Section 1 - Introduction

This **policy** document has been designed to set out all the features and benefits of the **policyholder's** Care Plus **plan**. On the next few pages the **policyholder** will find details of **his/her** cover followed by the terms and conditions which includes definitions relevant to **his/her plan.**

1.1 What the healthcare insurance cover is designed to do

Care Plus **plan** covers the **policyholder, his/her dependant** partner and/or **dependant** child(ren) (as shown on the **policy schedule**) for costs arising from an unforeseen event. For healthcare insurance this means the cost of **medically necessary eligible treatment** resulting from an unexpected illness or **accident**.

1.2 A personal service

At PJICO, **we** are always aware that behind every claim there is a person who needs help and assistance. If there is anything the **policyholder** does not understand, please do not hesitate to call **our** Customer Service/Direct Billing and Claims Support team team.

*1.3 What **our** Customer Service/Direct Billing and Claims Support team is here to do*

It is the role of **our** Customer Service/Direct Billing and Claims Support team to assist the **policyholder** and the **insured person**, wherever possible, within the terms and limits of the **policyholder's Care Plus plan**. The **policyholder** will find the number of **our** Customer Service/Direct Billing and Claims Support team on the reverse of **his/her** membership card. Please also see Section 11 of this **policy** document for details of **our** Customer Service/Direct Billing and Claims Support team. For the **policyholder** or **insured person's** own protection, calls may be recorded in case of subsequent query or for training purposes.

Please take note of this and advise the **insured person** to keep his/her membership card in a safe place where he/she can find it easily. The **policyholder/insured person** is to have their membership card on hand whenever they call **our** Customer Service/Direct Support and Billing team. The information on their membership card will help them to deal with their enquiry as quickly as possible.

1.4 What this document means

This document sets out the terms of the **policy** with **us** and must be read in conjunction with any supplementary documentation **we** provide to the **policyholder** from time to time (e.g. the **policy schedule** and membership card etc). **We** have tried to keep this as clear as possible however, if there is anything the **policyholder** does not understand or would like to clarify, please contact **us**. Decisions regarding the benefits and/or changes to the terms of the **policy** cannot be made verbally but must be confirmed by **us** in **writing**.

In this **policy** document the **policyholder** will find detailed definitions, terms and exclusions forming part of the contract between the **policyholder** and **us**. Please read them carefully and ask **us** if there is anything the **policyholder** or the **insured person** do not understand.

1.5 Free look provision – Applicable only to Individual Policy

The **policyholder** has a free-look period of seventeen (17) days from the date the **policyholder** sign this policy contract. If the **policyholder** decides that this **policy** does not suit **his/her** needs, **he/she**

may request to cancel it by giving **us** clear, written instructions and returning the **policy** documents and membership card(s) to **us** within the free-look period. Provided that no claim has been made during this period, **we** shall refund the **premium**s paid by the **policyholder**, in full, without interest. This free-look period shall not apply to policies with terms of less than one (1) year. It will also not apply to **policy** renewals.

Section 2 – Eligibility

*2.1)Care Plus **plan** covers those who comply the following criteria:*

- Vietnamese living and working in Vietnam, or
- Vietnamese full time students studying outside Vietnam, or
- Vietnamese who are working temporarily outside Vietnam and who will be returning to Vietnam, or
- Foreigners living and working legally in Vietnam.

An **insured person** must be **aged** between at least fifteen (15) days old and not more than aged eighty (80) years old at time of application to be eligible to be covered under this policy.

*2.2) For an **insured person** who is **aged** between fifteen (15) days to five (5) years old (inclusive)*

For a child **aged** between fifteen (15) days old to five (5) years old at time of application, the child must enrol with a parent or **guardian** on the same **policy** or on a **Care Plus policy**. On subsequent **policy anniversaries**, the **policy** must be renewed with the child together with the parent or **guardian** until the **policy anniversary** following the child reaching **aged** five (5)years old.

*2.3) For an **insured person** who is **aged** six(6) to seventeen(17) years old (inclusive)*

Child who is **aged** six (6) years to seventeen (17) years old, he is eligible for cover without one parent or **guardian** covered on any **Care Plus policy**. The **policy** issued must be to a parent or **guardian** who is **aged** eighteen (18) years old and above.

