

COMPREHENSIVE HEALTHCARE INSURANCE POLICY WORDING (NEW PAC)

(Issued in accordance with Decision No. 49/2025-QĐHN-TMIV dated 12 December, 2025
by General Director of Tokio Marine Insurance Vietnam Company Limited)

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SECTION I - DEFINITIONS

Certain words and expressions in this Policy Wording shall be defined as below:

1. The Insured

Means the person whose life and health are covered under the Policy and whose name is included in the list of Insured attached to the Policy or specified in the Certificate of Insurance or Policy Schedule, or any Endorsement and approved by the Company.

2. The Policyholder

Means an entity legally established and operating in Vietnam, or an individual in Vietnam aged 18 years or older with full civil capacity at the time of entering into the policy, who pays the insurance premium and is stated as the policyholder in the Policy, the Schedule and/or Insurance Certificate or Endorsement (if any). The policyholder must have insurable interests in relation to the insured. For Group policy, the Policyholder is an individual who legally and validly represents the group of individuals participating in the Group policy.

3. Dependents

Mean the Insured's legal spouse, parents, and children. The Insured's children shall be from 15 days old up to 18 years old or 24 years old if they are enrolled in a vocational training or higher education program and have not been married since the start date of the first insurance period or any subsequent Renewal Date.

Dependents may include other persons as agreed by the Company and the Policyholder as specified in the Schedule or any Endorsements. All Dependents shall be named in the List of Insured.

4. The Beneficiary

Means persons, organisation designated by the policyholder or the insured to receive all or part of the benefits in the policy. The beneficiary is named in the Application Form, the Policy. In the absence of a designated Beneficiary, the Company will settle in accordance with current legal regulations on inheritance.

5. The Company

Means Tokio Marine Vietnam Insurance Company Limited.

6. Policy

Means the written agreement signed between the Policyholder and the Company whereby the Policyholder shall pay the premium payable and the Company shall pay the indemnity to Beneficiary or compensate the insured when occurring an insured event. The Schedule, Table of Benefits, Policy Wording and any Endorsements attached or issued from time to time shall be read as one Policy.

7. Table of Benefits

Means the table shows the various benefits available to the Insured and specifies the respective Sum Insured or limit of liability applicable to each benefit.

8. The start date of the first insurance period

Means the first day of a continuous and uninterrupted Period of Insurance during which the Insured is insured under the Policy or Certificate of Insurance and any subsequent Renewal Policy, unless there is any other agreement.

9. Date of Occurrence

In case of an Accident, the Date of Occurrence is the date such Accident occurs. In case of any Sickness, the Date of Occurrence is the date medical services are provided, or the first day of Hospitalization, whichever comes first. Providing that, the date of medical service is supplied must be within the insurance period.

10. Waiting Period

Means the period during which the relevant occurrence are not payable by the Company. Waiting period is applied from the Commencement date of the first insurance period.

The Waiting Period applicable to any benefit shall be specified in the Schedule or Certificate or any Endorsements.

11. Period of Insurance

The period of insurance is stated in the Schedule and inclusive of both the inception date and expiry date of this period of insurance.

12. Accident

Means any sudden or unforeseeable event, caused by an external, violent, and visible force during the Period of Insurance impacting to the Insured's body and occurring beyond the Insured's control.

Suffocation as a result of inhalation of smoke or toxic fumes or gases and drowning shall be deemed an Accident under this Policy, provided that such Accident is not caused by the Insured's intentional acts.

13. Injury

Means any injury sustained during the Period of Insurance solely resulted from an Accident other than a Sickness, health impairment, neurological deterioration or degeneration over time.

14. Total permanent disablement

Means an injury caused:

- The insured suffers completely loss, paralyzed, and cannot recover the function of: both hands; or both legs; or one hand and one leg; or both eyes; or one hand and one eye; or one leg and one eye. In this case, total loss, complete paralyzed, and irrecoverable function of the hand is counted from the wrist upwards; complete loss, complete paralysis, and irreversible loss of leg function from the ankle up; complete and irreversible loss of eye function is understood as total loss or complete blindness and other cases as listed in the attached Table of compensation.
- The insured suffers from a physical injury of 81% or more, as confirmed by a medical authority or the Provincial Medical Council or a legal medical appraisal organization approved by the Company.

According to this Policy, the Total permanent disability can only be determined after the treatment of the bodily injury has been completed.

15. Partial Permanent Disablement

"This English version is for reference only"

Means any Injury that causes one or more body parts of the Insured can not recover normal function and has no prospect of improvement. Partial Permanent Disablement ratings are specified in Appendix I: Table of Compensation and shall be used as the basis for the Company to make payment of the indemnity.

16. Temporary Disablement

Means any body Injury that renders the Insured unable to perform part or all of his/her daily work for a certain period.

17. Sickness

Means a physical health condition marked by a pathological deviation from normal healthy condition manifested by symptoms or syndromes as diagnosed by the Doctor.

18. Hospital

Means a legally established and legally operating medical examination and treatment facility, which:

- has capabilities and facilities for diagnosis, treatment and surgery;
- provides certain conditions for inpatient treatment and uses health monitoring system for inpatient;

Hospitals do not include medical facilities with the main purpose of health convalescence & rehabilitation, massage, or a special place with the sole purpose of serving the elderly or helping with alcohol and drug stimulants addiction, or treating mental disorders, or leprosy treatment.

19. Medical Facility

Means a medical examination and treatment facility, which is legally established and legally operating healthcare provider, is licensed to provide inpatient and/or outpatient treatment, and does not include medical facilities with the main purpose of health convalescence & rehabilitation, massage, or a special place with the sole purpose of serving the elderly or helping with alcohol and drug stimulants addiction, or treating mental disorders.

20. Doctor

A legally licensed Doctor is recognized by the law of the country where treatment is provided, and practices within the scope of his/her licensing and trained education in rendering such treatment, excluding such Doctor is the Insured himself/herself, or an immediate family member (spouse, parent/child or sibling) of the Insured. A Doctor may be recognized as a Medical Consultant or Specialist.

21. Emergency Treatment

Means an urgent treatment at a Medical Facility following an Accident or a sign of Sickness may result in a Serious Medical Condition of the Insured necessitating urgent treatment in an emergency room and incurring room and board charges, provided that medical documents are stamped and certified by the Medical Facility.

Where the Insured is treated at the emergency unit solely for the reason that the Medical Facility is out of its working hours, such treatment shall be deemed as Outpatient Treatment.

22. Serious Medical Condition

Means a condition where the patient has any life-threatening disease, injury or disorder, with a high risk of death if no Emergency treatment is provided.

23. Hospitalization

Means an admission to a Hospital as an inpatient for at least 24 hours as prescribed in writing by the Doctor and room and board charges are charged on the Insured by the Hospital. Hospitalization unit is determined as per hospital bed, which is indicated detailed in medical bills or 24 hours in the Discharge Certificate.

24. In-patient Treatment

Means a medical treatment where the Insured admits to and stays on a hospital bed overnight. The Discharge Certificate shall be required to claim for this benefit.

25. Day-patient Treatment

Means a medical treatment where the Insured is required to be confined for any treatment on a hospital bed but is not required to stay at the Hospital overnight or stay at the Hospital overnight but not exceed 24 hours. The Discharge Certificate or medical bills shall be required to claim for this benefit.

26. Out-patient Treatment

Means a medical treatment is provided to the Insured by a legally licensed Medical Facility without Hospitalization for any treatment and/or no room and board charges are incurred like In-patient Treatment or Day-patient Treatment.

27. Reasonable Medical Charges

Means a medically necessary expenses incurred for the diagnosis, monitoring and treatment of a Sickness, Injury or Maternity sustained by the Insured, provided that such expenses are customary, reasonable and/or consistent with the Ministry of Health of Vietnam's guidelines for diagnosis and treatment.

28. Medical Necessity

Means any service or supply provided by a Hospital or Doctor, which is necessary to diagnose or treat Injuries or Sickness and is a service determined that:

- is appropriate and intended for the diagnosis and treatment of any Sickness or Injury; and
- is in accordance with generally accepted medical standards; and
- is not only for the convenience of the Insured or any Doctor; and
- offers and/or means a service level as standard (normally applied for most of patient such as operation, examination fee, diagnostics services), not priority service.

In the case of Hospitalization, this also means that such service is necessary for the treatment of any symptom or medical condition but may not be safely provided in the form of Out-patient Treatment.

29. Prescribed Medicine

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Means a medicine and pharmaceuticals that are sold and used as prescribed by Doctors under applicable laws and exclude supplements, cosmeceuticals, cosmetics, tonics, vitamins and minerals except for the case where any vitamins and minerals are prescribed by Doctors and the cost of such vitamins and minerals is not greater than that Medicine costs for treatment.

30. Surgery

Means a scientific method to treat any Injury or Sickness, is undertaken by a legally licensed surgeon through manual operations using medical instruments or equipment at Hospitals, including but not limited to laparoscopic and laser surgery, extracorporeal lithotripsy and endoscopic procedures using medical instruments and equipment at Medical Facilities. Surgery shall be determined based on the Ministry of Health of Vietnam's applicable List of Surgical Procedures.

