to decide the means or method by which such repatriation will be carried out having regard to all the assessed facts and circumstances. The Insurer shall pay for the expenses necessarily and unavoidably incurred in the services so arranged by the Medical Assistance Provider PROVIDED always that if the return of the Insured's body is to a country other than his/her Home Country and/or Usual Country of Residence, the Insured shall pay the expenses incurred but in no event exceeding VND100,000,000 per Insured. The Insured/The representative of the Insured must contact to the Insurer or The Medical Assistance Provider in advance for the approval and arrangement of transportation.

Unless Item 1 is applicable, the Medical Assistance Provider will (i) arrange for the return of the Insured's body or ashes who is dead in a place outside his/her Home Country or Usual Country of Residence to his/her Home Country by air and/or surface transportation. The Medical Assistance Provider reserves the right to decide the means or method by which such repatriation will be carried out having regard to all the assessed facts and circumstances; or (ii) at the choice of the representative of the Insured, arrange for preparing the body or mortal remains of the Insured for local burial or cremation at the place of death. The Insurer shall pay for the expenses incurred in the services so arranged by the Medical Assistance Provider but in no event exceeding VND200,000,000 per Insured. The Medical Assistance Provider shall be contacted in advance for the arrangement.

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

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

Return of Minor Child
The return of minor child (aged below 18 years old and unmarried) to the Home Country or Usual Country of Residence if he/she is left unattended as a result of the accompanying insured Adult's Emergency Medical Evacuation. The Insured/The representative of the Insured must contact to the Insurer or The Medical Assistance Provider in advance for the approval and arrangement of transportation.

2. Insurance Policy

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

(i) The Endorsements;
(ii) the Certificate;
(iii) the Policy Schedule;
(iv) this Liberty HealthCare Insurance Policy Wording; and
(v) the Benefit Plan.

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

3. Insurance Effectiveness

Subject to the terms and condition of the Insurance Policy, the Insurer's liability to an Insured under the Insurance Policy shall become effective from the commencement of the Insured Period with respect to such Insured, and will remain effective until the end of the Insured Period of such Insured unless otherwise terminated in accordance with the Insurance Policy.

4. Termination of Benefits

4.1 For individual insurance policy

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

4.2 For Group Policy

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

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

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

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

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

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

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

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

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

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

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

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

5. Termination of Insurance Policy

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

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

In all cases, the Policy Insurance is subject to a minimum premium of VND2,000,000 plus tax (if any) for each Insurance Policy or Endorsement. If the premium is to be returned by bank transfer as requested by the Policyholder, all bank charges are payable by the Policyholder.

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

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

6. Co-ordination of Benefits/Other Insurance

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

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

7. Governing Law

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

8. Prevailing Language

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

PART II – INSURED OBJECTIVES

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

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

PART III – SCOPE OF INSURANCE

1. Coverage of Insurance

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

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. Representative/Inheritance

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

4. Consideration for Insurance for Pre-existing Conditions

Unless the Insurer agrees otherwise in the Endorsement, all IPre-existing conditions will not be covered in accordance with the Insurance Policy.

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

PART IV - EXCLUSIONS

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

(1) Treatments of mental illness, behavioural, psychiatric disorders including but not limited to depression, eating disorder, sleeping disorders or any neuroses and their physiological or psychosomatic manifestations except pre-authorized hospitalisation treatment.

(2) Services or treatments at any institution that is mainly a long-term care facility, spa, hydro-clinic, or sanatorium and that provides only incidental or limited hospital services.

(3) Tests and treatments relating to birth defects and congenital illnesses. Birth defects are deemed to include hereditary conditions. Treatment for learning problems or speech defects of a dependent child. Foetal surgery when still being in the womb.

(4) Tests and treatments relating to infertility, contraception, sterilisation, inducing pregnancy or any abortion, caesarean section performed due to non-medical reason and the consequences of treatments.

(5) Tests and treatments not undertaken by or on the recommendation of an authorized medical facility or which is reasonably considered by the Insurer's medical advisors as not medically necessary.

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

(7) Routine eye and ear examinations, including the cost of spectacles, contact lenses, correction of eye visions or eye refraction, including but not limited to myopia, hyperopia and presbyopia.

(8) Treatments arising out of addictive conditions/disorders such as abuse of drug or alcohol.

(9) Treatments for self-inflicted injury or suicide.

(10) Routine medical examinations and preventive treatment (including vaccinations or inoculations, preventative medicine and test), unless otherwise explicitly provided and endorsed on the Policy Schedule.

