

HEALTH INSURANCE FOR CORPORATE CLIENT WORDING

*(In accordance with the Decision No. 6028/QĐ-BHBV dated June 27, 2025
of the Chief Executive Officer of Bao Viet Insurance Corporation)*

**This Insurance wording shall be made in Vietnamese and English with equivalent legal value.
In case of differences in language and/or meaning leading to different understanding of the
terms and conditions, the Vietnamese version shall prevail.*

CONTENT

PART I: DEFINITIONS.....	3
PART II: INSURANCE COVERAGE AND INSURANCE BENEFITS.....	14
I. Term life.....	14
II. Death, permanent disability due to accident.....	14
III. Medical expenses due to accident	14
IV. Inpatient treatment due to disease, maternity.....	15
V. Optional benefits	16
1. Out-patient treatment due to disease, maternity, dental care	16
2. Comprehensive dental care	17
3. Daily allowance due to loss of income/Salary allowance	18
PART III: GENERAL EXCLUSIONS	19
PART IV: GENERAL CONDITIONS.....	23
I. Geographical limit.....	23
II. Eligibility of Insured person	23
III. Placement of insurance policy and renew insurance policy	23
IV. Other insurance policies/Other types of insurance.....	24
V. Insurance premium and sum insured	24
VI. Premium payment period	24
VII. Currency clause.....	24
VIII. Insurance benefits	24
IX. Benefit changes	25
X. Promotion and level change clause	25
XI. Effective date / Waiting period	26
XII. Termination of insurance benefits	27
XIII. Amendment, Supplement or Termination/Cancellation of the insurance policy.....	27
XIV. Automatic addition and deletion applied for employees/dependents.....	27
XV. Premium payment warranty and reinstatement of insurance policy's validity ...	28
XVI. Obligations of the Policyholder and the insured person	28
XVII. Verification	29
XVIII. Governing law and dispute resolution	29
XIX. Protection and Processing of personal data.....	29
PART V: CLAIM SETTLEMENT AND DIRECT BILLING PROCEDURE...	30
I. Claim documents.....	30
II. Claim settlement procedure and direct billing.....	32
III. Time limit for appealing claim	32
APPENDIX I: SCALE TABLE OF DEATH / PERMANENT DISABILITY ..	33

PART I: DEFINITIONS

1. Physician

Is a legally licensed physician (doctor) recognized by the law of the country where treatment is provided and who, in giving such treatment, is practicing within the scope of his/her license and specialization, but excluding a physician who is the insured person himself/herself, or is the spouse or legal relatives of the insured person. A physician may be recognized as a specialist doctor or a medical advisor.

2. Policy summary

The policy summary provides details of the Policyholder and the insured person, summary of insurance benefits.

3. Policyholder

An organization legally established and operates in Vietnam signs an insurance policy with the Insurer. The Policyholder must qualify the requirements for purchasing insurance according to the insurance wording, terms and conditions, and pay the insurance premium to the Insurer. The Policyholder must have insurable benefits according to the provisions of law.

4. Disease/Illness

Means a physical condition with pathological symptoms that differ from the normal health state, shown by symptoms or syndromes diagnosed by a physician. Under this insurance wording, disease does not include conditions related to maternity and dental.

5. Congenital disease/Congenital anomaly

Is any disease/anomaly that develops in the fetus during the mother's pregnancy is due to the impact of environmental factors on the development of the fetus and can be described by medical authorities under different names, such as "congenital disease, congenital malformation, congenital defect, chromosomal abnormality". Congenital disease/Congenital anomaly can be detected during the mother's pregnancy, childbirth, or the development of the insured. The determination of a Congenital disease/Congenital anomaly condition must be performed by a physician.

6. Pre-existing conditions

Are disease or injury conditions of the insured person that existed before the effective date and are disease/injury in which the insured person:

- a. Have been diagnosed or treated before the effective date, and/or
- b. For which signs, symptoms of disease/injury began within 36 months before the effective date that the insured person knew or was aware of, regardless of whether the insured person went for medical treatment and examination or not.

Determination of pre-existing conditions must be based on: medical records stored at legally established hospitals or medical facilities; medical documents issued by the Ministry of Health and competent authorities; or self-declared information by the Policyholder, insured person on the insurance application form or supplemental insurance declaration form; or claim history of the insured person.

7. Special diseases

Are cancer, tumour/lump of all types; blood pressure diseases, diseases of the heart, stroke, impaired/varicose veins; gastric ulcer, intestinal ulcer; hepatitis A/B/C, liver cirrhosis, liver failure; gallstones, kidney and ureter stones, lower urinary tract stones; nephrotic syndrome, kidney failure, hemodialysis; blood filtration, blood substitution, bone marrow failure, leukocytes; chronic arthritis, degenerative spine; pathological cataract; Parkinson's, Alzheimer's, dementia syndrome; diabetes; pneumothorax; lupus erythematosus.

8. Occupational disease

Is disease caused by harmful working conditions which affects the employee. The list of occupational diseases is issued by the Ministry of Health and the Ministry of Labor - Invalids and Social Affairs or equivalent competent authority.

9. Hospital

Is a medical facility which is legally licensed and recognized by the State and:

- Has capabilities and facilities for diagnosis, treatment and surgical operation.
- Has sufficient conditions for inpatient treatment and a daily healthcare system for inpatients.
- Not a place for health recovery, massage, sauna or a place with the sole purpose of serving the elderly or alcoholics and drug addicts, simulant addicts rehab or for treatment of mental disorders.

10. Complications of maternity

The abnormal condition of the fetus, complications due to pathological causes arising during the pregnancy of the insured person (but not related to the treatment of infertility, premature birth, childbirth) must be treated as prescribed by the physician. Complications of maternity include the followings:

- Miscarriage or when the fetus has died and remains in the womb (stillbirth);
- Hydatidiform mole (Molar pregnancy);
- Ectopic pregnancy;
- Post-partum haemorrhage;
- Retained placental membrane;
- Therapeutic abortion, including abortion cases due to hereditary diseases/congenital malformation of the fetus or to save the mother's life;
- Threatened preterm labor from week 22 to week 35 of pregnancy;
- Complications following any of the above conditions.

11. Prosthesis

Shall refer to all artificial appliances/equipments/materials which are installed/implanted/planted into the human body to replace and perform the function of a body part that is defective, lost, or has lost/reduced function.

12. Medical supportive appliances/devices/equipments used for treatment

Are medical appliances/devices/equipments:

- Are put/implanted/inserted into any part of the body in order to maintain/assist bodily function including the below listed medical appliances/devices/equipment and/or listed appliances/devices/equipment in endorsements attached to the insurance wording/ insurance policy such as: stent, heart valve, pacemakers and cardioverter, catheter, mesh filter, mesh for hernia, 3D titanium mesh, spinal cement, spinal implant, tissue regeneration film, biological film, suture anchor implant, all types of brace/vis/splint/screw, rectum lifting plate, mesh.
- Are specialized in performing specific procedure or surgical operation, and used only once and not consumable, including the below listed medical appliances/devices/equipment and/or listed appliances/devices/equipment in endorsements attached to the insurance wording/ insurance policy such as: plasma scalpel, coblator, hummer, longo surgical equipment, articular surgical blades, cartilage cutter, radio frequency coolcut, ultrasound cutter, catheters, harmonic scalpel used in endoscopy or open surgery, robotic systems, balloon catheter, stone baskets, surgical shaver blade, trocar, guidewire, ligasure equipment, endoscopy lithotripsy surgical kit and support kit, Radio-Frequency Ablation equipment.
- Outside the body that support functional mobility or other functions including the below listed medical appliances/devices/equipment and/or listed appliances/devices/equipment in endorsements attached to the insurance wording/insurance policy such as: crutches, braces, wheelchairs, hearing aids, prescription glasses, heart assist devices, ECMO machine.
- Any other orthopedic appliances/devices intended for aesthetic purpose.

13. Professional sport activities

Are any sport activities, which brings main and regular earning to the insured person.

14. Hazardous sport activities

Are activities on air (except for traveling by air), winter sports, hang gliding, hunting, ice hockey, parachute jump, wrestling, polo, water-skiing, yachting beyond 5 km of a coastline, racing (except for charitable racing, internal race hosted by the Policyholder).

15. Organ transplantation

Surgical transplant of heart, lung, liver, pancreas, kidney, including bone marrow for the insured person performed in a hospital by a physician duly qualified to perform such operation. The cost of organ purchase, transportation, preservation of organs and all medical expenses for the donor are not covered under this insurance wording.

16. New-born baby care

Is any necessary medical expense for newborn baby including but not limited to pediatric medicine, pediatric tests, baby sanitation right after being born at the hospital, provided that the mother remains hospitalized (congenital diseases and vaccine are excluded).

17. Pre-admission examination charges

Are general practitioners and specialist fees, examination, ultrasound, imaging diagnostic, basic tests and medicine as prescribed by a physician, directly related to

the disease/illness/injury that required immediate admission for treatment, and are the basis for the attending physician to conclude that the admission are necessary. The Insurer only pay for one nearest pre-admission examination charges performed within 30 days prior to the hospital admission, unless otherwise agreed in the insurance policy.

18. Post-admission examination charges

Are medical expenses as prescribed by an attending physician immediately following a hospital discharge and are directly related to the previous inpatient treatment. These medical expenses include general practitioners and specialist fees, examination, imaging diagnostic, medicine within 30 days after the date of hospital discharge, unless otherwise agreed in the insurance policy.