For the purpose of this Policy Wording, Surgery also includes endoscopic procedures performed to treat any Sickness (but excludes endoscopic procedures performed for the diagnosis of gastrointestinal conditions).

31. Organ Transplantation

Means a Surgery performed to transplant heart, lungs, liver, pancreas, kidneys or marrowbone for Insured and it is performed at a Hospital by a qualified surgeons. The cost of acquisition of the organ and all expenses incurred by the donor shall not be covered under this Policy Wording.

32. Medical Appliance or Part to assist in the treatment

Means the following medical parts/equipment/instruments:

- Mobility aids: Crutches, canes, walkers, manual wheelchairs, and non-motorized trolleys.
- Artificial replacement material implanted or incorporated into a body: Means any artificial material implanted or incorporated into the Insured's body during a surgery to repair or replace a body part, including stents, heart valves, balloons, discs, screws, slings, pacemakers, artificial hip, knee, artificial joint fluid, crystalline lens and other artificial materials.
- Other specialized medical equipment and instruments which are separately used for each individuals during Surgery only include cartilage blades, planers, ultrasound blades, scalpels used in Longo's hemorrhoidectomy, stone extraction baskets in lithotripsy and other similar equipment.
- Prescription glasses, neck brace.

33. Prostheses

Means an artificial devices that replace body parts as prescribed by the Doctor as part of the treatment of the Insured's any Injury or Sickness and include dentures, artificial limbs, artificial lenses and other prostheses.

34. Rehabilitation Treatment

Means a part of any inpatient treatment program under the Doctor's supervision, which shall be a recognized rehabilitation treatment program and is aimed at restoring the normal status and/or function after an acute injury or condition. Rehabilitation treatment consists of medical therapy, Surgery and any other techniques, including physiotherapy.

35. One Visit

Means a visit when a patient is clinically examined by a Doctor, undergoes laboratory tests, diagnostic imaging, functional examination or any other procedures and receives any prescribed medicine at a Medical Facility for the purpose of diagnosis and treatment.

If more than one Doctor involves in the consultation according to the Medical Facility's rules, it is considered one (01) visit.

Where the patient is examined at a department several times a day, it is also considered one visit.

If the patient is required to be examined at other departments (whether prescribed by the attending Doctor or not) at the same Medical Facility, on the same day, it is also considered one visit.

If, due to any objective reasons or professional requirements, such medical examination may not be completed on the first day and shall be continued on the next day, it is also considered one visit.

36. Pre-existing Conditions

Means any Injury or Sickness sustained by the Insured prior to the the start date of the first insurance period and:

- for which treatment has been received for three years prior to the First Effective Date;
- the symptoms of which have appeared or occurred before the start date of the first insurance period and the Insured was aware or should have been aware, whether the Insured was actually examined and treated or not.

37. Special Diseases

Means tumors of all types, blood pressure, heart/blood vessels, gastritis/stomach ulcers, Digestive tract inflamamation/ ulcers (stomach, duodenum, intestine, colon, rectum, anal fissure, anal fistula excluding appendicitis, acute enteritis), gallbladder and pancreatic disease, chronic polyarthritis, Deviated nasal septum surgery, gallbladder, pancreatic disease, deviated nasal septum surgery, hepatitis of all types, endometritis, hemorrhoids, stones of all types, cataracts, sinusitis, tonsillitis/ Adenoditis necessitating surgical removal, osteoarthritis, disc herniation, Parkinson's disease, diabetes, bone density/lipid metabolism disorders.

38. Congenital Conditions

Means any genetic condition, birth defect, physical abnormality and/or any other deviation from normal development present at birth of the insured, which may not have been apparent at that time.

39. Physiotherapy

Means a treatment method using physical methods (including using water, air, temperature, power, X-rays, ultraviolet rays, infrared rays, ultrasound, radioactive isotopes and manually passive manipulation...) to relieve pain, restore muscle function or normal daily activities of the patient who is an insured member as prescribed by the treating physician (not massage methods of any kind, spa or gait correction exercises).

40. Co-pay

Means the prorated portion of recoverable expenses for which the Insured is liable to pay by himself/herself as agreed by and between the Company and the Policyholder and specified in the Schedule. In respect of each claim, the co-pay is calculated as a percentage (%) of the total amount of recoverable expenses or the sub-limit applicable to the relevant benefit, whichever is less. During the Period of Insurance,

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the total amount of recoverable expenses after the application of the copay shall not exceed the sub-limit applicable to the relevant benefit as stated in the Table of Benefits.

The benefits, co-pays and medical facilities where such copays are applied shall be specified in the Schedule.

SECTION II – SCOPE OF COVER

I. PERSONAL ACCIDENT

The Company shall pay the Insured or the Beneficiary the death/permanent disablement benefit and a daily allowance/salary-based allowance and reimburse any reasonable and customary medical charge incurred by the Insured as a result of an Injury due to Accident, which the date of Accident occurs during the Period of Insurance and any consequences of an Accident occurring within 104 weeks from the date of such Accident occurs up to the amount stated in the Table of Benefits.

1. Death & Permanent Disablement due to Accident:

- a. Death & Total Permanent Disablement due to an Accident: 100% of the Sum Insured.
- b. Partial Permanent Disablement: A percentage of the Sum Insured under Appendix I – Table of Compensation.

2. Allowance during injury treatment

Where the Insured sustains any Injury during the Period of Insurance and suffers a Temporary Disablement as a result of such Injury, the Company agrees to pay a salary-based allowance (calculated based on the salary declared by the Policyholder divided by the number of working days) or fixed daily allowance as specified in the Schedule, but always subject to the terms, conditions and exclusions set forth in this Policy.

Date of compensation shall be based on the actual number of days the Insured is absent from work for any treatment for temporary disabilities following the Accident (including Saturday and Sunday if the policyholder declare the number of working days is 30 days unless there is any other agreements on the Summary of the Insurance Contract) and the number of days of treatment as prescribed by the attending Doctor.

The company will cease payment of this benefit immediately upon the death of the insured or upon determination of permanent disability. In case of payment of salary-based allowance, Salary that are based to reimburse to claim amount will be the salary that the insured receive at the time of treatment.

3. Medical Expenses due to an Accident

The Company shall reimburse all actual and reasonable Medical Expenses incurred for any diagnosis and treatment, including the cost of inpatient treatment, surgery, outpatient treatment, medical supplies, and emergency evacuation services (including emergency medical evacuation services by taxi) subject to the limit stated in the Table of Benefits as a result of the same Accident.

II. DEATH / TOTAL PERMANENT DISABLEMENT DUE TO SICKNESS & MATERNITY

The Company shall pay the Sum Insured in full to the Beneficiary in the event of the Insured's death or Total Permanent Disablement resulting from a Sickness or Maternity (if stipulated in the Benefit table) and any sudden and unexplained death but not excluded under this Policy provided that the date of death or the date of determination of total permanent disability occurs within the insurance period (unless otherwise specified).

III. HOSPITALIZATION AND SURGICAL DUE TO SICKNESS & MATERNITY

The Company shall pay all Reasonable Medical Expenses incurred as a result of a Sickness or Maternity necessitating Hospitalization or Surgery up to the limit specified in the Table of Benefits with the condition that the occurrence date is within insurance period.

1. Hospitalization charges

If the Insured is confined Hospitalization for Inpatient Treatment or Day-patient Treatment, the Company shall pay the Insured the cost of any reasonable and customary charges or Prescribed Medicine, including the following costs and expenses:

- a. Room & board charges and meals according to the Hospital's treatment standards, excluding VIP room, deluxe room and "phòng bao" (a room with two or more beds that is used by a registered patient) unless there is any other agreement in the policy;
- b. Administrative costs, costs of blood and plasma;
- c. Prescribed Medicine and pharmaceuticals used during the Hospitalization;
- d. Intravenous infusion;
- e. Regular bandages, splints and casts;
- f. Medical supplies, consumables;
- g. Laboratory tests, electrocardiograms or diagnostic imaging tests such as X-rays, MRI, CT and PET scans (these testing costs shall be prescribed by the attending Doctor as a measure necessary to evaluate the medical condition and shall be included in Hospitalization Expenses);
- h. Hospital accommodation costs incurred by the Insured's legal parent or guardian means the cost of an extra bed in the same room where the Insured is under 18 years old;

2. Intensive Care Unit

The Company shall pay any costs and expenses related to patient care at the ICU (Intensive Care Unit), HDU (High Dependency Unit), ITU (Intensive Treatment Unit) or CCU (Coronary Care Unit) as directed by the attending Doctor during the Insured's Hospitalization.

3. Surgery Expenses

The Company shall pay any medical expenses related to any Inpatient, Day-patient or Outpatient Surgery, including the cost of medicines used in such Surgery, medical supplies and equipment necessary for such Surgery, operating room costs, surgeons' fees, anesthesia, post-operative recovery and redone surgery costs. Surgical costs do not include diagnostic procedures.