*2.4) For an **insured person** who is **aged** eighteen (18) to eighty (80) years (inclusive)*

The **policy** may be issued to the **insured person.**

*2.5) For an **insured person** who is residing outside Vietnam*

For an i**nsured person** who is residing outside Vietnam, that **insured person's** nationality must be Vietnamese.

We may be required to apply legitimate international sanctions to this **policy** and may be unable to meet its full obligations under the terms of this **policy** where to do so would render it subject to legal action under international or domestic law. **We** and other service providers will not cover or pay claims under this **policy** if doing so would expose **us** or the service provider to a breach of international economic sanctions, laws or regulations by countries and international organizations.

Please note:

For avoidance of doubt, each of the person to be insured in this **policy** mentioned in Section 2.1 to 2.5 must submit evidence of insurability, and accepted by **us** in writing.

Section 3 - Definitions

Some words and phrases have special meanings. These meanings are set out below. When **we** use these terms they are in bold print.

a) **Accident/accidental**
Refers to any external, sudden, non-disease, unforeseen, visible, violent and unexpected physical event beyond the control of the **policyholder** or the **insured person** resulting in bodily injury.

b) **Acute**
Refers to a disease, illness or injury that is likely to respond quickly to **treatment** which aims to return the **policyholder's insured person** to the state of health the **insured person** was in immediately before suffering the disease, illness or injury, or which leads to the **insured person's** full recovery.

c) **Alternative practitioner**
Refers to a person ((other than **policyholder,** the **insured person,** or a family member (including parent(s), parent(s)-in-law, brother(s),sister(s), spouse or child(ren))of **policyholder** or the **insured person**) who is registered and qualified to practice acupuncture, chiropractic, homeopathy, naturopathy, Chinese traditional medicine, or provide nutrition advice by the relevant licensing authority where the treatment is given.

For description on the following alternative treatment: acupuncture, chiropractic, homeopathy, naturopathy, Chinese traditional medicine, please refer to the information provided by US National Institutes of Health (NIH) (www.nlh.gov).

d) **Alternative treatment**
Refers to consultation and treatment provided and prescribed by an **alternative practitioner** or **physiotherapist**. Please refer to the **benefit table** according to the **insured person's plan** to check the availability and the limits of the 'alternative treatment' benefit.

e) **Annual deductible**
Refers to the aggregate amount of eligible expenses claimed that the **insured person** will have to bear each **policy year** before any benefits are payable under the **insured person's plan**.

f) **Age/aged**
Refers to the **insured person's** age on his / her next birthday (and the expression "Aged" shall be construed accordingly).

g) **Area of cover**
Refers to one of the following as stated on the **insured person's plan** on the **policy schedule** and/or **endorsement:**
- **South East Asia:** Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand, Vietnam, Timor-Leste, Singapore
- **Vietnam**: Vietnam
- **Worldwide excluding USA:** worldwide excluding the USA.

h) **Assisted conception/assisted pregnancy**
Refers to the use of medical technology to increase the number of eggs during ovulation or to bring a human sperm and an egg, or eggs, close together, thereby increasing the chance of conception. This includes intra-uterine insemination (IUI), in-vitro fertilisation (IVF),

intracytoplasmic sperm injection (ICSI) or the use of any form of **treatment** to induce or increase ovulation. This includes surrogate conceptions.

i) **Benefits table**
Refers to the table applicable to the **insured person's plan** stated on the **policy schedule** showing the maximum benefits **we** will pay for each **insured person**.

j) **Congenital conditions**
Refers to a genetic (including hereditary condition), physical or biochemical defect or disease, malformation or anomaly, present at birth and whether or not manifest, diagnosed or known about at birth.

k) **Co-insurance/Co-payment**
Refers to a share of the eligible medical expenses that the **policyholder** and/or the **insured person** need to pay after the **annual deductible**(if applicable). Please refer to the **insured person**'s **benefits table** and/or the **policy schedule** and/or **endorsement** on the co-insurance percentages. Where applicable, in applying **annual deductible** and co-insurance (the percentage of eligible benefits payable by the **insured person**), **we** will subtract the **annual deductible** first and then apply the co-insurance to the balance of eligible benefit remaining.