19. Customary and reasonable expenses

Are the necessary medical expenses that do not exceed the general level of price of medical facilities with similar servicing level of within the geographical limit regulated in the insurance policy, of where the treatment incur, of providing similar medical treatment service or similar level of treatment, services, or of providing services for a similar disease/illness/condition.

20. Home nursing

Is the expenses for medical care services provided by a legally licensed nurse, immediately after hospital discharge, at the insured person's residence, as prescribed by the attending physician within 30 days after discharge.

21. Actual medical expenses

Are customary and reasonable expenses as prescribed by attending physician, incur when the insured person must receive medical treatment for event within scope of insurance coverage.

22. Medical facility

Is a legally licensed medical facility and is legally licensed to provide inpatient and/or outpatient treatment services, is not a place for rest or convalescence or a place with the sole purpose of serving the elderly or alcoholics, drug addicts, simulant addicts rehab.

23. Insurer

Is Bao Viet Insurance Corporation (Bao Viet Insurance) or its company members established and operated under the Vietnamese law.

24. Emergency transportation

Is the use of the ambulance car service by road (not an air transportation service) in the event that the insured person has a life-threatening disease/ illness/ injury that required the insured person to be taken to the nearest hospital/ clinic or from one hospital to another as prescribed by a physician.

25. Emergency ward treatment

Is an emergency treatment at a medical facility within 24 hours after an accident or disease/illness that may be life-threatening, require an emergency treatment in the

emergency ward, with room/board costs and with the emergency confirmation stamp of the medical facility.

In case a treatment is taken in the emergency ward/room for a sole reason of treatment outside of the medical facility's working hours, it is considered as an outpatient treatment.

26. Outpatient treatment

Is the treatment where the insured person visits a clinic/hospital/medical facility as defined without hospitalization and without room/board costs as inpatient treatment or daypatient treatment. In case the insured person is to undergo endoscopy/procedure only for the purpose of diagnosing a disease without treatment (including inpatient, daypatient or outpatient), it can only be reimbursed subject to outpatient treatment benefits.

27. Inpatient treatment

Is the insured person's hospitalization for treatment of event within scope of insurance coverage, with room/board costs incurred, and the insured person has to stay at least 24 consecutive hours in the hospital. Inpatient treatment is accepted to be eligible when the insured person stays in a hospital as defined, not in a clinic or outpatient medical facility. In case the insured person stays in a hospital to undergo examination, imaging diagnostic, endoscopy/procedure only for the purpose of diagnosing a disease without treatment is not considered an inpatient treatment.

28. Rehabilitation

Is a treatment method which aims to help the insured person recover from an acute disease/illness/injury to their normal health state from the time when the insured person is indicated by the attending physician to receive treatments at the department of rehabilitation.

29. Daypatient treatment

Shall refer to the treatment of event within scope of insurance coverage which requires the patient to be admitted to hospital with room/board cost during the day, but does not stay overnight at the hospital. The hospital discharge certificate is a required document to claim this benefit.

Hospitalization for test or diagnosis without treatment shall not be treated as daypatient treatment.

30. Medical treatment

Is the use of recognized medical technical expertise and licensed medicine, as prescribed by a physician, for the sole purpose of disease/illness treatment and/or alleviating physical injury or for medical treatment related to maternity.

31. Co-payment/Co-insurance

Refers to the share between the Insurer and the Insured person upon covered eligible benefits. The Co-payment is a percentage calculation (%) of the total valid reimbursed amount or of the sublimits of insurance benefits, whichever is lower.

The covered amount limit after co-payment application is equal to the limit of the respective benefit item in the table of benefits.

When the co-payment is subject to specific medical facilities, such co-payment shall be applied to all expenses incurred at such medical facilities and all the related incurred expenses which are indicated/prescribed by the physician at such clinics/hospitals.

When the insurance policy stipulates more than one co-payment ratio, each co-payment ratio shall be applied simultaneously and in turn.

32. Sub-limits

Is the maximum compensation limit for each insurance benefit item specified in the table of benefits. In all case, the total compensation amount of the sub-limits does not exceed the sum insured.

33. Direct billing network

Is a list of medical facilities that have signed direct billing agreement with the Insurer. When the insured person is examined and treated at these medical facilities, the Insurer will guarantee payment for the medical expenses incurred within the scope of insurance coverage and within the insurance limits specified in the insurance policy. The insured person must pay for the medical expenses that are not within scope of insurance coverage and/or the expenses exceed the insurance limits specified in the insurance policy at the time of having medical treatment.

The list of medical facilities in the direct billing network may be revised without prior notice and updated in the Insurer's official website.

34. Insurance policy

Is an agreement between the Policyholder and the Insurer, in which the Policyholder must pay the insurance premium and commit to having carefully read and understood all the contents in the insurance wording/insurance policy; the Insurer settle insurance claims as agreed in the insurance policy.

35. A medical examination/treatment

A medical examination/treatment is when a patient receives clinical examination, laboratory tests, diagnostic imaging or other diagnostic procedure and/or any treatment medicine prescribed by a physician at a legal medical facility for medical diagnosis and treatment of event within scope of coverage.

- Where a patient is consulted by more than one specialist physician as requested by the hospital, such consultations shall be considered one medical examination/treatment.

- Where a patient receives a series of examinations at a specialized department during the day, such examinations shall be considered one medical examination/treatment.

- Where a patient is required to seek further examination at more than one specialized departments at a medical facility in one day as prescribed by a physician, such examinations shall be considered one medical examination/treatment.

- In case the Insured person is examined/tested on the first day but there is no diagnosis conclusion from the physician and the physician request the insured person to do additional examination/test on the following day to have the basis for diagnosis conclusion, the costs incurred on all these days shall be considered one medical examination/treatment.

- In case the insured person is examined and treated at one hospital/clinic, but is assigned to have tests/diagnostic imaging at another hospital/clinic, all examinations/treatments shall be considered one medical examination/treatment.

36. Disappearance

The insured person shall be presumed death if he or she is not found for twenty-four (24) consecutive months and there is sufficient evidence for conclusion that the death was caused by an accident. However, if any time after the Insurer settled claim for that death case, the insured person is found alive, then the claim amount paid must be refunded to the Insurer.

37. Effective date

Is the effective date of the first insurance policy (calculated from 0:01 AM on the date specified in the policy) when the Policyholder enrolls in this insurance program or of the annual renewal insurance policy. For insurance policies that are not annually consecutive renewed, the first effective date of the insurance policy is the effective date of the latest insurance policy unless otherwise agreed.

38. Insured person

An individual whose life or health condition is insured under the insurance policy, satisfying the eligibilities regulated in the insurance wording and/or insurance policy.

39. Dependents

Are defined as legal spouse, biological parents, parents-in-law under 66 years old (up to 70 years old for renewal insured person unless otherwise agreed) of the insured employee, legally children aged from 1 year old to 18 years old, or to 24 years old if still being in continuous full-time education in Vietnam and not yet married, from the effective date or the annual renewal date. All dependents must be named in the insured list during the insurance period.

40. Beneficiary

An individual or group of individuals designated by the Policyholder/Insured person to receive all or part of the insurance benefits of the insurance policy. The beneficiary is named in the insurance application form, insurance claim form, insurance policy. In case the Policyholder is not the insured person, the Policyholder must have the consent in writing from the insured person when designating the beneficiary; in case the insured person is a minor, the designation of the beneficiary must be approved by the legal representative.

In case there is no beneficiary designation, the Insurer will reimburse according to the provisions of the law on inheritance.

41. Employee

Are insured persons who have Labor contracts/Probation contract/Labor agreement signed with Policyholder in accordance with Labor code of Vietnam, working for the Policyholder and be named in the insured list during the insurance period.

42. Surgical operation

Shall refer to a scientific method for body injury, disease/illness treatment or maternity treatment under insurance coverage conducted by certified surgeon through manual operations with medical instruments or equipment in legal medical facilities including open surgery, endoscopic surgery, laser surgery, minor surgery and surgical treatment procedure.

Surgical Operation including:

- Inpatient Surgery: shall refer to surgical operation whereof Insured person is required to stay at hospital at least twenty-four (24) hours;
- Daypatient Surgery: shall refer to surgical operation whereof Insured Person is required to stay at hospital less than twenty-four (24) hours with cost of room/board incurred;
- Outpatient Surgery: shall refer to surgical operation whereof Insured Person is required to stay at hospital less than twenty-four (24) hours without cost of room/board, or the surgical operation conducted at a clinic.

43. Clinic

Is an outpatient medical facility that operates legally under the provisions of Vietnamese law (with a valid business license, its own seal and practicing certificates of each individual in the clinic), with the ability and facility to examine, diagnose, treat or perform surgical operation. Payment documents such as invoices/receipts arising at the clinic must comply with the regulations of the Ministry of Finance.

This definition does not include private clinic.

44. Room & Board

Shall refer to cost of single room and bed and other related expenses incurred for treatment of the insured person, including intensive care unit and other medical care service expenses provided by a legally licensed nurse.

45. Sum insured

The maximum insurance liability of the Insurer for the insured person during the insurance period. The insurance amount is specified in the insurance policy and/or the table of benefit attached to the insurance wording/insurance policy.