4. Extended Benefits, if stipulated in the Benefit table (Not applicable to Day-patient Treatment and Maternity Care)

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a. Emergency Medical Evacuation

The Company shall pay any expenses actually and reasonably incurred for:

- The use of a Medical Facility's ambulance services or 115 emergency transportation services in the event that the Insured is in a Serious Medical Condition following a Sickness and needs to be transferred to an appropriate Medical Facility for Emergency Treatment.
- The use of a taxi where the Insured is in a Serious Medical Condition following a Sickness and needs to be transferred to an appropriate Medical Facility for Emergency Treatment up to the amount stated in the Table of Benefits.
- The transportation of the Insured where he/she needs to be transferred to another Hospital: The Company shall pay the actual and reasonable cost of transporting the Insured from one Hospital to another within the territory of Vietnam if this is necessary for his/her treatment as prescribed by the attending Doctor.

b. Emergency Treatment

The Company shall pay for any emergency medical services rendered at the emergency department of a Hospital or Medical Facility if the Insured is in a Serious Medical Condition following a Sickness.

c. Organ Transplantation

The Company shall reimburse the cost of consultation, anesthesia, resuscitation, Surgery and Hospitalization if the Insured undergoes an Organ Transplantation at a Hospital.

d. Rehabilitation Treatment

The Company shall pay the cost of any Rehabilitation Treatment as part of an inpatient treatment program in case of Hospitalization and/or Surgery following a Sickness.

e. Pre-Hospitalization Treatment

The Company shall reimburse any medical expenses reasonably incurred for the Insured's most recent examination and testing, such as X-rays, CT scans and diagnostic imaging tests as prescribed by the attending Doctor and directly related to a Sickness necessitating Hospitalization for Inpatient Treatment and monitoring, provided that such examination and testing shall be performed within the period specified in the Table of Benefits.

f. Post-Hospitalization Treatment

The Company shall pay for any follow-up treatment prescribed by the Insured's attending Doctor immediately following the discharge from the Hospital, provided that the period of such follow-up treatment shall not exceed the number of days stated in the Table of Benefits and such follow-up treatment is directly related to the previous Inpatient Treatment of the same Sickness. These costs include the cost of any follow-up examination, testing and Prescribed Medicine.

g. Home Nursing

The Company shall pay the cost of home nursing services performed by a nurse, who is working at a legally licensed medical facilities, at the Insured's home immediately following discharge from the Hospital. These services shall be prescribed by the attending Doctor. This cover shall be available for the maximum number of days set out in the Table of Benefits, provided that the Insured shall have been hospitalized for at least seven (7) days.

h. Daily Allowance

The Company shall pay the amount stated in the Table of Benefits in respect of each day of the Insured's Hospitalization for Inpatient Treatment, provided that there shall be a Discharge Certificate or medical record indicating the period of treatment or the statement of hospital fees, including room and board charges.

i. Burial Allowance

In case of the Insured's death as a consequence of a coverable Sickness, the Company shall pay the burial allowance stated in the Table of Benefits.

5. Extended Benefit Maternity Care

a. Normal delivery

The Company shall reimburse any medical expenses incurred for the Insured's natural childbirth, including but not limited to delivery, general hospital fees and specialists' fees.

b. Caesarean

The Company shall reimburse any medical expenses as prescribed by a Doctor and incurred for the Insured's Caesarean, including and not limited to the following expenses: Caesarean delivery, general hospital fees and specialists' fees. Caesarean may only be covered if prescribed by a Doctor as necessary for a difficult or failed natural childbirth and Caesarean at the Insured's request or redone Cesarean following the Insured's requested Cesarean shall be excluded.

c. Maternity complications

The Company shall reimburse any medical expenses incurred for the Insured's Inpatient Treatment as a result of a pregnancy or childbirth complication necessitating obstetric procedures for treatment as prescribed by the attending Doctor. Maternity complications include and are not limited to the following:

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- Abnormalities in pregnancy that need to be treated as prescribed by the Doctor: fetal growth arrest, stillbirth, threatened miscarriage, miscarriage, molar pregnancy, ectopic pregnancy, placenta previa, placental abruption, threatened premature birth, cesarean scar pregnancy and abortion due to congenital conditions or to protect the mother's life.
- Diseases during pregnancy: gestational diabetes, gestational hypertension and embryotoxicity, excluding profuse and severe vomiting.
- Obstetric complications: postpartum infections of all types, preeclampsia, eclampsia, threatened uterine rupture, uterine rupture, hemorrhage, acute pulmonary edema, amniotic fluid embolism and placental remnants after delivery.
- Any other maternity complications necessitating Hospitalization or Surgery as prescribed by the Doctor.
- Any maternity complications of these above results.

d. Newborn baby care

The Company shall reimburse the Insured for Newborn Care Costs, including the cost of pediatric medications, screening tests, vaccinations and newborn hygiene and any medical expenses incurred for the newborn's Inpatient Treatment, provided that such costs and expenses are related to pathological symptoms that are present at birth or manifest within seven (07) days after birth.

e. Pregnancy check up

The Company shall reimburse the Insured for the cost of prenatal and postnatal examination and follow-up examination, medications prescribed by a physician, including vitamins for the Insured up to the limit stated in the Table of Benefits.

The Company shall not pay the cost of prenatal screening tests for early detection of fetal anomalies, genetic disorders or intellectual impairment such as fetal anomaly screening tests (the Double Test and Triple Test), and chromosome analysis tests.

SECTION III – GENERAL EXCLUSIONS

(Applicable to the entire Policy)

The Company shall have no responsibility to pay for the following treatment, medical conditions and activities and any costs or expenses as a result of, or in connection with such treatment, medical conditions and activities are excluded under this Policy:

1. Any willful act of the Insured or the Beneficiary;
2. Any self-inflicted Injury or Sickness, suicide or attempted suicide or the Insured's intentional exposure to danger (except for saving lives);
3. The Insured's violation of applicable laws, violation of regulations on labor safety or violation of traffic laws, including but not limited to driving a vehicle without a valid driver's license (where a driver's license is required for such vehicle), racing (either legal or illegal), driving on restricted roads or in restricted areas or passing other vehicles in no-passing zones, driving in the wrong direction of one-way streets or of two-way roads separated by concrete median barriers, running a red light or failing to obey traffic controllers' instructions, driving at night without lights as prescribed or exceeding the regulated speed. Where the Insured is tested with a blood or breath alcohol content while driving, this exclusion applies only when the alcohol content is over 50 milligrams per 100 milliliters of blood or 0.25 milligrams per one liter of exhaled air;
4. Treatment of alcoholism, drug addiction, or use, abuse or addiction of any substance and any Injury or Sickness arising directly or indirectly from such use of alcoholism, drug or any substance;
5. Any Outpatient, Inpatient, Day-patient Treatment related to dental care. This exclusion shall not apply to the dental care benefits listed in the Table of Benefits; emergency treatment of any Injury of natural teeth following an Accident, provided that such Injury is not directly or indirectly caused by biting or chewing;
6. The Insured's act of fighting (unless such act can be proved that it is only for legitimate self-defense);
7. Any treatment or medication not prescribed by a Doctor;
8. Participation in air transport activities (other than as a fare-paying passenger) or participation in military maneuvers or training, or combats of armed forces;
9. Acts of God such as earthquakes, volcanic activities, tsunamis and radioactive contamination;
10. War, civil war, strike, terrorism, riot, civil commotion, rebellion, civil activities or any act of any person acting on or on behalf of or in connection with any organization actively directed towards the overthrow or to the influencing of any government or ruling body by violence;
11. Training for any professional sports or participation in professional sports competitions;
12. The Insured's participation in cave exploration, mountaineering, rock climbing, potholing, adventure skydiving, parachuting, bungee jumping, hot air ballooning, roller-coaster riding, deep-sea diving, water sports activities that require the use of compressed air or oxygen, road racing, racing of any kind by any motor vehicle or equipment, and any organized and sponsored professional sporting activity, or as a result of any activity required from or a ship or oil rig platform, or at a similar offshore location;
13. Tuberculosis; malaria; leprosy; occupational diseases;
14. Sexually transmitted diseases (including the following diseases: Chancroid, granuloma inguinale, Gonorrhoea, Syphilis, Tinea cruris, Genital Herpes, Genital warts, Cock's comb disease, Genital HPV, Molluscum contagiosum, Sexually transmitted parasitic diseases, Chlamydia, pubic lice (also known as crab lice), flagellate, Lymphoma of the pelvis (or Genital Lymphoma), Cytomegalovirus infection, Sickness associated with the human immunodeficiency virus (HIV), including AIDS-related syndromes and/or any complications or transformations;
15. Treatment of and/or surgery for Congenital conditions, genetic disorders, any complications or consequences related thereto and surgical indications prior to the inception date, including but not limited to congenital heart diseases, Down syndrome, cleft lips, cleft palates, hydrocephalus, anal stenosis, phimosis and congenital deviated septums;
16. Screening test and medical check-ups, including gynecological/ andrological exams (however, gynecological/ andrological exams for the purpose of medical treatment are covered under this insurance), periodical tests, well-baby exams, all forms of vaccination, vaccines

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(not applicable for tetanus and rabies vaccination after accident) and preventive drugs, periodical antenatal check-ups. Exclude ultrasounds and tests that are unrelated or inappropriate to the final diagnosis, as well as cancer screening tests that yielded negative results for cancer.