l) **Day-care treatment**
Refers to an **eligible treatment** (excluding **out-patient treatment)** at a **hospital** (where a discharge summary or a day-care summary is issued by the **hospital**) and the **insured person** requires a medically supervised recovery but does not occupy a bed overnight. This excludes all forms of **alternative treatment** and traditional medicine.

m) **Dental practitioner**
- For a dental **eligible treatment** in Vietnam, a dental practitioner refers to a person ((other than **policyholder,** the **insured person,** or a family member (including parent(s), parent(s)-in-law, brother(s), sister(s spouse or child(ren) of **policyholder** or the **insured person**)) who has relevant degree following attendance at a recognised medical school and who is licensed or registered with the relevant statutory dental board or council in Vietnam to provide dental treatment.

- For a dental **eligible treatment** outside Vietnam, a dental practitioner refers to a person ((other than **policyholder,** the **insured person,** or a family member ((including parent(s), parent(s)-in-law, brother(s), sister(s), spouse or child(ren) of **policyholder** or the **insured person**)) who has the primary degree in dentistry following attendance at a recognised dentistry school, who is licensed and registered with the relevant statutory dental board or council to provide dental treatment.

n) **Dependant(s)**
Refers to **policyholder's** partner and unmarried children (or those of **policyholder's** partner) living with the **policyholder** when the **policyholder** take out the **policy** or when this **policy** is renewed. By partner **we** mean **policyholder** current legally married spouse who is **aged** between eighteen (18) to eighty(80) years (inclusive). For the child, he/she must be **aged** at least fifteen (15) days old to twenty-one (21) years (inclusive). Child(ren) who are eligible under this **policy** cannot stay on the **policy** after the **policy anniversary** following his/her twenty-first (21) birthday. However, his/her cover may be renewed up to the **age** of twenty-five (25) years old provided he/she is unmarried and is still a full time student in an educational institution.

o) **Diagnostic procedure(s)**

Refers to consultations and investigations needed to establish a diagnosis for an **eligible treatment** where there are symptoms.

p) **Eligible treatment**
Refers to those **treatments** and charges that are covered by the **policy**. In order to determine whether a **treatment** or charge is covered, all sections of the **policy document** should be read together, and are subject to all the terms, benefits and exclusions set out in this **policy** document.

q) **Emergency**
Refers to a sudden, unexpected **acute medical condition** which constitutes a serious or life threatening emergency which requires immediate surgical or medical attention to avoid death or permanent and irreversible total loss of function.

r) **Endorsement(s)**
Refers to the supplementary document **we** issue to the **policyholder** to record and confirm changes to this **policy** document.

s) **Evacuation or Repatriation Service**
Refers to moving the **insured person** to another **hospital** which has the necessary medical facilities either in the country where the **insured person** is taken ill or in another nearby country (evacuation) or bringing the **insured person** back to his/her **principal country of residence** or his/her home country(repatriation). The service includes any **medically necessary treatment** administered by the service provider appointed by **us** while they are moving the **insured person**.

t) **Global Directory of Hospitals**
Refers to the network of **hospitals** with which **we** have direct settlement arrangements. This means that if the **policyholder** choose any of the **hospitals** listed in the directory, **we** will be able to settle the bills for eligible **in-patient treatment** directly with the **hospital**, provided the **policyholder** have informed **us** of the **treatment** in advance.

The **policyholder** and/or the **insured person** are still responsible for any **co-insurance**, **annual deductible** applicable, which must be settled directly with the **hospital** at the time of **treatment**. Please bear in mind that there still may be some costs which the **policyholder** need to pay for such as telephone calls, newspapers, etc. which the **hospital** may ask the **policyholder** to pay for upon discharge.

Please note:
Where an **insured person** receives **treatment** for a **medical condition** that is not covered within the terms of this **policy**, the **insured person** remains liable for the costs of such **treatment**, which must be settled in full upon request. Failure to act accordingly will result in the suspension or cancellation of the cover.

An insured person should use a **hospital** listed in this Global Directory of Hospitals except in the case of **emergency** where this may not be possible.