46. Accident

Any sudden or unforeseen event, caused by a visible external force/agent on the body of the insured person and occur during the insurance period, which is the direct cause of bodily damage or death to the insured person and occurs beyond the control/intention of the insured person.

Under this insurance wording, food or drink poisoning or inhalation of toxic fumes, toxic gases, poisons, gases, drowning, electric shock are considered accidents.

47. Maternity

Maternity is the process from conception to childbirth. For the coverage of this insurance wording, maternity includes childbirth and complications of maternity.

48. Waiting period

Is defined as a time period in which the insurance event will not be paid by the Insurer, including cases where the date of event occurrence is within the waiting

period but the medical expenses incurred or the consequences of that event occur after the waiting period has passed. The waiting period is calculated from the effective date of insurance policy. For insurance policies that are renewed annually and do not change the insurance benefits, the waiting period is calculated from the effective date of the first insurance policy.

49. Insurance period

The insurance period is calculated from the effective date until the end of the insurance policy. The insurance period starts at 0:01 A.M. on the effective date and ends at 23:59 P.M. on the expiry date of the insurance policy. The insurance period is 01 year or less, and is specified in the insurance policy.

50. Prescribed medicine

These are medicines sold and used with physician's prescription, according to the law and do not include functional foods, pharmaceutical cosmetics, cosmetics, minerals, medical products not on the list of treatment drugs of the Ministry of Health, supplements, vitamins. However, the Insurer will consider to pay for vitamins on the condition that the vitamins are prescribed by a physician and the cost of these vitamins is not greater than the cost of treatment drugs.

51. Partial permanent disability

Shall refer to any injury caused solely by an accident which causes the loss of function of one or more than one Insured person's body parts as a result of amputation (loss) or completely permanent paralysis of that part.

Partial Permanent Disability is only determined after such injury treatment is completely finished. In case the determination could not be made immediately after the end date of injury treatment, such disability shall be considered to be Partial Permanent Disability provided that it lasts 52 consecutive weeks from the end date of treatment.

The Insurer only covers Partial Permanent Disability which is listed in the Scale table of Death/Permanent Disability attached to policy wording.

52. Total permanent disability

Shall refer to bodily damage which entirely prevents the insured person from attending to any business or occupation of any and every kind, or causes entire loss of the insured person's working capacity for any type of work, provided that such disability lasts 180 consecutive days from the date of finishing treatment and is beyond hope of any improvement thereafter.

a) Total permanent disability benefits are considered for payment when one of the following cases occurs:

- The Insured person is completely lost, is completely 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, completely lost, completely paralyzed and irrecoverable function of hand is counted from the wrist upwards (from wrist to shoulder direction); completely lost, completely paralyzed and irrecoverable function of the leg is counted from the ankle upwards (from ankle

to thigh direction); complete and irreversible loss of eye function is understood as complete loss or complete blindness;

- The Insured person suffers from a physical injury of 81% or more which entirely prevent the insured person from attending to his/her business or occupation of any and every kind as confirmed by a medical authority or the Provincial or Centrally-run city Medical Council, or a legal medical assessment organizations approved by the Insurer.

- Other total permanent disabilities listed in the Scale table of Death/Permanent Disability attached to the insurance wording.

b) Certification that the insured person has completely lost body parts (hands, legs, or eyes) may be made immediately after the insurance event occurs or after the end of treatment.

Certification of completely paralyzed and cannot 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 occurs or from the date the disease is diagnosed.

53. Serious medical condition

Mean a condition, which in the opinion of physician is a serious medical condition requiring emergency medical treatment to avoid death.

54. Bodily damage

Is biological damage to the human body caused by any impact. This damage can be caused by accident or by disease. Under this insurance wording, bodily damage does not include conditions related to maternity.

55. Hospitalization daily allowance

Insurer shall pay the amount of money stated in the table of benefit for each day of inpatient treatment or daypatient treatment, provided that there is a hospital discharge certificate and room and board cost are incurred. This benefit does not apply to maternity cases.

56. Daily allowance during injury/disease treatment

This is the amount of money the Insurer pay based on the actual number of days off for bodily damage treatment as prescribed by the physician, not exceeding the maximum sum insured and number of covered leave days as specified in the table of benefits.

57. Burial allowance

In case of the Insured person's death during his/her hospitalization within scope of coverage, the Insurer shall pay burial allowance as specified in the insurance policy.

58. Insurance age

Is the age of the insured person on the effective date of the insurance policy, count on the latest birthday immediately preceding to the effective date of the insurance policy.

59. Physiotherapy

Is a treatment method using physical, natural or artificial therapy such as: water, air, temperature, electricity, X-rays, ultraviolet rays, infrared rays, ultrasound, radioactive isotopes, massage, catgut embedding therapy... This insurance wording does not cover expenses for the purpose of relaxation, massage, spa, or gait correction.

60. Consuming medical supplies

Are supplies used once or many times for the purpose of supporting treatment and medical examination, not permanently installed in the body except in cases where these supplies are self-dissolved in the body or could have been removed from the body without affecting the body's functioning but because the body does not reject them, it is not necessary to remove them.

PART II: INSURANCE COVERAGE AND INSURANCE BENEFITS

The Insurer shall pay benefits within the scope of insurance coverage based on the sub-limits and sum insured stated in the insurance policy. In all cases, the total reimbursement amount shall not exceed the sum insured. The coverage of medical expenses is limited to actual, customary, and reasonable expenses.

I. Term life

➤ Scope of cover:

Cover for Death/Total Permanent Disability due to all causes, excluding accident(s) and exclusions as specified in the insurance wording/insurance policy.

➤ Insurance benefit:

In case of Death or Total Permanent Disability within the scope of insurance coverage, the Insurer shall pay the total sum insured stated in the insurance policy. The total reimbursement amount for an insured person shall not exceed 100% of the sum insured corresponding to the Term life benefit.

II. Death, permanent disability due to accident

➤ Scope of cover:

Cover for Death, Total Permanent Disability or Partial Permanent Disability due to accident(s) occurring in the insurance period, provided that the accident(s) are not excluded under the insurance wording/insurance policy, and consequences of the accident(s) within 104 weeks since the date of occurrence (only applicable to Death, Total Permanent Disability benefits).

➤ Insurance benefit:

- In the event that the insured person dies or suffers total permanent disability due to accident(s) within the scope of insurance coverage, the Insurer shall pay the total sum insured specified in the insurance policy.
- In the event that the insured person suffers partial permanent disability due to accident(s) within the scope of insurance coverage, the Insurer shall pay based on the Scale table of Death/Permanent Disability attached to the insurance wording.
- In the event that the insured person suffers partial permanent disability due to accident(s) and the insured person has already been paid for this benefit, within 365 days from the date of occurrence, if the insured person dies as a direct consequence of that accident, the Insurer shall pay the variance between the sum insured for death benefit stated in the insurance policy and the amount previously paid for partial permanent disability benefit.
- Total reimbursement amount for one insured person shall not be exceeded 100% sum insured of the Death/Permanent Disability due to accident benefit.

III. Medical expenses due to accident

➤ Scope of cover:

Cover for actual, customary, and reasonable medical expenses due to accident(s) occurring during the insurance period, on the condition that the accident(s) are not excluded under the insurance wording/insurance policy, up to the maximum limit stated in the insurance policy.

➤ **Insurance benefit:**

Including medical expenses for inpatient/outpatient treatment, medicines, and necessary medical supplies prescribed by the attending physician, emergency transportation (excluding by air and international assistance services) occurring for bodily damage treatment due to accident(s).

IV. Inpatient treatment due to disease, maternity

➤ **Scope of cover**

Cover for medical expenses for disease or maternity treatment which required the insured person to have inpatient treatment and/or surgical operation at a hospital during the insurance period, excluding the exclusions specified in the insurance wording/insurance policy.

➤ **Insurance benefit**

1. Hospitalization:

In the event that the insured person requires hospitalization for treatment (including daypatient treatment), the Insurer will reimburse the insured person for necessary and reasonable medical expenses within scope of insurance coverage incurred as prescribed by a physician for the event within scope of insurance coverage within the insurance period, excluding the exclusions specified in the insurance wording/insurance policy, and includes the following expenses:

- Room and board, meals according to the hospital's standard room and board.
- Costs for intensive care unit (ICU), high dependency unit (HDU), coronary care unit (CCU), and comparable care units; emergency ward treatment.
- Costs for blood, oxygen, blood transfusion/blood products.
- Costs for medicine and pharmaceutical used during the hospitalization.
- Costs for bandages, splints.
- Costs for intravenous fluids.
- Costs for diagnostic imaging examinations such as X-rays, MRI, CT, PET, ultrasounds, endoscopies, and similar procedures. These examinations must be prescribed by a physician as necessary to assess the medical condition and are part of the inpatient treatment costs.
- Delivery charges.
- Other relevant medical expenses.

2. Surgical operation:

The Insurer shall pay for the medical expenses within scope of insurance coverage incur during hospitalization for an inpatient or daypatient surgical operation/treatment procedure, including:

- Surgical operation/treatment procedure costs. The list of treatment procedures is regulated in the Classification of Surgeries and Medical Procedures of the Ministry of Health
- Medicine and medical supplies used during the surgical operation.
- Necessary and reasonable medical appliances as prescribed by the physician that are not excluded.
- Operating theatre charges, surgeon fee, and anesthesia fees
- Fees for consultation before surgery and post-operation recovery, redone operation
- Organ transplantation costs (excluding organ procurement costs, transportation, preservation, organ care, and all other costs incurred by the organ donor).
- Other medical expenses for the surgical operation/treatment procedure.