17. Normal vision and hearing screening tests, treatment of natural/non-pathological hearing and vision impairment (such as refractive errors: nearsightedness, farsightedness and astigmatism) and any Corrective and Restorative Surgery for hearing and vision degeneration, cataracts due to natural degeneration/aging;

18. Treatment or Surgery at the Insured's request not related to any prescribed treatment or Surgery, medical services including examination, surgery/VIP, as requested by the Insured (except for examination costs at public hospitals and public medical facilities), conventional treatment prescribed by the Ministry of Health of Vietnam or the foreign country (including Caesarean at the request of the Insured or his/her representative);

19. Plastic Surgery or examination or treatment and any Complications of Plastic Surgery or treatment, Orthopedic Surgery or Rehabilitation Treatment that is not a follow-up treatment to a Covered Sickness or Injury;

20. Cosmetic treatments, including treatment of hyperpigmentation (melasma), acnes (excluding warts), pimples, or hair loss, etc. are excluded under the Outpatient Treatment benefit. Where the Insured suffers from these conditions and needs Inpatient Treatment, the Inpatient Treatment due to Sickness benefit shall be payable;

21. Any costs and expenses incurred for the supply, maintenance and repair of Medical Aids, orthopedic devices, hearing or visual aids, machines, devices or equipment personally used by the Insured for the diagnosis of diseases or assistance in medical treatment and Prostheses. Surgical aids including discs and screws, shall be covered under the Medical Expenses due to an Accident benefit.

22. Products are classified as vitamins, minerals, nutritional/nutrient supplements and organic substances, dietary supplements, cosmetics, unless such vitamins and minerals are prescribed for the treatment of vitamin deficiency diseases or any supportive treatment, provided that the cost of such vitamins and minerals is not greater than that of therapeutic medicine;

23. Family planning measures, consequences of any abortion due to psychological or social reasons, infertility treatment, intrauterine insemination, treatment of impotence or erectile dysfunction or gender reassignment and any consequences or complications therefrom;

24. Fertility-related tests or treatments, assisted conception, contraceptives, even if such medications are prescribed for a purpose other than self-contraception or any other any treatment not scientifically recognized, sterilization including any reversal of previous sterilization procedures;

25. Weight control treatment (weight gain or loss), obesity, rickets, malnutrition, treatment of growth retardation, growth control, hormone replacement therapy;

26. Mental illnesses, mental and behavioral disorders, memory impairment, neurasthenia, physical weakness (without a specific pathological cause), fatigue, insomnia (including sleep disorders), nervous tension syndrome (stress), mental retarded, attention deficit disorder, autism, snoring and sleep apnea, fatigue and/or related conditions;

27. Any costs and expenses incurred for acquiring, including donating, receiving, purchasing, transporting and preserving organs for Organ Transplants. However, medical expenses incurred for an Organ Transplantation shall not be reimbursable;

28. Any costs and expenses related to the blood regeneration system such as kidney dialysis, hemodiafiltration, exchange transfusion and hemodialysis;

29. Any experimental treatment or treatment not scientifically recognized;

30. Treatment at a Medical Facility that is not licensed to provide medical examination and treatment and/or fails to provide financial documents/invoices as prescribed by applicable laws or regulations treatment at a medical facility with a license to operate medical examination and treatment and failure to provide financial documents/invoices as prescribed by law;

31. Special Disease, Pre-Existing Conditions and Maternity Care during the Waiting Period;

32. Any Injury caused by food and drink poisoning;

33. Any Injury caused by the performance of police or military service;

34. Any costs or expenses related to Surgery and treatment of Injuries and Sickness by stem cell transplantation, such as the cost of extraction, processing and transplantation, post-transplantation maintenance treatment, consequences of this treatment method;

35. Outpatient Treatment services other than those resulting from an Accident. This exclusion shall not apply if the "Outpatient Treatment" optional benefit is selected.

36. Cancer.

SECTION IV – GENERAL CONDITIONS

1. Entire Agreement

The Policy Wording, Policy Schedule, certificate, proposal & declaration, quotation, and endorsements shall be read as one contract and these policy documents must be read in conjunction with one another.

Any change of terms and conditions requested by the Policyholder/Insured shall be valid upon the approval by the Company's authorized person in form of endorsement issued and/or intended to issued and attached, and/or intended to be attached to the Policy by the Company.

If any word or expression to which a specific meaning has been ascribed in any part of the Policy shall bear such meaning wherever it may appear. In case of a conflict of terms, conditions, and expression, the latest agreement in writing between the Company and the Policy holder shall prevail unless otherwise agreed between two parties on solving such a conflict.

2. Geographical Scope

This Policy covers any costs and expenses related to an Injury, Sickness or Maternity sustained by the Insured within the territory of Vietnam unless otherwise specified in the Policy Schedule.

3. Eligibility

a. Anyone who meets the following conditions shall be eligible for this insurance:

- Age: From 15 days old to 80 years old (calculated according to the last birthday); and
- Person over 70 years old only is covered provided that he/she has been insured with the Company for at least 2 consecutive years.
- Individual who meets the conditions of a Dependent as defined in the Policy Schedule.

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- b. The Company shall not provide cover and/or shall not be liable to:
 - Persons suffering from mental illness, down syndrome, or leprosy;
 - Persons with a permanent disablement rating or loss of work ability 50% or more (only applicable to insured joining at the first year);
 - Persons are under inpatient treatment for accident or disease (only applicable to insured joining at the first year);
 - At the time of renewal, the Insured is over 80 years old.
- c. If the Company may discover the ineligibility after the inception date, the Company shall have the right to cancel the coverage for such an ineligible person and refund the earned premiums minus policy administration and management fee.

4. Other Insurance

If at the time a claim is made under this insurance, other insurance exists that would cover the same loss, damage or expenses, the Insured may choose to claim under either effective policy. Where any medical expenses have been paid under other insurance, this Policy shall only cover any amount unrecoverable by the operation of such other insurance or as otherwise agreed upon in the Schedule.

5. Fraud

Upon the execution of the Policy, the Company shall provide sufficient information related to the Policy, explain the conditions and terms of the Policy to the Policyholder; The Policyholder shall give complete information in connection with the subject matter insured to the Company. The parties shall be liable for the accuracy and truthfulness of such information. The Company shall keep any information provided by the Policyholder confidential.

The Company reserves the right to unilaterally terminate the performance of the Policy and collect the premium corresponding to the time of termination when the Policyholder commits one of the following acts:

- Intentionally providing any fraudulent information when entering into the Policy in order to receive any indemnity or compensation;
- Failing to notify any circumstances that may increase either the insured risk or the Company's liability during the performance of the Policy at the Company's request.

Where the Company intentionally provides any inaccurate information in order to enter into the Policy, the Policyholder has the right to unilaterally terminate the performance of the Policy; The Company shall compensate the Policyholder in respect of any loss caused by the provision of such inaccurate information.

6. Period of Insurance and Waiting Period

The Period of Insurance shall commence from the effective date stated in the Policy. Any benefit shall not be payable until the first premium payment or subsequent premium installments have been made.

No benefit shall be payable during the Waiting Period specified below:

- 30 days from the First Effective Date in case of common Sickness (applicable only to Death/Total Permanent Disablement due to Sickness);
- 90 days from the First Effective Date in case of maternity complications;
- 270 days from the First Effective Date in case of childbirth;
- 365 days from the First Effective Date in case of Pre-Existing Conditions;
- 90 days from the First Effective Date in case of Special Diseases;

If the Insured is to be treated for a pregnancy complication during the 90-day waiting period or gives birth during the 270-day waiting period, the amount payable shall be based on the proportion of the number of days from the start date of the first insurance period to the date of occurrence of the insured event, to 90 days or 270 days, respectively. This provision applies only if stated in the Policy.

7. Policy Termination

Where the termination of the Policy is requested by either party, the requesting party shall notify the other party thereof in writing 30 days in advance from the date it intends to terminate the Policy. Such termination shall be subject to the provisions of the Law on Insurance Business and the Civil Code and shall be either of the following two cases:

- If the Policy is terminated at the Policyholder's request, the Company shall refund 80% of the premium in respect of the unexpired period of insurance, provided that no claim has been made.
- If the Policy is terminated as requested by the Company, the Company shall refund 100% of the premium in respect of the unexpired period of insurance if no claim has been made.

8. Guarantee of Renewal

The Company warrants that this Policy shall be renewed at the expiry of the Period of Insurance subject to fulfillment of the following conditions:

- The Company receives the confirmation of the request for renewal by the expiry date of the Policy at the latest;
- The premium payable in respect of the renewal policy shall be paid on time as specified in the renewal policy or in accordance with applicable laws;
- At the expiry of the Period of Insurance, based on the loss ratio, the Company has the right to adjust the benefits and increase/decrease the premium rate accordingly.