The **policyholder** may contact **our** hotline on the membership card or access www.pjico.com.vn for the latest information.

u) **Guardian**
Refers to a person required by law or appointed to take care of and protect legitimate rights and interests of a minor.

v) **Hospital**

Refers to any establishment which is licensed as a medical or surgical hospital**,** specialist centre or provider in the country where it operates and it meets all the following requirements:

- it operates primarily for the reception, care and **treatment** of sick, ailing, or injured persons as in-patients;
- it provides twenty-four (24) hours a day nursing service by **nurses**;
- it has a staff of one or more licensed **medical practitioners** available at all times;
- it provides organised facilities for diagnosis and major surgical facilities;
- it is not primarily a nursing home, rest home, convalescent home or similar establishment, geriatric ward, an institution for **treatment** of substance abuse, alcoholic rehabilitation or drug rehabilitation.

w) **Independent medical practitioner**

Refers to an independent **medical practitioner** which both the **policyholder** and PJICO agree to ask for advice on medical facts relating to a claim or to medically examine the **insured person** in connection with the claim and provide **us** with the report.

x) **In-patient treatment**

Refers to **eligible treatment** at a **hospital** where the **insured person** has to stay in a **hospital** bed for one or more nights. This excludes all forms of **alternative treatment** and traditional medicine**.**

y) **Insured person(s)**

Refers to a person for whom the insurance coverage is made for, with an insurable interest relation with the **policyholder** and named as an **insured person** on the **policy schedule** and may, as applicable, include the **policyholder**.

z) **Intensive care unit**

Refers to a section within a **hospital** which is designated as an intensive care unit by the **hospital** and which is maintained on a twenty-four (24) hours basis solely for **treatment** of patients in critical condition and is equipped to provide special nursing and medical services not available elsewhere in the **hospital**.

aa) **Lifetime**

Refers to the period in which the applicable **insured person** is alive. This does not refer to the duration of the **policy**.

bb) **Medical adviser**

Refers to any of the following: '**our** claims team or **our** medical team or **our** service provider' who manage/assess/approve claims.

cc) **Medical condition(s)**

Refers to any eligible disease, illness or injury covered by this **policy**.

dd) **Medical practitioner(s)**

Refers to a person (other than **policyholder,** the **insured person,** or a family member ((including parent(s), parent(s)-in-law, brother(s), sister(s,) spouse or child(ren) of **policyholder** or the **insured person**)) who has primary degree in the practice of western medicine and surgery following attendance at a recognised medical school and who is licensed to practice western medicine by the relevant licensing authority where the **treatment** is given.

By 'recognised medical school' **we** mean "a medical school which is listed in the AVICENNA Directory, which is in collaboration with the World Health Organisation and the World Federation for Medical Education."

ee) **Medically necessary**
Refers to any **eligible treatment**, test, medication, or stay in **hospital** that has been prescribed by a **medical practitioner**, which is appropriate and consistent with the diagnosis, and is in accordance with generally accepted medical standards that could not have been omitted without adversely the **insured person's** condition or the quality of medical care rendered.

ff) **Nurse(s)**
Refers to a qualified nurse who is registered to practice as such where the **treatment** is given.

gg) **Out-patient treatment**
Refers to **eligible treatment** by a **medical practitioner** at a **hospital** where the **insured person** is not admitted to a bed. For avoidance of doubt, this excludes all forms of **alternative treatment .**

hh) **Outside Area of Cover**
Refers to one of the following as stated on the **insured person's plan** on the **policy schedule** and/or **endorsement:**

- **Asia:** Afghanistan, Bangladesh, Bhutan, Brunei, Cambodia, China, Hong Kong, India, Indonesia, Japan, Kazakhstan, Kyrgyzstan, Laos, Macau, Malaysia, Maldives, Mongolia, Myanmar, Nepal, North Korea, Pakistan, Philippines, Singapore, South Korea, Sri Lanka, Taiwan, Tajikistan, Thailand, Timor-Leste, Turkmenistan, Uzbekistan, Vietnam
- **South East Asia:** Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Philippines, Thailand, Vietnam, Timor-Leste, Singapore
- **Worldwide excluding USA:** worldwide excluding the USA and US Minor Outlying Islands
- **Worldwide:** worldwide.