(11) Tests and medical expenses not incident to treatment or diagnosis of a covered Sickness or Injury; or any treatment which is not medically necessary according to professional advice of an Doctor engaged by the Insurer for such advice. Treatment by a family member. The Policyholder/Insured Member as doctor treats themselves or dependants in the hospitals where they are working.

(12) Prostheses, corrective devices and medical appliances, as well as artificial heart implantation, mono or bi-ventricular assist device(s), except standard surgical implants. Charges for the procurement or use of special braces, appliances, wheel chairs, crutches or other equipment.

(13) Cosmetic surgery for purposes of beautification or plastic surgery. Treatment related to or arising from the removal of healthy, surplus or fat issue including but not limited to treatment of obesity or and diet program to weight loss or other treatment undergone for cosmetic or psychological reasons, including but not limited to hair loss treatment, freckle, hyperpigmentation.

(14) Maternity Care. No benefit shall be payable, unless otherwise explicitly provided and endorsed in the Policy Schedule.

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

(16) Tests and treatments of sexually transmitted diseases and treatment of impotence or any related condition.

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

(18) Acquisition of the organ itself and all expenses incurred by the donor.

(19) 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 qualified period has been fulfilled and subject to the sub limit as stated in the Schedule.

(20) Pre-Existing Conditions or any related, associated or consequential disabilities, unless disclosed to and accepted in writing by the Insurer.

(21) Charges exceeding the reasonable and customary range as defined.

(22) Non-approved Elective Treatment (refer to Definition).

(23) 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.

(24) Experimental and yet to be scientifically proven medical treatment.

(25) Treatments for Injury or Sickness incurred while serving as a member of police or military forces or as a result of performing Class III or IV occupation (unless otherwise agreed in advance by the Insurer).

(26) Treatments for injuries or diseases sustained while participating in (including any practice or conditioning program for) contest or competition including but not limited to the following activities: Racing of any form other than on foot including but not limited to auto or car racing, professional sport, contact sport, motorcycle racing, powerboat racing, and dressage competition; skydiving, parasailing, hang-gliding, flying (other than as a fare-paying passenger on a duly licensed commercial aircraft), caving, rock or mountain climbing (with or without the use of ropes or other equipment), bun gee jumping, scuba diving, polo, steeple chasing, martial arts, ballooning, and any organized sports undertaken on a sponsored basis, or any other hazardous activity, unless declared to and accepted by the Insurer or deliberate exposure to exceptional danger (except in an effort to save human life);

(27) Tests and treatments for sleep-related breathing disorders, including snoring, fatigue, jet lag, sonasthenia or work-related stress or any Related Condition.

(28) Dietary supplements and substances which are available naturally and that can be purchased without prescription, including but not limited to vitamins, minerals, supplements, food for medical purposes, etc..

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

(30) Treatment for Injury or Sickness resulting from war, invasion, acts of foreign enemies, hostilities or warlike operations (whether war be declared or not), civil war, rebellion, revolution, insurrection, civil commotion assuming the proportions of or amounting to an uprising, military or usurped power.

(31) Treatment for Injury or Sickness resulting from Terrorist Act.

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

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

(34) Injury sustained or disease contracted as a direct result of participation in illegal acts; such acts include but are not limited to burglary, robbery, failure to obey an order given by an officer of the law, drug abuse, use of explosives or incendiary devices (unless permit has been issued), assault and battery, etc.

(35) Sterm Cell Therapy except bone marrow transplant.

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

(37) 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.

(38) The Insurer shall not provide cover and shall not be liable to pay any claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such claim or provision of such benefit would expose the 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 State of America.

(39) Other exclusions as agreed with the Insured and as set forth in the Policy Schedule.

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

1. Conditions Precedent to Liability

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

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

(b) the complete truth and accuracy of all statements and declarations made in respect to any claim made against the Insurer by the Policyholder or any Insured under the Insurance Policy.

(c) the due and fully compliance with all the terms and conditions of the Insurance Policy insofar as they relate to anything to be done, restrained from doing or to be complied with by the Policyholder and/or any Insured.

2. Pre-Authorization Requirement

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

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

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

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

such Elective Treatment has been accepted by the Company..

3. Data Required

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

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

4. Eligibility

1. For Individual policy:

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

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

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

The coverage under the Insurance Policy is only applicable for those holding Class I and II occupations, unless agreed otherwise with the Insured and by the Insurer in writing. The Insured is required to inform the Insurer as soon as the occupation changes to Class III or IV. Failure to inform may result in a claim being denied or benefits terminated by the Insurer.