9. Optional Extensions

The Policy also considers the non-application of the Waiting Periods regulated above and/or extension of certain exclusions under SECTION III – GENERAL EXCLUSIONS and/or modification of certain definitions in SECTION I – DEFINITIONS, subject to the Company's approval and the Policyholder's agreement to pay an additional premium (if any) for such extension or modification. Such extension or modification, if any, shall be detailed in the Schedule Policy and any Endorsements.

10. Applicable laws

The Policy shall be construed and governed by the laws of Vietnam.

11. Medical Assessment

The Company reserves the right to request the Insured to undergo certain laboratory tests or medical assessments at its own expense if it is found that a claim is directly or indirectly related to an exclusion. The Insured is obliged to cooperate in such assessment, otherwise, the Company may reject the relevant claim.

In addition, the Company has the right to request that an autopsy be performed in case of death if it does not violate any applicable laws as well as does not affect any beliefs and customs.

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SECTION V – CLAIM PROCEDURE

1. Time Limit for Making Claims

The time limit for making a claim under this Policy shall be one year from the Date of Occurrence of the insured event. The period of force majeure events or other objective obstacles shall not be included in the time limit for making claims.

Where the Policyholder proves that he/she had not been aware of the Date of Occurrence of the insured event, the time limit specified above shall be counted from the date the Insured becomes aware of the Occurrence of the insured event.

2. Claim Documents

To protect the Policyholder/Insured' interests, within 90 days or other period as mutually agreed (if any), from the Date of Occurrence of the insured event, the Policyholder or the Insured shall notify the Company in writing of the event in respect of which a claim may be made.

- a. After a notice of claim is received, the Company shall request the Policyholder or the Insured to provide the following claim documents:
- Fulfilled Claim Form (as per the latest template provided by the Company)
 - Evidenced documents about the eligibility of the Insured: Policy Schedule, Identity Card/ Citizen ID/ Birth Certificate/ The Insured's Passport
 - Evidenced documents about the insured event for which a claim arises: Accident report with confirmation of local authority or policemen where the Insured's accident happened (in case of a serious accident) or Incident report of the Insured (in other cases)
 - Valid invoices, documents, and evidence related to medical examination and treatment (including a detailed list of expenses incurred)

The form and method of providing claim documents and dossiers to the Company will be specified in accordance with the Claim Handling Guidelines which are published on the Company's website or e-commerce application applicable as of the time of claim submission.

- b. If any claim documents are made originally in a foreign language, the Company may request and instruct the Insured to have such documents translated, notarized, certified, or legalized at the Insured's expense to ensure compliance with the law of Vietnam.
- c. The Insured is required to undergo a medical examination upon the reasonable request of and at the expense of the Company whenever deemed necessary. The Company has the right to request an autopsy in the event of death if it does not violate applicable laws and regulations as well as does not affect any folk belief and customs.

3. Claim Settlement

The benefits payable may be paid to the Insured, the Beneficiary or the Insured's legal heir.

All the benefits payable shall be paid in Vietnam Dong.

Any amount payable to the Insured under the Policy shall be paid by the Company to the Insured or the Beneficiary and the receipt of such amount by the Insured or the Beneficiary shall discharge the Company from its liability for the respective claim.

The Insured shall manage any information related to the amount paid in respect of each benefit. The Company shall have no obligation to give notice of the application of the limits of liability under the Policy. Any claim made after the maximum limit of liability has been exhausted shall be rejected.

4. Time limit for claim settlement, and paying insurance proceeds

Unless otherwise agreed, the time limit for settling a claim will be within 15 working days from the date the Company receives a completed and valid claim dossier requesting the indemnity or insurance payment. In case the dossier requires further investigation or verification, the time limit for settling a claim shall be extended and informed to the claimant.

The time limit for paying insurance proceeds: within 5 working days from the date the Company sends a notice on the acceptance of claim payment.

5. Right of Recovery

Where a claim has been paid by the Company or on the Company's behalf and such claim is not covered by this insurance or exceeds the annual aggregate limit specified in the Policy or is in connection with a fraudulent claim, the Company reserves the right to recover any amount paid or overpaid from the Policyholder/the Insured.

6. Time Limit for Filing Lawsuits

The time limit for filing any lawsuit with respect to the Policy shall be three (3) years from the occurrence of the relevant dispute.

SECTION VI – RIGHTS AND OBLIGATIONS OF THE PARTIES

1. Rights and obligations of the Company

- a. Rights of the Company
- To collect the premium payable as agreed in the Policy.
 - To request the Policyholder/the Insured to provide complete and accurate information pertaining to the conclusion and performance of the Policy.
 - To unilaterally cancel the performance of the Policy in accordance with the Law on Insurance Business.
 - To refuse to make payment to the Beneficiary or indemnify the Insured in respect of any event for which the Company is not liable or which is excluded under the Policy.
 - To request the Policyholder to take measures to prevent and reduce losses in accordance with applicable laws and regulations.
 - To have any other rights as prescribed at this Wording and by the current law.
- b. Obligations of the Company
- To explain the terms and conditions of this insurance and the rights and obligations of the Policyholder/the Insured to the Policyholder.

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- To issue the Policy to the Policyholder immediately after the conclusion of the Policy.
- To make timely payment to the Beneficiary or indemnify the Insured upon the occurrence of an insured event.
- To explain in writing the reason for its refusal to make payment to the Beneficiary or to indemnify the Insured.
- Confidentiality of information provided by the Policyholder and the Insured shall be maintained, except where disclosure is required by a competent state authority or upon the consent of the Policyholder or the Insured.
- Retention of insurance contract records shall be carried out in accordance with the provisions of law.
- To have any other obligations as prescribed by the law.

2. Rights and obligations of the Policyholder/the Insured

a. Rights of the Policyholder/the Insured

- To request the Company to explain the terms and conditions of this insurance and issue the Schedule Policy.
- To unilaterally terminate the performance of the Policy if the Company intentionally provides any inaccurate information in order to conclude the Policy or if the Company refuses to reduce the premium in respect of the unexpired Period of Insurance from the time when there is any change in the factors used as the basis for calculating the premium payable, thereby leading to a reduction in the insured risk.
- To request the Company to make payment to the Beneficiary or indemnify the Insured as agreed in the Policy upon the occurrence of an insured event.
- To have any other rights as prescribed by the law.

b. Obligations of the Policyholder/the Insured

- To pay the premium payable in full within the specified time limit and under the terms of payment as agreed in the Schedule Policy;
- To declare any details related to the Policy completely and accurately at the request of the Company;
- To read and fully understand the insurance terms and conditions, the rights and obligations of the Policyholder upon entering into the insurance contract, as well as other contents of the insurance contract.
- To notify any circumstances that may increase the insured risk or the Company's liability during the performance of the Schedule Policy at the Company's request.
- To notify timely the Company of the occurrence of any insured as specified herein.
- To take measures to prevent and reduce losses in accordance with applicable laws.
- To have any other obligations as prescribed by the law.

SECTION VII – DISPUTES RESOLUTION

Any dispute related to this Policy shall be settled by negotiation between the Company and the Policyholder. If both parties fail to amicably negotiate to reach a mutual agreement, then within 30 days from the raising date of such dispute, it shall be referred to the dispute resolution body as mentioned in the Schedule.

SECTION VIII - OPTIONAL BENEFITS

The optional benefits below are payable only if stated in the Policy or Certificate of Insurance or any Endorsements (if any).

OPTIONAL BENEFIT 1: OUTPATIENT TREATMENT DUE TO SICKNESS

In consideration of the Policyholder's payment of an additional premium, the Company agrees to reimburse any Medical Expenses reasonably incurred for Outpatient Treatment subject to the limits specified in the Schedule of Insurance Benefits, provided that the Date of Occurrence of the insured event falls within the Insurance Period:

- a. Medical examination and treatment expenses
 - Cost of medical examination by a Doctor;
 - Cost of Prescribed Medicine;
 - Cost of laboratory tests and diagnostic imaging as prescribed by a physician and deemed necessary for the diagnosis and treatment of the illness.
 - Consumable supplies: cotton, bandages, injection gauze, and infusion sets for cases requiring minor surgery
 - Procedural treatment methods excluding pain relief procedures
- b. Treatment with physical therapy, radiation therapy, heat therapy, thread implantation, light therapy as prescribed by the attending doctors at medical facilities and according to the sub-limits on the Insurance Benefits Table.
- c. Oriental treatment: The Company shall pay the cost of any Oriental treatment as prescribed by the attending Doctor at the Medical Facility subject to the sub-limit specified in the Table of Benefits (Extended Benefits)
- d. Basic dental treatment: (This benefit shall not apply if OPTIONAL BENEFIT 2: Separate Dental Care is selected)

The Company shall pay the following basic dental treatment expenses incurred at the Medical Facility, including:

- Examination and diagnosis;
- Prescribed Medicine;
- Tooth cleaning and polishing;
- X-ray imaging;
- Treatment of gingivitis and periodontitis;
- Normal fillings (using composite, amalgam, Fuji or any equivalent material);
- Root canal treatment;
- Extraction of decayed, impacted or buried teeth or misaligned wisdom teeth, extraction of dental roots or solid odontomas, apicoectomy or root canal treatment (without Surgery);
- Inpatient extraction of teeth is covered under this benefit.