The total reimbursement amount for a covered surgical operation/treatment procedure will not exceed the sum insured of the insurance benefit selected by the insured person and as specified in the insurance policy.

Surgical operation costs do not include costs for diagnostic procedures.

Out-patient surgery is not covered under this benefit.

3. Pre-admission examination charges

4. Post-admission examination charges

5. Home nursing immediately following discharge

6. Hospitalization daily allowance

7. Additional allowance for treatment at public hospital

8. Rehabilitation

9. Emergency transportation

10. Burial allowance (death during hospitalization)

11. New-born baby care within 7 days after birth at the hospital provided that the mother remains hospitalized (applicable for group of more than 50 employees)

12. Maternity (childbirth and complications of maternity)

Normal delivery: The Insurer shall pay medical expenses incurred for a normal delivery, including but not limited to delivery charges, hospital miscellaneous expenses, specialist fee.

Caesarean section (C-section): is only covered if medically necessary prescribed by a physician for that specific birth, excluding C-section requested by insured person (or redone operation due to previous C-section requested by Insured person).

Complications of maternity: The Insurer shall pay medical expenses arising from complications of maternity (as defined) during pregnancy, or during childbirth as prescribed by the physician.

V. Optional benefits

1. Out-patient treatment due to disease, maternity, dental care

➤ **Scope of cover**

The Insurer shall pay the insured person participating in this optional insurance benefit for the actual, customary, and reasonable medical expenses incurred for outpatient treatment due to disease, maternity, or dental treatment within the insurance period, up to the insurance limit as specified in the insurance policy.

➤ **Insurance benefit**

a. Out-patient treatment due to disease:

- Costs of medical examination, prescribed medicines, laboratory tests, X-ray tests, ultrasound, and diagnostic imaging for the treatment of illness or disease within the scope of insurance coverage.
- Out-patient surgery/procedure, day-patient surgery/procedure (without room and board cost).
- Endoscopy/procedures (including inpatient/daypatient/outpatient) for diagnosis purpose only with no treatment incurred.
- Outpatient complications of maternity.

b. Physiotherapy:

Physiotherapy, radiotherapy, heat therapy, catgut embedding therapy, phototherapy, and similar therapies as prescribed by a physician.

c. Basic dental care:

- Examination, X. Ray.
- Gingivitis, pyorrhoea.
- Normal compound fillings including amalgam, composite, fuji, or similar material.
- Root canal treatment.
- Teeth cleaning.
- Extraction of diseased teeth (including surgery/minor surgery).

Dental treatment medical facilities:

This policy covers for reasonable and eligible dental treatment expenses incurred at medical facilities in accordance with the following provisions:

- + Odontic/Dental departments at all legal hospitals in Vietnam.
- + In Ha Noi and Ho Chi Minh city: Besides Odontic/Dental departments at all legal hospitals above, dental treatment is limited at the clinics/dental clinics in the Direct billing system of the Insurer.
- + In other cities/provinces: Besides Odontic/Dental departments at all legal hospitals above, dental treatment is limited at legally licensed clinics/dental clinics which can issue legal invoices in accordance with the regulation of Ministry of Finance.
- + The Insurer will not cover for treatments at some medical facilities in the list of "Medical facilities where insurance benefits are not covered" updated on the Insurer's official website.

d. Pregnancy check-ups during pregnancy occurring at medical facilities, including:

- Examination costs.
- Ultrasound fees.
- Pregnancy-related urine tests.
- Complete blood count (CBC) test costs.
- Medicines prescribed by physician

2. Comprehensive dental care

On the condition that the insured person has paid the additional premium for this benefit, the Insurer shall pay the following dental care costs arising at medical facilities, subject to the insurance limit as specified in the insurance policy, which include:

- Teeth cleaning (2 times/year)
- Extraction of diseased teeth requiring surgery

- Roots removal
- Solid odontomes removal
- Apicoectomy (surgical removal of the root tip)

When the insured person participates in this benefit, the basic dental care costs under the outpatient treatment benefit shall not be applied. The following dental treatment costs are not covered under this benefit:

- Dentures (repair, renew, fix or replace dentures);
- Cosmetic orthodontics;
- Tooth damage, dental implants due to accident consequences;
- Other exclusions specified in the insurance wording.

3. Daily allowance due to loss of income/Salary allowance

Allowance due to loss of income during accident/disease treatment:

During Accident treatment: Compensation for loss of income during the period of inpatient and/or outpatient treatment as prescribed by the attending physician, not to exceed the covered leave days duration chosen by the insured person.

During Disease treatment: Compensation for loss of income during the period of inpatient treatment as prescribed by the attending physician, not to exceed the covered leave days duration chosen by the insured person. This benefit does not apply for maternity.

Compensation under this insurance benefit is based on the actual number of days of leave for inpatient/outpatient treatment due to accident or inpatient treatment due to disease/illness. The number of leave days must be prescribed by a physician and confirmed by the human resources department of the Policyholder, and the Insurer shall only pay the allowance when the Policyholder confirms that the insured person did not receive salary during the treatment leave period. The reimbursement amount per day per person (including Saturdays, Sundays, and public holidays) will be calculated as follows:

(Maximum sum insured/person/year) / number of covered leave days as specified in the table of benefits x actual number of leave day(s)

Or

(Monthly salary/person) / 30 days x actual number of leave day(s)

Note: Monthly salary (excluding overtime fee, bonuses, or non-fixed allowance...) stated in the labor contract or other equivalent documents used for reimbursement of all insurance benefits will be the salary calculated at the date the insurance event occurs. Any salary changes must be notified to the Insurer and the premium must be fully paid.

PART III: GENERAL EXCLUSIONS

The following exclusions apply to all insurance benefits, including optional benefits.

The Insurer shall not be liable for any risks, below listed items and related medical expenses or their complications/ consequences:

1. Any expenses in excess of medically necessary, customary and reasonable expenses and not prescribed by physician.
2. Treatment and medical expenses incurred before the effective date of insurance policy.
3. Wilful misconduct of the insured person or the legal beneficiary.
4. The insured person aged 14 or over violate laws leading to the criminal prosecution, violation of regulation of local authorities or of social associations. The insured person violates labour regulation according to labour laws (only applicable for death benefit).
5. The insured person drives any kind of transportation while having blood alcohol content exceeds 50 milligrams/100 milliliters of blood or 0.25 milligrams/1 liter of breath; or violating other provisions of the Law on Road Traffic Order and Safety (and its amendments, supplements, or replacements, if any).
6. The insured person being under the influence of stimulants, narcotics, addiction-cessation drugs, medicines that are not prescribed by a physician, alcohol, beer, or any other alcoholic substances, where such influence is the cause of the accident.
7. Consequences arising from the use of illegal drugs, alcoholic substances, or addiction treatment.
8. Costs of acquisition of organs for transplant, including but not limited to, expenses for organ donation, receiving, purchase, transportation, or preservation of organs. However, medical expenses incur for the surgical transplantation of an organ into the body of the insured person shall be covered.
9. Any loss, damage, or expense arising directly or indirectly from any intentional unlawful act or brawl committed by the insured person, unless such act is confirmed by a competent authority as being performed in the act of saving a life, protecting property, or in self-defense.
10. Costs for dental examinations and treatments, including both inpatient and outpatient treatment, unless the insured person enrolls the optional "Basic Dental Care" benefit under Outpatient treatment or the "Comprehensive Dental Care" benefit.
11. Engaging in aviation activities (unless as a fare-paying passenger on a commercial flight), participating in military training courses, or engaging in combat operations by armed forces.
12. Disaster risks such as earthquakes, volcanoes, tsunamis; radioactive contamination; epidemics of infectious diseases group A&B/pandemics/public health emergency officially declared by WHO or the local authorities.

13. Risks arising from or related to war, civil war, strikes, terrorism, riots, civil commotions, armed insurrection disturbing public order, rebellions, or actions of any leader of an organization aiming to overthrow, threaten government, or control by force.
14. Engaging in training for or participating in professional sports activities, or engaging in hazardous sports activities, unless otherwise agreed in the insurance policy.
15. Examination and treatment of sexually transmitted diseases such as: chancroid, granuloma inguinale, gonorrhea, syphilis, genital herpes, genital warts, genital HPV, pubic lice (genital crabs), chlamydia, trichomonas, trichomonas, lymphogranuloma venereum, molluscum contagiosum for insured person above 10 years old, acquired immunodeficiency syndrome (AIDS), HIV-related conditions and diseases, other sexually transmitted diseases; and any complications/consequences related to the above diseases/ syndromes/ conditions.
16. Congenital diseases, birth defects, congenital anomalies, genetic deformities or diseases, hereditary medical conditions with symptoms occur at birth.
17. Routine health check-ups, periodic examinations; general health check-ups; cancer screenings; medical assessments or medical consultations unrelated to the treatment of disease/illness or injury, including gynecological/andrological examinations; examination/treatment for growth hormone deficiency/disorder, pre-menopause or menopause in women; routine examinations for newborns; all forms of immunizations, vaccines, and preventive medicines (except for vaccinations administered after an accident or animal/insect bite); and pregnancy check-ups (unless otherwise agreed in the insurance policy).
18. Degenerative cataracts; strabismus (squint); Routine vision/hearing tests; Aging, degeneration, or treatment for natural/non-pathological deterioration of hearing or vision, including but not limited to: refractive errors including myopia (nearsightedness), hyperopia (farsightedness), and astigmatism, and any treatment/surgical operation for their correction. However, dry eyes, accommodative asthenopia, and accommodative disorders are covered, with a total limit per visit equal to 5% of the sum insured of outpatient treatment benefit, and not exceeding the outpatient treatment benefit sum insured.
19. Treatment and surgical operation carried out as requested by the insured person which are not associated with common treatment or operation as regulated by the health industry.
20. Examinations and laboratory tests/diagnostic imaging without a physician's disease diagnosis, or the physician conclude that there is no diagnosed disease (this does not apply to the first follow-up examination after inpatient discharge as prescribed by a physician); and medical expenses unrelated to the event within scope of coverage.
21. Cosmetic treatment, cosmetic surgery, plastic surgery, complications arising from cosmetic treatment/cosmetic surgery/plastic surgery; and orthodontics (this exclusion does not apply to reconstructive surgery performed to restore the function of an injured organ/body part incur during the insurance period).