2. For Group policy:

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

New-born children shall be eligible for insurance 15 days after the date of birth or 15 days after discharge from Hospital where the birth takes place, whichever is the later, upon submission by the Policyholder

of an application for insurance, subject to satisfactory evidence of good health and acceptance by the Insurer.

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

The maximum age for enrolment is 64.

The coverage under the Insurance Policy is only applicable for those holding Class I and II occupations, unless otherwise agreed otherwise by the Insured and by the Insurer in writing. The Insured is required to inform the Insurer as soon as the occupation changes to Class III or IV. Failure to inform may result in a claim being denied or benefits terminated by the Insurer.

5. Examination

The Insurer shall have the right and opportunity through his medical representative to examine any Insured Member whenever and as often as may be reasonably required within the duration of any claim. In addition the Insurer shall have the right to require an autopsy in the case of death, where this is not forbidden by law or religious belief.

6. Medical Evaluation

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

7. Reasonable Precautions and Material Changes

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

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

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

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

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

As a condition precedent to liability under this Policy, the Insurer must be informed immediately in writing of any change in the Usual Country of Residence of the Policyholder or any Insured Member. A change in the Usual Country of Residence shall be deemed to mean the Insured Member ceasing to reside in his Usual Country of Residence, or intending to be relocating in another country for a period in excess of 12 weeks.

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

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

PART VI - CLAIMS PROCEDURE

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

Option 1 – Self-Paid
If the Insured choose the self-paid option, the Insured shall notify in writing to the 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;
- the test results;
- The prescription;
- Supporting invoices and receipts.
  Photocopies are not acceptable. The claim dossier must be fully submitted to the Company within the time limit as provided for by law.

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

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

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

Option 2 – Direct Billing Service
Direct Billing Service is a cashless service provided by the Insurer that allows Insured to receive General Outpatient Services and Hospital treatment at the Insurer’s appointed healthcare providers. For elective hospital treatment, Insured has to follow the “Elective Treatment-Pre-authorization requirement”. The Insurer will issue a Letter of Guarantee for Payment if the medical condition is covered by the Insurance Policy.

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

PARTY VII – FRAUD AND HANDLING METHODS

1. For individual policy

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

2. For group policy

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

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

PART VIII - PREMIUM WARRANTY

1. It is hereby declared and agreed that it is a condition precedent to liability under the Schedule, the Renewal Schedule and Endorsement(s) that any premium due must be paid and duly received in full by the Company, the registered broker or registered agent through whom this Policy was effected:

   (a) unless the below Item (b) is applicable, with respect to the Schedule and the Renewal Schedule,

      (i) within fifteen (15) days from the INCEPTION date of the cover under the Schedule or the Renewal Schedule; or

      (ii) where the Insured Person requests, the Company may accept to extend the period of payment by issuing the Endorsement and sending to the Insured, within fifteen (15) days from the INCEPTION date of the Schedule or the Renewal Schedule with the extended period of payment as stipulated in the Endorsement, subject that total period of payment including extended period will not more than thirty (30) days from the INCEPTION date of the Schedule or the Renewal Schedule; or

   (b) with respect to the Schedule or the Renewal Schedule, where the Company has allowed payment of the policy premium in installments:

      (i) within fifteen (15) days from the INCEPTION date of the cover under the Schedule or the Renewal Schedule for the first installment and thereafter from the agreed dates on which the subsequent installments are due; or

   (c) with respect to the Endorsement(s) which may increase premium:

      (i) unless the below item (ii) , (iii) and (iv) is applicable, within fifteen (15) days from the INCEPTION date(s) of the Endorsement(s)

      (ii) unless item (iii) is applicable, where the Insured requests, the Company may accept to extend the period of payment by issuing the Endorsement and sending to the Insured, within fifteen (15) days from the INCEPTION date of the Endorsement with the extended period of payment as stipulated in the Endorsement, subject that total period of payment including extended period will not more than thirty (30) days from the INCEPTION date of the Schedule or the Renewal Schedule; or

      (iii) if the period of payment under item (i) or (ii) above extend past the due date of the latest installments of the Schedule (for policies on a premium installment plan), the premium must be paid no later than the due date of the latest installment of the Schedule.

(iv) unless above item (i), (ii) and (iii) is applicable, the premium will be paid immediately to the Insurer when the period of insurance is less than thirty (30) days.

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

3. In the event the accumulated claim amounts of the Schedule or the Renewal Schedule and Endorsements exceed the outstanding premiums, all the outstanding premiums will be paid immediately to the Insurer.