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OPTIONAL BENEFIT 2: BASIC DENTAL CARE 2

The reimbursable expenses are specified in the Basic Dental Care benefit under OPTIONAL BENEFIT 1: OUTPATIENT TREATMENT DUE TO SICKNESS. The sum insured under this benefit shall not be included in the maximum limit applicable to the Outpatient Treatment benefit.

OPTIONAL BENEFIT 3: SPECIAL DENTAL CARE

Option 1: Cover for the cost of dentures for teeth damaged by Accident

This benefit shall be payable only when the Personal Accident benefit is selected and shall not be included in the maximum limit applicable to the Personal Accident benefit.

If an Accident occurs, resulting in any injury to a healthy and natural tooth necessitating dental treatment within seven (7) days from the date of the Accident at a Medical Facility, the Company shall reimburse any covered medical expenses actually incurred in connection with such dental treatment, including the cost of dental care consultation, hemostasis, tooth extraction, root canal removal and dental crowns subject to the maximum limit specified in the Table of Benefits.

The Company shall not reimburse any medical expenses related to the realignment or restoration of teeth, the use of precious metal materials or orthodontic dental treatment of any kind or dental surgery performed at a Medical Facility unless this is the only possible pain relief method;

In addition, the Company shall not pay any medical expenses related to the treatment of the following tooth injuries:

- Injuries sustained while eating and drinking;
- Injuries during the natural erosion of teeth;
- Injuries while brushing or using any oral hygiene practice.

Option 2: Cover for the cost of dentures with pathological teeth

This benefit shall be payable only when the Basic Dental Treatment or Separate Dental Care benefit is selected.

The Company shall pay the cost of dentures incurred at a Medical facility, including the cost of reconditioning or repairing bridges, dental crowns, porcelain crowns and dentures.

OPTIONAL BENEFIT 4: SPECIAL MATERNITY CARE

The reimbursable expenses are specified in the Maternity Care benefit under the MEDICAL EXPENSES FOR CONFINEMENT AND SURGERY DUE TO SICKNESS & MATERNITY section. This benefit shall not be included in the maximum limit applicable to the Inpatient Treatment benefit.

OPTIONAL BENEFIT 5: SALARY ALLOWANCE DURING TREATMENT FOR SICKNESS (not applicable to children under 18 years old)

This benefit shall not be included in the maximum limit applicable to the Inpatient Treatment benefit.

This benefit shall not apply to the Insured's pregnancy or childbirth.

It is agreed that the Insured shall be entitled to a cash allowance due to loss or reduction of income (if specified in the Schedule of Insurance Benefits) during his/her inpatient and/or outpatient treatment period (if specified in the Schedule of Insurance Benefits), which shall not exceed the period specified in the Table of Benefits. Payment under this benefit shall be based on the actual number of days the Insured is absent from work for the treatment of his/her Sickness and the number of days of treatment as prescribed by the attending Doctor. The amount of such cash allowance/person/day (including Saturdays, Sundays, and public holidays) shall be calculated as follows:

(Maximum Limit of Compensation/person)/number of days this benefit is payable as specified in the Table of Benefits x actual number of days the Insured is absent from work.

SECTION IX – COMPULSORY CLAUSES

1. War and civil war exclusion

This Policy does not cover any liability assumed by the Insured for loss or damage directly or indirectly occasioned by, happening through or in consequence of war, invasion, acts of foreign enemies, hostilities or war-like operations (whether war be declared or not), civil war, mutiny, military rising, insurrection, rebellion, revolution, military or usurped power, martial law, confiscation or nationalisation or requisition or destruction of or damage to property by or under the order of any Government or public or local authority.

2. Terrorism exclusion endorsement (NMA 2921)

Notwithstanding any provision to the contrary within this Agreement or any endorsement thereto it is agreed that this Agreement excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any act of terrorism regardless of any other cause or event contributing concurrently or in any other sequence to the loss.

For the purpose of this endorsement, an act of terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

This endorsement also excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from, or in connection with any action taken in controlling, preventing, suppressing or in any way relating to any act of terrorism.

If the Company alleges that by reason of this exclusion, any loss, damage, cost, or expense is not covered by this Policy the burden of proving the contrary shall be upon the Insured.

In the event any portion of this endorsement is found to be invalid or unenforceable, the remainder shall remain in full force and effect.

3. Sanction exclusion

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Comprehensive Health care insurance wording

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No (re)insurer shall be deemed to provide cover and no (re)insurer shall be liable to pay any claim or provide any benefit hereunder to the extent and for such period that the provision of such cover, payment of such claim or provision of such benefit would expose that (re)insurer to any sanction, prohibition or restriction under United Nations resolutions or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom or the United States of America.

4. Total asbestos exclusion clause

It is hereby understood and agreed that this policy shall not apply to and does not cover any actual or alleged liability whatsoever for any claim or claims in respect of loss or losses directly or indirectly arising out of, resulting from, or in consequence of asbestos in whatever form or quantity.

5. CL370 Institute radioactive contamination, chemical, biological, biochemical, and electromagnetic weapons exclusion clause - 10/11/2003

This clause shall be paramount and shall override anything contained in this insurance inconsistent therewith

In no case shall this insurance cover loss damage liability or expense directly or indirectly caused by or contributed to by or arising from:

- ionising radiations from or contamination by radioactivity from nuclear fuel or any nuclear waste or the combustion of nuclear fuel
- the radioactive, toxic, explosive or other hazardous or contaminating properties of any nuclear installation, reactor or other nuclear assembly or nuclear component thereof
- any weapon or device employing atomic or nuclear fission and/or fusion or other like reaction or radioactive force or matter
- the radioactive, toxic, explosive or other hazardous or contaminating properties of any radioactive matter. The exclusion in this sub-clause does not extend to radioactive isotopes, other than nuclear fuel, when such isotopes are being prepared, carried, stored, or used for commercial, agricultural, medical, scientific or other similar peaceful purposes
- any chemical, biological, bio-chemical, or electromagnetic weapon

6. Nuclear energy risks exclusion

This policy shall exclude all Nuclear Energy Risks.

- (I) All Property, on the site of a nuclear power station.
 - Nuclear Reactors, reactor buildings, and plants and equipment therein on any site other than a nuclear power station.
- (II) All Property, on any site (including but not limited to the sites referred to in I above), used or having been used for:
 - The generation of nuclear energy; or
 - The Production, Use or Storage of Nuclear Material.
- (III) Any other Property eligible for insurance by the relevant local Nuclear Insurance Pool and/or Association but only to the extent of the requirements of that local Pool and/or Association.
 - The supply of goods and services to any of the sites, is described in I to III above.

DEFINITIONS

"Nuclear Material" means:

- Nuclear fuel, other than natural uranium and depleted uranium, capable of producing energy by a self-sustaining chain process of nuclear fission outside Nuclear Reactor, either alone or in combination with some other material; and
- Radioactive Products or Waste.

"Radioactive Products or Waste" means any radioactive material produced in, or any material made radioactive by exposure to the radiation incidental to the production or utilization of nuclear fuel, but does not include radioisotopes that have reached the final stage of fabrication to be used for any scientific, medical, agricultural, commercial or industrial purpose.

"Nuclear Installation" means:

- Any Nuclear Reactor;
- Any factory using nuclear fuel for the production of Nuclear Material, or any factory for the processing of Nuclear Material, including any factory for the reprocessing of irradiated nuclear fuel; and
- Any facility where Nuclear Material is stored, other than storage incidental to the carriage of such material.

"Nuclear Reactor" means any structure containing nuclear fuel in such an arrangement that a self-sustaining chain process of nuclear fission can occur therein without an additional source of neutrons.

"Production, Use or Storage of Nuclear Material" means the production, manufacture, enrichment, conditioning, processing, reprocessing, use, storage, handling and disposal of Nuclear Material.

"Property" shall mean all land, buildings, structures, plant, equipment, vehicles, contents (including but not limited to liquids and gases) and all materials of whatever description whether fixed or not.

"High Radioactivity Zone or Area" means:

- For nuclear power stations and Nuclear Reactors, the vessel or structure which immediately contains the core (including its supports and shrouding) and all the contents thereof, the fuel elements, the control rods, and the irradiated fuel store; and
- For non-reactor Nuclear Installations, any area where the level of radioactivity requires the provision of a biological shield.