22. Treatment for hyperpigmentation (melasma), acne/pimples, and hair loss treatment are specifically excluded for the outpatient treatment benefit. However, if the insured person is required to have inpatient treatment for these diseases/illnesses, the treatment shall be covered under the inpatient treatment benefit.
23. Costs of buying, providing, maintaining, fixing or replacing: prosthesis, medical supportive appliances/devices/equipments used for treatment as defined (unless otherwise agreed in the insurance policy).
24. Dietary supplements, minerals, organic substances augmenting nutritional intake or serving dietary regimens available naturally, cosmeceutical products, and vitamins (unless such vitamins are prescribed accompanied by treatment drug and total expenses for these vitamin/minerals shall not exceed the total expenses of treatment drug).
25. Family planning; examination and treatment for infertility/subfertility; treatment for impotence; sexual dysfunction or physiological treatment; artificial insemination (including all types of artificial insemination), treatment of complications of maternity/childbirth on people got pregnant by artificial insemination; treatment for gender issues; or any consequences or complications of the aforementioned treatments.
26. Body weight control (weight gain or weight loss treatment), malnutrition, rickets, obesity.
27. Mental and behavioral disorders, mental illnesses, psychoneuroses, psychological conditions, somatoform disorders, mental retardation, attention deficit disorders, autism spectrum disorders, sleep disorders, insomnia, snoring without specific cause, neurasthenia and physical debility without pathological cause, stress syndrome or related conditions arising therefrom.
28. Treatment at a private clinic and dental clinic, which is unlicensed or is not able to provide payment documents/invoices in accordance with legal regulations, unless otherwise specified in the policy schedule or any endorsement.
29. In the event that the Policyholder/insured person declares or provides dishonest or incomplete information regarding their medical condition/injury, the Insurer reserves the right to reduce its liability in full or in part for the claim under the insurance policy.
30. All costs incurred in related to persons who is ineligible to be insured under this insurance policy.
31. Home examination/treatment services; remote medical examination and treatment services from hospitals/clinics; examination and treatment at hospitals/clinics that do not comply with the definition of hospitals/clinics in the insurance wording, including the indication from physician of such hospitals/clinics for prescription/tests/treatment at legal hospitals/clinics/pharmacies (unless otherwise agreed in the insurance policy).
32. Experimental treatment, treatment that is not scientifically recognized. Medical expenses derived from free treatment service at any medical facility, preventive examination/treatment.

33. Treatment due to the attending physician's fault.
34. Use of medicine without a prescription; medical treatment and/or use of medicine not in accordance with a physician's prescription; or medicines not legally permitted for circulation in Vietnam.
35. Treatment and surgical operation for disease/illness/injury by stem cell transplantation methods, such as: costs for extraction, processing, transplantation of stem cells, maintenance treatment after stem cell transplantation, and consequences of this treatment method. Stem cell transplantation is only covered for inpatient treatment costs at public hospitals, unless otherwise agreed in the insurance policy.
36. Medical expenses incurred or prescribed by medical facility where insurance benefits are not covered updated on the Insurer's website and/ or regulated in the insurance policy, in case of any difference, the provisions in the insurance policy will prevail.
37. Diseases/disabilities excluded in the first 365 days of insurance period includes: tonsillitis requiring tonsillectomy, adenoiditis need curettage, nasal septum deviation requiring a surgery, otitis media requiring a surgery, sinusitis, asthma, vestibular disorders, all kinds of polyp, herniated disc, gout, hemorrhoids, carpal tunnel syndrome requiring a surgery, all kinds of metabolic disorder, examination/treatment related to ligament and meniscus tears/ruptures/reconstruction.
38. Medical expenses for people who are not the insured person (such as room/board expenses for relatives, other expenses for relatives of the insurer person).

PART IV: GENERAL CONDITIONS

I. Geographical limit

The geographical limit covered by this insurance wording is the territory of the Socialist Republic of Vietnam, unless otherwise specified in the insurance policy or its endorsements/appendices. This geographical limit applies to both the risks arising and the treatment process.

II. Eligibility of Insured person

1. Insured person

1.1. Employees of the Policyholder as defined.

1.2. Dependents of the employees as defined

- Dependents of the existing employees must be enrolled in the program once at the effective date.
 - Mid-term declaration is only applicable for:
 - Dependents of new staff joining after effective date;
 - Newly-married wife or husband;
 - Newborn baby when being eligible to join into the policy;
 - Dependant(s) of employees who passed the probationary period/promoted during the insurance period attaining to join according to company policy.
 - The dependents (if applicable) will be deleted automatically from the employees' leaving date.
 - All the dependents of any employee could be only enrolled and updated into the insurance policy with benefits equivalent to or lower than those of the employee.
- The Policyholder is responsible for providing the list of employees and dependents as per the above eligibility. Failure to do so will lead to the claim(s) declined and cancellation with specific cases.

2. Eligibility of Insured person

- From 12 months old to 66 years old; Extend to cover for insured person from 15 days old to 1-year-old and from 65 years old if renewal: loading from 1% to 50% premium.
- Not suffer from mental illness, leprosy
- Not suffer from cancer (applicable for the person joining in first year).
- Not suffer more than 80% permanent disabilities (applicable for the person joining in first year).
- Not under inpatient treatment(s) of any special disease as defined (applicable for the person joining in first year).
- Vietnamese or Foreigner residing legally within the territory of Vietnam and not travel away Vietnam for more than consecutive 180 days

If the insured person is not eligible to join into this insurance policy, the Insurer has the right to cancel the insurance coverage for that insurer person and all benefits are forfeited.

III. Placement of insurance policy and renew insurance policy

1. Upon the request for insurance enrolment, the representative of the Policyholder commits that the Policyholder has been clearly and fully informed about the insurance benefits, has communicated this information to the insured person, and sent to the

Insurer the list of insured persons. List of insured persons is an integral part of the insurance policy.

2. At the end of the insurance period, the Insurer reserves the right to refuse to renew the insurance policy or to adjust the premium and terms and conditions, and insurance benefits specified in the insurance policy.

IV. Other insurance policies/Other types of insurance

The insurance policy issued under this insurance wording shall be first priority. If at the time of a claim occur, the insured person is covered under another valid insurance policy that provides the same coverage for that claim, the insured person has the right to submit a claim under any of the valid insurance policies. In the event that claim has already been paid under another insurance policy, the insurance policy issued under this insurance wording shall only cover for the claim amount that is not paid by the other insurance policy. However, this provision does not apply to death and permanent disability benefits.

V. Insurance premium and sum insured

Insurance premium and sum insured are calculated in Vietnamese Dong (VND). The calculation of insurance premium and claim reimbursement shall be in accordance with the State regulations on foreign exchange management.

VI. Premium payment period

The insurance premium and the premium payment period are specified in the insurance policy and must comply with the applicable laws. In all cases, the Policyholder is obligated to pay the insurance premium as regulated in the insurance policy.

The Policyholder and the insured person agree that, during the placement of the insurance policy, the Insurer shall not be liable to send any notice of premium payment reminders.

VII. Currency clause

Under this clause, the parties agree that the insurance premium and claim reimbursement amount as per the terms and conditions of the insurance policy can be paid in a currency different from the currency stated in the insurance policy. The exchange rate shall be the selling rate of the Vietnam Joint Stock Commercial Bank at the time of payment or claim compensation.

VIII. Insurance benefits

a) If the insurance period is one year: the insurance benefit is full year benefit coverage

b) If the insurance period is less than one year:

The Policyholder choose one in two options as below:

1. Pro-rata insurance premium:

Insurance benefits: are used in proportion to the participating insurance period (applicable for sum insured, sub-amounts and sub-limits).

Insurance premium = pro-rata of participating insurance period multiple by annual insurance premium.

2. Short-term insurance premium:

Insurance benefits: are full year benefit coverage.

Short-term premium:

- For period not exceeding 1 month = 1/4 annual premium
- For period not exceeding 2 months = 3/8 annual premium
- For period not exceeding 3 months = 1/2 annual premium
- For period not exceeding 4 months = 5/8 annual premium
- For period not exceeding 6 months = 3/4 annual premium
- For period not exceeding 8 months = 7/8 annual premium
- For period exceeding 8 months = full annual premium

IX. Benefit changes

The insurance benefits cannot be changed during the whole insurance period. These benefits can only be changed on the renewal date of the insurance policy based on confirmation of the Insurer.

This provision does not apply to cases where the Insured person changes his/her position, his/her level according to the Policyholder's human resource policy. Insurance benefits can be changed under the following conditions:

- The insurance benefits is within the insurance levels regulated in the insurance policy at effective date.
- An issuance of endorsements and payment of additional insurance premium for the change in salary/ level are required; the Policyholder must provide documents proving this change according to the Policyholder's human resource policy if necessary.
- The claim amount used under previous level of the insured person will be included and continuously counted for the new insurance level.

In case of renewal with a higher sum insured/sub-limit and/or with new additional insurance benefits compared to the previous insurance year, the change must be approved by the Insurer; the difference in the sum insured/sub-limit and the new additional insurance benefits will not be considered as continuous renewal, and the waiting period for the difference in the sum insured/sub-limit and the additional new insurance benefits will be calculated from when the renewal insurance policy (applied for the higher limits in sum insured/sub-limit and/or the additional new insurance benefits) takes effect, unless otherwise agreed in the insurance policy.

X. Promotion and level change clause

In the event that an employee is promoted/appointed to a higher position or demoted during the insurance period, the Insurer agrees to adjust the insurance level of the insured person during the insurance period, provided that the Policyholder updates the changes to the Insurer according to the monthly declaration regulation (before the 15th of the following month) and provide relevant promotion/demotion decision. The waiting period shall apply to the higher limits in insurance benefits of the new level (if any), unless otherwise agreed in writing.

Insurance benefits for level change will be settled as follows:

- Benefit of the insured person will be settled base on the date of insurance occurrence, the insured person belong to which level will be entitle for the insurance benefit of that level.

- In cases of promotion, the insured person will only be entitled to the benefits of the new level after deducting the benefits used under the previous level.
- In cases of demotion:
 - The insured person will be entitled to the benefits of the new (lower) level after deducting the benefits already used under the previous level, provided those benefits do not exceed the limits of the new level.
 - If the insured Person has already used benefits exceeding the limits of the new level, they will no longer be entitled to insurance compensation, and the Insurer will only record the demotion without further coverage.

XI. Effective date / Waiting period

1. Group less than 50 employees:

a. Personal accident:

Effective immediately from the policy effective date.

b. Term life:

- First 30 days in case of normal illness/diseases, dental care.
- First 365 days in case of pre-existing conditions, special diseases, maternity, diseases listed under general exclusion 37 of the insurance wording.

c. Inpatient treatment:

- First 30 days in case of normal illness/diseases, dental care.
- First 365 days in case of pre-existing conditions, special diseases, diseases listed under general exclusion 37 of the insurance wording.
- First 90 days in case of complications of maternity.
- First 270 days in case of childbirth.

d. Outpatient treatment:

- First 30 days in case of normal illness/diseases, dental care.
- First 365 days in case of pre-existing conditions, special diseases, diseases listed under general exclusion 37 of the insurance wording.
- First 90 days in case of complications of maternity.

e. Daily allowance due to loss of income:

- First 30 days in case of normal illness/diseases, dental care.
- First 365 days in case of pre-existing conditions, special diseases, diseases listed under general exclusion 37 of the insurance wording.

2. Group of from & above 50 employees:

a. Personal accident:

Effective immediately from the policy effective date.

b. Term life:

- First 30 days in case of normal illness/diseases, dental care.
- First 365 days in case of pre-existing conditions, special diseases, maternity, diseases listed under general exclusion 37 of the insurance wording.

c. Inpatient treatment:

- Not applicable in case of normal illness/diseases.
- Not applicable in case of pre-existing conditions, special diseases, diseases listed under general exclusion 37 of the insurance wording.
- First 90 days in case of complications of maternity as defined: claim settlement on pro-rata basis from the insurance participation date to the maternity complication treatment date to 90 days.

- First 270 days in case of childbirth: claim settlement on pro-rata basis from the insurance participation date to 270 days.

d. Outpatient treatment:

- Not applicable in case of normal illness/diseases.
- Not applicable in case of pre-existing conditions, special diseases, diseases listed under general exclusion 37 of the insurance wording.
- First 90 days in case of complications of maternity as defined: claim settlement on pro-rata basis from the insurance participation date to the maternity complication treatment date to 90 days.

e. Daily allowance due to loss of income:

- Not applicable in case of normal illness/diseases.
- Not applicable in case of pre-existing conditions, special diseases, diseases listed under general exclusion 37 of the insurance wording.

The Insurer may adjust the waiting period based on specific characteristics of the customer while ensuring the Insurer's ability to pay claims.

XII. Termination of insurance benefits

All insurance benefits under this policy shall cease at 23:59 on the last day of the insurance period or on the date the insurance coverage is terminated, whichever comes first.

XIII. Amendment, Supplement or Termination/Cancellation of the insurance policy

- a. Where either party requests for amendment or supplement to the insurance policy, such notice shall be provided in writing by either Party to the other within 30 days prior to the amendment/supplement date of the insurance policy. Endorsements will be made to attach to the insurance policy.
- b. In case the Policyholder does not comply with the provisions and conditions of the insurance policy package, the insurance policy shall be cancelled immediately. The Insurer shall refuse to settle any reimbursement. The Insurer will refund 70% of the premium of the remaining validity period, provided that at that time the Policyholder has not yet received any claim reimbursement.
- c. Where either party requests to terminate this insurance policy, it shall give the other party a 30-day written notice of such cancellation. Such cancellation shall be in compliance with the Law on Insurance Business and the Civil Code and:
 - Where such cancellation is requested by the Policyholder, the Insurer shall refund 80% of the premium collected in respect of the unexpired period, provided always that as of such agreed cancellation there is no claim incurred yet.
 - Where such cancellation is requested by the Insurer, the Insurer shall refund 100% of the premium collected in respect of the unexpired period regardless of paid claim.

XIV. Automatic addition and deletion applied for employees/dependents

This Policy shall automatically cover for any new eligible employees of the Policyholder on joining the Policyholder's employment for an amount of sum insured not exceeding the amount for similar occupational category of the employees as specified in the Policy, and automatically delete any existing employees on leaving the Policyholder's employment from the date of their employment termination, provided that the Policyholder shall declare actual employees' monthly movement to the Insurer before the 15th of the next month during the insurance period.

The declaration shall include name of additional or deleted person, date of birth, date of joining or date of deletion, ID number, position, level of insurance, salary and other relevant information.

It is further agreed that the insurance policy is automatically extended to cover the monthly salary adjustment of the employees (if applicable) subject to the labor contract between the Policyholder and the employees provided that the Policyholder shall declare any monthly payroll adjustment or monthly payroll sheet to the Insurer before the 15th of the next month during the insurance period. Premium will be adjusted subject to salary alteration.

For any new employees whose monthly salary equals to or exceeds VND 140,000,000 or sum insured of death and permanent disablement is higher than VND 4,200,000,000, they will not be automatically included into the insurance policy. The Policyholder has to declare to the Insurer and receive prior confirmation from the Insurer. The Policyholder has to declare the monthly salary information to the Insurer only when having insurance benefits based on monthly salary.

The new dependents who are eligible to join after inception date will be updated at the same time with employees' declaration (before the 15th day of the next month during the insurance period). New married spouses/ new-born children of former employees declare within 30 days from the date of marriage registration/the date when new-born children is eligible for insurance. The effective date of the mid-term added dependents should be the date when they are eligible to join into this Policy (the effective date of new employee's labor contract/the registry date of marriage certificate/ the date when newborn offspring is eligible to join/the date when the employee passes the probationary period-level up attaining to join group allowed to buy insurance for their dependents according to the company's policy).

XV. Premium payment warranty and reinstatement of insurance policy's validity

The Insurer shall be responsible for claims incurred during the premium payment period as stated in this policy provided that the Policyholder ensures premium payment be made in full and within the time stipulated above.

In case any of the above-mentioned premium is not fully paid nor actually transferred to the Insurer within the premium payment period stipulated above, this insurance policy's validity shall automatically be terminated right when the premium payment period ends and the Policyholder is responsible for paying the insurance premium to the time the Policy's validity automatically be terminated.

It is further agreed that in case the above premium is fully paid to the Insurer (or the party which the Insurer gives authority to collect premium) after the premium payment period as prescribed above, the validity of the insurance policy shall be deemed to be reinstated from the time when the premium is fully paid to the Insurer (or the party which the Insurer gives authority to collect premium) based on written confirmation of the Insurer. The Insurer shall in no case be liable for any risks/claims occurred during the period when the Policyholder was overdue in paying the insurance premium until the time the insurance policy's validity be reinstated based on confirmation of the Insurer (and the relevant consequences of these risks).

XVI. Obligations of the Policyholder and the insured person

a) Fully and truthfully declare all information related to the insurance policy as required by the Insurer;

- b) Read and clearly understand the terms and conditions, as well as the rights and obligations of the Policyholder when entering into the insurance policy and other contents of the insurance policy;
- c) Pay the insurance premium in full and on time as agreed in the insurance policy;
- e) Implement preventive measures and loss mitigation in accordance with the Law on Insurance Business and other relevant legal regulations;
- f) The Policyholder is responsible for collecting the signatures/authorizations of the insured persons confirming their consent for the Policyholder to arrange insurance on their behalf;
- g) Others obligations as prescribed by law.