APPENDIX I – TABLE OF COMPENSATION

No.	Insured event	Percentage of Sum Insured (%)
A	DEATH	100
B	TOTAL PERMANENT DISABLEMENT	100
1	Total Permanent Disablement as defined	
2	Adding cases of total and permanent disability	100

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2.1	Total blindness and permanent loss of vision in one eye	100
2.2	Complete and incurable mental disorder	
2.3	Complete loss of chewing and speaking function	
2.4	Removal of an entire lung and part of the other lung	
2.5	Total and permanent disablement due to amputation or permanent loss of use one leg or one hand	
C	PARTIAL PERMANENT DISABLEMENT	
	HEAD	
1	Remove part of the upper jaw bone or a part of the lower jaw bone from 1/3 to 1/2 missing from the high branch or less	32
2	Removal of cerebral hemispheres	48
3	Removal of part or all of a lobe of the brain	40
4	Removal of the entire upper jaw bone and part of the lower jaw bone from the upper branch or lower on the other side	68
5	Removal of the entire upper jaw bone and part of the lower jaw bone from the top down on the same side	60
6	Removal of the entire upper or lower jaw	60
7	Remove $\frac{3}{4}$ of the tongue with the base of the tongue (from the V spine outwards)	64
8	Cut off 2/3 from the tip of the tongue	44
9	Removing 1/3 of the tongue affects pronunciation	16
10	Removal of a small part of the tongue (less than 1/3) that affects pronunciation	8
11	Cut or press the strings	10
12	Cut off the tear bag	13
13	Completely deaf in 1 ear	28
14	Completely deaf in 2 ears	64
15	Mastectomy	28
16	Cut the earlobes on both sides	24
17	Cut one ear lobe	12
18	Complete nose cut	32
	UPPER LIMB	
19	Totally lost thumb	25
20	Lose 1 knuckle of thumb	10
21	Lost index finger	17
22	Lose 2 segments 2 and 3	8
23	Burn loss 3	7
24	Loss of middle or ring finger	14
25	The middle finger is missing 2 segments 2 and 3	8
26	Middle finger missing 3	4
27	Lost 1 thumb and 1 other finger	26
28	Lost 1 thumb and 2 other fingers	30
29	4 fingers of 1 hand	40

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30	Thumb and 4 fingers of 1 hand	50
31	Lost 1 index finger and 2 other fingers	30
32	Lost 1 index finger and 1 middle finger	26
33	Loss of 1 middle or ring finger (including knuckles)	16
34	Lost both pinky and knuckles	14
35	Lost even pinky	10
36	Lose 2 segments 2 and 3	7
37	Burn loss 3	4
	LOWER LIMB	
38	Complete paralysis of the external popliteal nerve	32
39	Complete paralysis of the medial popliteal nerve..	24
40	Loss of most of the patella, breaking into pieces and greatly limiting the ability to extend the leg above the thigh.	40
41	Loss of most of the kneecap but still able to move the limbs	20
42	Shorter lower limb at least 5cm..	30
43	Shorter lower limb from 3-5 cm ..	20
44	Lost all 5 toes	40
45	Lost 4 fingers and thumb	34
46	Lost 1 thumb	14
47	Lose 1 knuckle	8
48	Loss of 1 finger other than thumb	10
49	Loss of tibia and fibula causes a pseudo-joint of the lower leg	32
50	Loss of fibula	20
51	Cut the outer or inner ankle	10
52	Lost 4 fingers except thumb	32
53	Missing 3 fingers, 3-4-5	22
54	Loss of 3 fingers, 1-2-3	26
55	Loss of 1 thumb and 2 finger	18
56	Stiff hip	40
57	Stiffness of the knee joint	28
	SPINE	
58	Anterior or posterior intervertebral disc ablation	26
59	Removal of the posterior arch of a vertebra	28
60	Removal of the posterior arch of 2-3 or more vertebrae	40
	CHEST	
61	Remove 1-2 ribs	14
62	Resection from 3 ribs (each rib resection over 3 ribs increases by 5%)	20
63	Per-rib resection (increase of 3% per rib resection)	7
64	Total removal of one lung	60
65	Multiple hydropneumonia resection on both sides, DTS reduced by more than 50%	56

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66	Multiple hydropneumonia on 1 side	44
67	Cut the pleura into	24
68	Remove 1 lobe of lung	32
	STOMACH	
69	Removal of the entire stomach	64
70	Cut $\frac{3}{4}$ or $\frac{2}{3}$ with vagus nerve ablation	32
71	Resection of most of the small intestine (less than 1 m left)	64
72	Small bowel resection	36
73	Total colon resection	64
74	Colon resection	44
75	Resection of the right liver is simple	60
76	Resection of the left liver alone	52
77	Resection $\frac{1}{2}$ of a lobe of the liver	48
78	Resection of $\frac{1}{3}$ of a lobe of the liver	32
79	Inferior resection of one-third of the lobe of the liver	24
80	Gallbladder removal	21
81	Removal of the spleen	36
82	Removal of tail of pancreas, spleen	52
83	Pancreatectomy with jejunostomy	32
84	Appendectomy	12
85	Esophagectomy, esophagectomy with gastric bypass	40
	URINARY AND GENITAL ORGANS	
86	Remove 1 kidney, the other kidney is normal	44
87	Remove 1 kidney, the remaining kidney is damaged or pathological	60
88	Partial removal of left or right kidney	28
89	Ureterectomy	24
90	Loss of penis and 2 testicles in a childless person under 55 years old	60
91	Loss of penis and 2 testicles in people under 55 years old who already have children	48
92	Loss of penis and 2 testicles in people over 55 years old	32
93	Unilateral hysterectomy and ovary removal in childless women under 45 years of age	52
94	Removal of the uterus and ovaries on one side in a person under 45 years old who has had a child	28
95	Hysterectomy and unilateral ovary removal in people over 45 years old	22
96	Mastectomy in women under 45 years old on one side	20
97	Mastectomy in women under 45 years old on both sides	40
98	Mastectomy in women over 45 years old on one side	14
99	Mastectomy in women over 45 years old on both sides	28
100	Cut a part of the bladder	24
101	Resection of the gland, bartholin's adenoma	5
102	Totally cut open vagina	14

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103	Complete removal of the fallopian tubes and ovaries on one or both sides	17
104	Abdominal hysterectomy without tubes or ovaries	20
105	Removal of ovaries with omentum	16
106	1 testicle removed	8
107	Removal of 2 testicles	11

- In the event of multiple Injuries in the same body part, the total amount paid for the Injuries cannot exceed the percentage of loss of that body part.
- If the Insured dies (within 24 months from the date of Injury) after receiving the indemnity of the Partial Permanent Disablement, the Company will pay the remaining sum insured if the limit of death is more than the amount stated in the above Partial Permanent Disablement received.
- Injury cases not listed here will be compensated as a percentage of the degree of Injury based on similar cases listed, regardless of the Insured's occupation or opinion of the Medical Assessment Council of the province/city or higher levels.
- Disability Injuries of limbs or parts of limbs will be assessed similarly to injuries resulting from cut out.
- The certification of the insured having completely lost a body part (hand, leg, or eye) can be done immediately after the insurance event occurs or after the treatment has concluded.
- Certification of complete paralysis and the inability to recover the function of the body parts or total blindness or physical injury of 81% or more shall be made no earlier than 180 days from the date of the insurance event or from the date the pathology is diagnosed.
- In case the consequences of an Accident covered by insurance are aggravated due to the Insured's pre-existing illness or the Injury is not treated promptly and not according to the instructions of the Medical Facility, the Company will only pay the insurance money as for the same type of Injury in a person with normal health who is treated properly.

APPENDIX 2 – ADDITIONAL BENEFITS

The additional benefits below are payable only if stated in the Policy or Certificate of Insurance or any Endorsements (if any).

ADDITIONAL BENEFIT 1: SYSTEMIC LUPUS ERYTHEMATOSUS WITH LUPUS NEPHRITIS

Now this Policy witnesses that in consideration of the Policyholder paying or agreeing to pay to the Company additional premiums for such extension clause and subject to the general conditions, coverage, exclusions hereof, the Company will indemnify the Insured against all allowances equivalent to each Benefit occurring or arising during the period of insurance.

Part I: Definition

Systemic Lupus Erythematosus with Lupus Nephritis

A clear diagnosis of systemic lupus erythematosus is based on recognized diagnostic criteria and supported by clinical and laboratory evidence. Under this agreement, systemic lupus erythematosus will be limited to forms of lupus with renal involvement (lupus nephritis class III to VI, based on kidney biopsy results and consistent with the RPS/ISN classification). The final diagnosis must be determined by a specialist in rheumatology and immunology.

RPS/ISN Classification of Lupus Nephritis:

- Class I: Minimal mesangial lupus nephritis.
- Class II: Mesangial proliferative lupus nephritis.
- Class III: Focal lupus nephritis (active and chronic lesions; proliferation and sclerosis).
- Class IV: Diffuse proliferative lupus nephritis (active and chronic lesions; proliferation and sclerosis, segmental and global).
- Class V: Membranous lupus nephritis.
- Class VI: Advanced sclerosing lupus nephritis.

If there is no biopsy result, the following three criteria must be fully met:

- a) Presence of nonspecific inflammatory signs:
 - Prolonged fever of unknown infectious cause, especially tuberculosis.
 - Increased erythrocyte sedimentation rate (ESR) and elevated blood gamma globulin level.
- b) Fulfillment of 4 out of 11 diagnostic criteria for systemic lupus erythematosus (SLE), including at least one immunological criterion (either positive antinuclear antibody [ANA], positive anti-DNA antibody, or positive LE cells).
- c) Renal involvement:
 - Must have positive proteinuria of at least 1(+) (>0.2 g/24h), possibly accompanied by hematuria and urinary casts.

Part II: Coverage

Insurance coverages payable under these Rules:

"This English version is for reference only"

If the Insured Person is diagnosed with a systemic lupus erythematosus with lupus nephritis as defined, after a waiting period of ninety (90) days from the commencement date of the coverage for this additional benefit, and survives for thirty (30) days following the diagnosis, the Insurer shall pay the Insured Person one hundred percent (100%) of the Sum Assured.

This benefit shall be payable one (01) time only during the lifetime of each Insured. Once an Insured has received payment of this benefit, such Insured shall not be entitled to any further payment of this benefit in subsequent policy years or under any other insurance policies.

Part III: Exclusion Clause

The Insurer shall not pay any benefits as stated if the diagnosis of the Insured Person's a systemic lupus erythematosus with lupus nephritis as defined is caused, in whole or in part, by any of the following reasons:

1. Any illness or injury other than the diagnosed critical illness as defined;
2. A systemic lupus erythematosus with lupus nephritis as defined for which the Insured Person had symptoms, was confirmed, or diagnosed prior to or during the waiting period;
3. A systemic lupus erythematosus with lupus nephritis as defined arising directly from a congenital defect or disease that appeared or was diagnosed before the Insured Person reached eighteen (18) years of age;
4. If the Insured Person does not survive for at least thirty (30) days after the diagnosis of systemic lupus erythematosus with lupus nephritis as defined;
5. A systemic lupus that has developed or was diagnosed prior to enrolling in the additional benefit for a systemic lupus erythematosus with lupus nephritis as defined.

ADDITIONAL BENEFIT 2: ALLOWANCE FOR HEART ATTACK OF SPECIFIED SEVERITY

Now this Policy witnesses that in consideration of the Policyholder paying or agreeing to pay to the Company additional premiums for such extension clause and subject to the general conditions, coverage, exclusions hereof, the Company will indemnify the Insured against all allowances equivalent to each Benefit occurring or arising during the period of insurance.

Part I: Definition

Covered illness/condition: Heart Attack of Specified Severity

Cardiac activity ceases due to obstruction of blood flow, confirmed by at least three of the following criteria demonstrating the occurrence of a new myocardial infarction:

- Typical angina pectoris;
- Characteristic electrocardiogram changes, with progression of any of the following conditions: ST-segment elevation or depression, T-wave inversion, pathological Q waves, or left bundle branch block;
- Elevation of cardiac biomarkers, including CKMB above generally accepted normal levels, or Troponin T or I measurement results of 0.5 ng/ml or higher;
- Evidence of newly lost viable myocardium or new regional wall motion abnormality. Imaging diagnosis must be performed by a cardiologist appointed by the Insurer.

Under the above definitions, the following cases are excluded:

- Angina;
- Unconfirmed myocardial infarction;
- Elevation of cardiac biomarkers or Troponin T or I following cardiovascular procedures, including but not limited to coronary angiography and angioplasty.

Note: 0.5 ng/ml = 0.5 µg/L = 500 pg/mL.

Part II: Benefit

Insurance coverages payable under these Rules:

If the Insured Person is diagnosed with a heart attack of specified severity as defined, after a waiting period of ninety (90) days from the commencement date of the coverage for this additional benefit, and survives for thirty (30) days following the diagnosis, the Insurer shall pay the Insured Person one hundred percent (100%) of the Sum Assured.

This benefit shall be payable one (01) time only during the lifetime of each Insured. Once an Insured has received payment of this benefit, such Insured shall not be entitled to any further payment of this benefit in subsequent policy years or under any other insurance policies.

Part III: Exclusion Clause

The Insurer shall not pay any benefits as stated if the diagnosis of the Insured Person's heart attack of specified severity is caused, in whole or in part, by any of the following reasons:

1. Any illness or injury other than the diagnosed critical illness as defined;
2. A heart attack of specified severity for which the Insured Person had symptoms, was confirmed, or diagnosed prior to or during the waiting period;
3. A heart attack of specified severity arising directly from a congenital defect or disease that appeared or was diagnosed before the Insured Person reached eighteen (18) years of age;
4. If the Insured Person does not survive for at least thirty (30) days after the diagnosis of heart attack of specified severity as defined;
5. Heart attack of specified severity that has developed or was diagnosed prior to enrolling in the additional benefit for heart attack of specified severity.

"This English version is for reference only"

ADDITIONAL BENEFIT 3 - ALLOWANCE FOR MAJOR CANCER

Now this Policy witnesses that in consideration of the Policyholder paying or agreeing to pay to the Company additional premiums for such extension clause and subject to the general conditions, coverage, exclusions hereof, the Company will indemnify the Insured against all allowances equivalent to each Benefit occurring or arising during the period of insurance.

Part I: Definition

1. Major Cancer

A malignant tumor diagnosed by histopathology and characterized by uncontrolled growth of malignant cells with invasion and destruction of normal tissues. The term "malignant tumor" includes leukemia, lymphoma, and sarcoma.

Major Cancer is determined based on the presence of tumor cells and/or tumor-related molecules in blood, saliva, stool, urine, or any other body fluid; however, such findings without accompanying diagnostic and clinical verification do not meet this definition.

Exclusions under this definition include:

- All tumors assessed by histopathology as any of the following:
 - i. Pre-malignant;
 - ii. Non-invasive;
 - iii. Carcinoma in situ;
 - iv. Borderline malignant;
 - v. Any degree of potential malignancy;
 - vi. Suspected malignancy;
 - vii. Uncertain or unknown tumors; or
 - viii. All grades of dysplasia, squamous intraepithelial lesions (high and low grade), and intraepithelial neoplasia.
- Non-melanoma skin cancers.
- All prostate cancers assessed by histopathology as stage T1N0M0 (per TNM staging system) or lower, or equivalent stages under other classification systems.
- All thyroid cancers assessed by histopathology as stage T1N0M0 or lower.
- All neuroendocrine tumors assessed by histopathology as stage T1N0M0 or lower.
- All urinary bladder tumors, primary cutaneous lymphomas, and Dermatofibrosarcoma Protuberans (DFSP), unless there is evidence of metastasis to lymph nodes or beyond assessed by histopathology as stage T1N0M0 or lower.
- All gastrointestinal stromal tumors assessed by histopathology as stage T1N0M0 or lower with mitotic count \leq 5/50 HPFs.
- Chronic lymphocytic leukemia (CLL) classified under the Rai system before stage 3.
- All malignant bone marrow tumors not requiring regular blood transfusions, chemotherapy, targeted cancer therapy, bone marrow transplantation, hematopoietic stem cell transplantation, or other major interventional treatments.
- All tumors in individuals infected with HIV.

2. Histopathology

The test result used to confirm the type of cells and the degree of cancer cell invasion through diagnosis by performing a biopsy (a medical procedure to collect a small sample of body tissue via surgery, or using a specialized needle inserted through the skin to aspirate fluid-containing cells from a tumor, then sending the sample to a laboratory for analysis).

3. TNM Classification System

One of the most widely used cancer staging systems, accepted by the Union for International Cancer Control (UICC) and the American Joint Committee on Cancer (AJCC).

The TNM system is based on: Extent of the primary tumor (T-Tumor), Degree of regional lymph node involvement (N - Node), and the presence of distant metastasis (M - Metastasis). Numbers following each letter indicate the size or extent of the tumor and metastasis.

- Primary Tumor
 - Tx: Primary tumor cannot be assessed
 - T0: No evidence of primary tumor
 - Tis: Carcinoma in situ (CIS): Abnormal cells are present but have not spread to nearby tissue. CIS is not cancer but may become cancer and is sometimes called pre-invasive cancer.
 - **T1, T2, T3, T4:** Increasing size and/or extent of the primary tumor.
- Regional Lymph Nodes
 - Nx: Regional lymph nodes cannot be assessed
 - N0: No regional lymph node involvement
 - N1, N2, N3: Increasing involvement of regional lymph nodes (number and/or extent)
- Distant Metastasis
 - Mx: Distant metastasis cannot be assessed
 - M0: No distant metastasis
 - M1: Distant metastasis present

Part II: Coverage

"This English version is for reference only"

If the Insured Person is diagnosed with a critical cancer as defined, after a waiting period of ninety (90) days from the commencement date of the coverage for this additional benefit, and survives for thirty (30) days following the diagnosis, the Insurer shall pay the Insured Person one hundred percent (100%) of the Sum Assured.

This benefit shall be payable one (01) time only during the lifetime of each Insured. Once an Insured has received payment of this benefit, such Insured shall not be entitled to any further payment of this benefit in subsequent policy years or under any other insurance policies.

Part III: Exclusion Clause

The Insurer shall not pay any benefits as stated if the diagnosis of the Insured Person's critical cancer is caused, in whole or in part, by any of the following reasons:

1. Any illness or injury other than the diagnosed critical illness as defined;
2. A cancer for which the Insured Person had symptoms, was confirmed, or diagnosed prior to or during the waiting period;
3. A cancer arising directly from a congenital defect or disease that appeared or was diagnosed before the Insured Person reached eighteen (18) years of age;
4. If the Insured Person does not survive for at least thirty (30) days after the diagnosis of the cancer;
5. A cancer that has developed or was diagnosed prior to enrolling in the additional benefit for severe cancer allowance.