XVII. Verification

The Insurer shall have the right to examine any insured person through his medical representative or any information whenever and as often as may be reasonably required within the duration of any claim at any time.

Additionally, the Insurer shall have the right to request an autopsy to be performed in the case of death, where this is not forbidden by law or religious beliefs.

The Insurer reserves the right to terminate the insurance policy at any given time without any obligation to pay reimbursement or refund premiums in case the insured person or Beneficiary/Legal heir provides dishonest information and/or does not comply with the provisions and conditions of this insurance policy and endorsements (if any). In case the Insurer has paid the insurance benefits due to the above acts, the Insured person/Beneficiary/Authorized Person/Legal Representative shall be obliged to return the paid amount to the Insurer.

XVIII. Governing law and dispute resolution

Any dispute arising from this insurance wording/ insurance policy which cannot be resolved through negotiation shall be settled in the Vietnamese court and under Vietnamese law (All court-related costs shall be determined by the court)

XIX. Protection and Processing of personal data

When participating under this insurance wording, by confirming/signing the insurance application form and/or insurance policy, the Policyholder and the insured person(s):

- (i) Agree to receive the “General Terms and Conditions on Personal Data Protection and Processing” provided/handed over by Bao Viet Insurance, either by proactively accessing, reading, or downloading the document from Bao Viet Insurance’s official website; and
- (ii) Voluntarily, knowingly, and explicitly agree to the list of personal data categories to be processed, the purposes of personal data processing, and the rights and obligations of the data subjects as specified in the “General Terms and Conditions on Personal Data Protection and Processing” of Bao Viet Insurance; and
- (iii) Consent to Bao Viet Insurance accessing, collecting (whether directly collect; or collect by hiring, using any third parties selected solely by Bao Viet Insurance without prior notice to the Policyholder or insured person, or via other legally compliant methods), controlling, processing (whether directly process; or process by hiring, using any third parties selected solely by Bao Viet Insurance without prior notice to the Policyholder or insured person, or via other legally compliant methods), and storing personal data in accordance with the content and purposes listed in the “General Terms and Conditions on Personal Data Protection and Processing” published on Bao Viet Insurance’s official website.

PART V: CLAIM SETTLEMENT AND DIRECT BILLING PROCEDURE

I. Claim documents

Unless otherwise agreed in the insurance policy, when submitting a claim, the insured person/his legal heir/his legal Beneficiary/his legally authorized representative/the parents of children under age of 18 must submit all claim documents (in English or Vietnamese) within 01 year from the end date of treatment period/discharge date/date of death. In cases the language used in the claim documents is not Vietnamese or English, the insured person is responsible for providing a notarized translation into either Vietnamese or English to enable the Insurer to process the claim. All translation costs shall be paid by the insured person. If the claim documents are submitted after claim submission timeline as above-mentioned, the Insurer may be partially or fully denied, except in cases of force majeure.

1. The claim form (following Insurer's claim form, signed and stamped by Policyholder) must be filled in and signed by the insured person or the claimant as the legal successor/beneficiary/representative of the insured person. In case the insured person is a child under 18 years, his/her father/mother (who is employee of the Policyholder) should fill in and sign.

2. In case of accidents:

- Accidents in daily life: The accident report is required a brief description of the accident, without the policy holder's confirmation or local authorities.
- Labor accidents: The accident report is required with the human resources department's confirmation.
- Traffic accidents: Subject to health condition and legal capacity, the insured person must declare information on an accident report; accident reports of police (when the police is involved or in case of death); the driver license, the vehicle registration form if the accident occurs when the insured person is driving a vehicle (required if the insured person was driving a motor vehicle at the time of the accident, except for motor vehicles under 50cc).

3. In case of permanent disability: disability certificate and/or disability assessment report provided by relevant authorities.

4. Records of treatment procedure:

- Medical prescriptions (stated on prescription/medical books/medical reports in accordance with regulations of the Ministry of Health);
- Medical reports/medical books with the Physician's diagnosis and treatment indication;
- Hospital discharge certificate (in case of hospitalization);

- Indication and results of examinations/imaging diagnostic tests, examination/imaging diagnostic test results, biopsy result,... (these are compulsory in outpatient claim. In case of inpatient claim, these should be provided upon request of the Insurer);
- Certificate of surgical operation (in case of surgical operation);
- Other related medical documents as required by the Insurer.

All such medical records must be original and signed and stamped by medical facilities (except for prescription at public hospitals using barcode). If the original versions are not available, the insured person may submit the copies certified by the Insurer. In all circumstances, the Insurer reserves the right to require originals for checking and/or reconciliation.

5. Records of payment procedure:

VAT invoices, bills, receipts are issued in accordance with regulation of Ministry of Finance, and relevant breakdowns. In respect of these payment records, only the originals are acceptable and shall be considered as the property of the Insurer after the claims are reimbursed (Certified copy of invoice breakdown is acceptable if the amount on the breakdown matches the amount on the invoice). The invoices/bills/receipts for medicine/treatment expenses must indicate the same dosage prescribed by the physician. The Insurer does not accept retail sales receipts for claim submission.

In case of Cesarean (C-section) at Hanoi obstetrics and gynecology hospital, National Hospital of Obstetrics and Gynecology, and other public hospitals (with similar issues or facts), the expenses of Cesarean delivery packages will be covered up to sub-limits of relevant benefits in benefit schedule without expense breakdown. Other expenses related to the C-section will be paid upon the policy regulation and relevant payment claim documents.

6. Records of Daily allowance due to loss of income:

The physician's indication for period off work on prescription/discharge notes/relevant medical documents; timesheets (or confirmation upon absence from Human resources), payrolls certified by the Policyholder; Labour contact/Labour agreement; Salary increase decision/Salary payrolls (not applicable when this benefit is not subject to salary benefit).

7. In case of death: medical records prior to death (if any), death certificate, death notice/certificate of cause of death issued by a competent authority, testament or legal certificate of inheritance in case of Insured's death and there is no previously nominated beneficiary or the nominated beneficiary has died or gone missing for a certain period. These documents must be original, or copied version with authorities' notarization.

8. Proofs of personal relations (in case of dependent's claim) upon the Insurer's request.

9. Others upon the Insurer's request.

II. Claim settlement procedure and direct billing

1. In case of pay first then submit claim later:

In cases the Insured person is not eligible to use direct billing services, or clinic/hospital which is not in the list of direct billing network, the insured person must pay all medical expenses first, and then submit the claim to the Insurer for reimbursement of medical expenses within scope of insurance coverage.

a. Claim payment timeline:

The Insurer is responsible for processing and settling the claim within the claim payment timeline in the insurance policy; in case there is no relevant regulatory in the insurance policy, the Insurer shall be responsible for claim handling and settlement, claim notification to the insured person/his legal heir/his legal beneficiary/his legally authorized representative within fifteen (15) working days from the date of receipt of all valid and sufficient claim documents.

b. General information of claim settlement:

- All documents (including original invoices, certificates, X-ray films, etc.) required by the Insurer to support the claim settlement process, including medical reports and any information related to the insured person's medical history must be provided free of charge to the Insurer, prior to any insurance payment being made. In cases medical information is missing or documents must be clarified, the insured person is responsible for providing the additional information, and the Insurer is not obligated to cover the costs associated with acquiring this additional information.
- Insurance benefits shall be paid to the insured person/his legal heir/his legal beneficiary/his legally authorized representative in accordance to applicable laws. In cases the insured person has not nominated his legal beneficiary, or this legal beneficiary has passed away or gone missing, the Insurer shall pay the claim amount to the legal heir(s) in accordance to the inheritance laws.
- The employee may act on his/her dependent's behalf to make a claim and receive claim reimbursement unless it is a death claim which shall be subject to applicable inheritance laws.

2. In case of direct billing (applicable for insurance policy with direct billing service)

Unless otherwise stipulated in the insurance policy, when visiting clinic/hospital which is in the list of direct billing network system, the insured person should follow steps described below:

- To show Baoviet direct billing insurance card issued by the Insurer and ID card/Passport/Residence card/Birth Certificate (in case the insured person is a child) to the hospital/clinic.
- To ensure to check the claim form provided by the hospital/clinic after treatment and sign on that form in order to confirm all information related to the insured person's treatment, make a deposit to the hospital/ clinic (if required).
- To pay the remaining costs which are not within the scope of coverage or exceed the benefit limits.

III. Time limit for appealing claim

The insured person has the right to appeal against any claim settlement within six (06) months from the date of receipt of Insurer's notification and the duration for any appeal must not exceed three (03) years from the date the entitled person knows or should know that his/her legitimate rights and interests have been violated.

APPENDIX I: SCALE TABLE OF DEATH / PERMANENT DISABILITY

NO.	BENEFITS	PERCENTAGE OF THE SUM INSURED
I -	DEATH	100%
II -	TOTAL PERMANENT DISABILITY	
1	Total loss of chewing and speaking function	100%
2	Complete loss, total paralysis and irreversible loss of function of: 2 hands, or 2 feet, or 1 arm and one foot, or 1 arm and 1 leg, or 1 hand and 1 leg, or 1 hand and 1 foot	100%
3	Cutting off of one lung and part of the other	100%
4	Bodily damage of 81% or more resulting in total impediment to the person's participation in all works or total loss of ability to work in any type of works, which is compared to the definition of Total permanent disability	100%
III -	PARTIAL PERMANENT DISABILITY	
	UPPER LIMBS	
5	Total loss of one arm at shoulder level (removal of shoulder joint)	75%
6	Amputation of one arm beneath shoulder level	70%
7	Amputation of one arm beneath elbow level (removal of elbow joint)	65%
8	Total loss of one hand or five fingers of one hand	60%
9	Total loss of four fingers of one hand	40%
10	Total loss of thumb and forefinger	35%
11	Total loss of three fingers: thumb, middle finger and ring finger	30%
12	Total loss of thumb and the other two fingers	35%
13	Total loss of thumb and the other one finger	30%
14	Total loss of forefinger and the other two fingers	35%
15	Total loss of forefinger and other one finger	25%
16	Total loss of middle finger and ring finger	19%
17	Total loss of middle finger and little finger	18%
18	Total loss of ring finger and little finger	18%
19	Total loss of thumb and its metacarpal bone	25%
20	Total loss of thumb	20%
21	Total loss of distal phalanx of thumb	10%
22	Loss of half of distal phalanx of thumb	07%
23	Total loss forefinger and its metacarpal bone	20%
24	Total loss of forefinger	18%

25	Total loss of distal and middle phalanges of forefinger	10%
26	Total loss of distal phalanx of forefinger	08%
27	Total loss of middle finger or ring finger (including the metacarpal bone)	18%
28	Total loss of middle finger or ring finger	15%
29	Total loss of distal and middle phalanges of middle finger or ring finger	08%
30	Total loss of distal phalanx of middle finger or ring finger	04%
31	Total loss of little finger and its metacarpal bone	15%
32	Total loss of little finger	10%
33	Total loss of distal and middle phalanges of little finger	08%
34	Total loss of distal phalanx of little finger	04%
35	Ankyloses of the shoulder joint	30%
36	Ankyloses of the elbow joint	25%
37	Ankyloses of the wrist	20%
38	Loss of substantial osseous substance of the upper arm leads to shortening of the Upper limb by over 3cm and affecting the pronation and supination or forming artificial joints	25%
	LOWER LIMBS	
39	Loss of one leg at hip level (removal of hip joint)	75%
40	Cutting off of a thigh	
	- Cutting off of a thigh: The upper third	70%
	- Cutting off of a thigh: The proximal or middle third	55%
41	Amputation of a leg at knee level (removal of knee joint)	60%
42	Removal of tarsal joint or loss of one foot	55%
43	Amputation of talus	35%
44	Amputation of calcaneus	35%
45	Amputation of portion of tibia or fibula resulting in false joint	35%
46	Amputation of portion of fibula	20%
47	Amputation of ankle: Lateral (outside) of Ankle	10%
48	Amputation of ankle: Medial (inside) of Ankle	15%
49	Total loss of five toes of one foot	45%
50	Loss of four toes including great toe of one foot	38%
51	Loss of 4 toes not including great toe	35%
52	Loss of 3 toes not including great toe	25%
53	Loss of 3 toes including great toe	30%
54	Loss of great toe and the second toe of one foot	20%
55	Loss of great toe and one other toe (except second toe)	16%
56	Loss of second toe of one foot and one other toe (except great toe)	11%
57	Loss of two toes: third and fourth toe; or third and fifth toe; or fourth and fifth toe	6%

58	Loss of great toe	15%
59	Loss of any one toe other than great toe	10%
60	Loss of one phalanx of great toe	8%
61	Loss of one phalanx of other toe	1%
62	Loss of two phalanx of other toe	2%
63	Ankylosis of hip joint	45%
64	Ankylosis of knee joint	30%
65	Loss of substantial portion of patella resulting in significant restricted extension of lower-leg	45%
66	Loss of substantial osseous substance of the lower leg leads to shortening of the lower limb	
	Loss of substantial osseous substance of the lower leg leads to shortening of the lower limb: By at least 5cm	40%
	Loss of substantial osseous substance of the lower leg leads to shortening of the lower limb: By 3cm to 5cm	35%
67	Total paralysis of common peroneal nerve	35%
68	Total paralysis of tibial nerve	25%
	SPINAL COLUMN	
69	Amputation of posterior arch of one vertebra	35%
70	Amputation of posterior arch of more than one vertebrae	45%
	SKULL AND BRAIN	
71	Loss of osseous substance of the skull (without symptoms of mental illness) causing chronic headache	35%
	THORAX	
72	Amputation of one to two ribs	15%
73	Amputation of three ribs and more	25%
74	Amputation of portion of each rib	08%
75	Total amputation of one lung	70%
76	Amputation of many pulmonary lobes in both lungs, respiration volume decreases by 50%	65%
77	Amputation of many pulmonary lobes in one lung	50%
78	Amputation of one pulmonary lobe	35%
	ABDOMEN	
79	Total gastrectomy	75%
80	Partial gastrectomy	50%
81	Enterectomy (remaining under 1 m)	75%
82	Partial enterectomy	40%
83	Total Colectomy	75%
84	Partial Colectomy	50%

85	Pure right hepatic lobectomy	70%
86	Pure left hepatic lobectomy	60%
87	Partial hepatic lobectomy	40%
88	Cholecystectomy	45%
89	Splenectomy	40%
90	Amputation of tail of pancreas-lien	60%
	UROGENITAL SYSTEM	
91	Total nephrectomy of one kidney, the function of the remain kidney is normal	45%
92	Loss of one side of testicle/ovaries	11%
93	Loss of both sides of testicle/ovaries	36%
94	Total loss of penis	41%
95	Total renoectomy of uterus	41%
96	Total nephrectomy of one kidney, the remain kidney is injured or contracted disease	70%
97	Partial left or right nephrectomy	30%
98	Removal of portion of bladder	27%
99	Loss of penis and two testicles	
	Loss of penis and two testicles, in respect of the person: who is under 55 years old and hasn't had children	70%
	Loss of penis and two testicles, in respect of the person: who is under 55 years old and has had children	55%
	Loss of penis and two testicles, in respect of the person: who is above 55 years old	35%
100	Total removal of uterus and ovaries	
	Total removal of uterus and ovaries, in respect of the woman: who is under 45 years old and hasn't had children	60%
	Total removal of uterus and ovaries, in respect of the woman: who is under 45 years old and has had children	30%
	Total removal of uterus and ovaries, in respect of the woman: who is above 45 years old	25%
101	Mastectomy	
	Mastectomy, in one side, in respect of the woman: who is under 45 years old	20%
	Mastectomy, in both sides, in respect of the woman: who is under 45 years old	45%
	Mastectomy, in one side, in respect of the woman: who is above 45 years old	15%
	Mastectomy, in both sides, in respect of the woman: who is above 45 years old	30%
	EYE	
102	Total loss of or total loss the use of one eye, and	

	- Not to be able to be installed artificial eye	55%
	- To be able to be installed artificial eye	50%
103	Loss or loss the use of one eye and there was loss or loss of use of the other eye before the accident	80%
	EAR-NOSE-THROAT	
104	Deafness of both ears, there is no ability of recovery	75%
105	Deafness of both ears: Severe condition (be able to hear speaker screaming or speaking loudly right into ear)	60%
106	Deafness of both ears: Moderate condition (be able to hear loud voices from a distance of 1 meter-2 meters)	35%
107	Deafness of both ears: Mild condition (be able to hear loud voices from a distance of 2 meters-4 meters)	15%
108	Deafness of one ear, there is no ability of recovery	30%
109	Deafness of one ear: Severe condition (be able to hear speaker screaming or speaking loudly right into ear)	20%
110	Deafness of one ear: Moderate condition (be able to hear loud voices from a distance of 1 meter-2 meters)	15%
111	Deafness of one ear: Mild condition (be able to hear loud voices from a distance of 2 meters-4 meters)	08%
112	Total loss of helix in both sides	20%
113	Total loss of helix in one side	10%
114	Total loss of nose	18%
	FACE	
115	Total loss of maxilla and mandible at its ramus downward:	
	Total loss of maxilla and mandible at its ramus downward: in different sides	80%
	Total loss of maxilla and mandible at its ramus downward: in one side	70%
116	Total loss of maxilla or mandible	70%
117	Partial loss of maxilla or loss of one-third to one-second of mandible from its ramus downward	35%
118	Loss of three-fourth of tongue, root remained (from the V shaped line and outward)	75%
119	Loss of two-third of tongue from tip of the tongue	50%
120	Loss of one-third of tongue, having adverse impact on pronouncing	15%
121	Loss of part of tongue (less than one-third) which adversely impacts on pronouncing	10%

Provisions of reimbursement:

a) In case of various disability incurred on the same limb, total claim reimbursement shall not exceed the sum insured for loss of that limb.

b) In case the Insured person suffered a permanent disability which is listed in various benefits, which category is higher (or highest) will apply. If a benefit has already been

paid for the loss of an entire body part, there is no longer a benefit for the loss of any part of that body part.

c) In case the consequences of an accident within the insurance coverage are aggravated by the existing conditions of the insured person or the treatment of bodily damage which is not in a timely manner and does not follow the instructions from the medical facility, the Insurer shall only consider to cover for the same type of disability in people with normal health conditions being treated appropriately.