ii) **Physiotherapist**
Refers to a person((other than **policyholder,** the **insured person,** or a family member (including parent(s), parent(s)-in-law, brother(s), sister(s), spouse or child(ren) of **policyholder** or the **insured person**))who is qualified and licensed to practice as a **physiotherapist** in the country the **treatment** is given in..

jj) **Plan(s)**
Refers to any **Care Plus** plan as detailed in the **policy schedule.**

kk) **Policy**
Refers to the insurance contract between the **policyholder** and **us**. Its full terms are set out in the current versions of the following documents as sent to the **policyholder** from time to time:

- any application form **we** ask the **policyholder** to fill in,
- these terms and the **benefits table** setting out the cover under the **plan**,
- **policy schedule**,
- **endorsements.**

Changes to these terms must be confirmed in **writing** and **we** will write to the **policyholder** to confirm any changes, undertakings or promises that **we** make.

ll) **Policy anniversary**
Refers to the same date and month following a year from the **policy commencement date** or last policy anniversary.

mm) **Policy commencement date**
Refers to the date on which the insurance coverage starts as noted in the **policy schedule.**

nn) Policyholder(s), You/Your/Yours

Refers to the owner of this **policy** as named in the **policy schedule**, with whom this **policy** is made, who is responsible for paying the **premiums** and who may exercise all rights under this **policy**.

oo) Policy schedule

Refers to the most recent document forwarded to the **policyholder** by **us** which forms part of the agreement **we** have with the **policyholder** which allows the **policyholder** to be registered as the **policyholder**. This certificate sets out who are the **insured persons**, the **Care Plus plan** each **insured person** has and when that cover begins.

pp) Policy currency

Refers to the currency in which claims reimbursed to the **insured person** will be paid and in which premium must be paid. It is in Vietnam Dong ('VND'). Reimbursement of eligible expenses other than in Vietnam Dong is also subject to the foreign exchange regulations stipulated by Vietnam Government.

qq) Policy year

Refers to each term of cover under the **policy**, which is stated in the **policy schedule** or **endorsement**.

rr) Pre-existing condition(s)

Refers to any **medical condition** preceding the **policy commencement date,** or **plan** upgrade date, whichever date is later:

- the **insured person** has been diagnosed by a **medical practitioner**; or,
- for which the **insured person** has received medication, advice or **treatmen**t, or,
- which the **policyholder** and/or the **insured person** should reasonably, in **our independent medical practitioner's** opinion, have known about; or,
- for which the **insured person** has experienced symptoms even if the **insured person** has not consulted a **medical practitioner**.

ss) Premium(s)

Refers to a sum of money to be paid by the **policyholder** to **us** according to time limits and by premium payment modes(mutually agreed by **policyholder** and PJICO.

tt) Prescription(s)

Refers to out-patient drugs and dressings as prescribed by a **medical practitioner** for the **treatment** of a **medical condition** covered by the **insured person's plan**. For avoidance of doubt, prescription will not include vitamins nor supplements nor over the counter medication nor herbal medication nor traditional Chinese medicine or traditional medicine , even if they are prescribed by a **medical practitioner**.

uu) Principal country of residence

Refers to the country where the **insured person** lives or intends to live for most of the **year** being one hundred eighty-five (185) days or more and which will be shown as the **insured person** address and place of residence in **our** records.

vv) **Reasonable and customary (R&C)**
Refers to charges for medical care which shall be reasonable and customary to the extent that they do not exceed the general level of charges being made by others of similar standing in the locality where the charges are incurred when giving like or comparable **treatment**.

For the avoidance of doubt when comparing **treatment**, **we** will take into account the complexity of the procedure and the standard of the medical facility where the **treatment** is received. If necessary, **we** can delay paying the claim until **we** are satisfied that the charges are appropriate, but **we** will not unreasonably delay paying the **treatment**.

If the charges are higher than is customary, **we** will only pay the amount which is customarily charged and the **policyholder** will have to pay the rest. In that case, **we** will identify the customary charges based on the pricing quotes of similar **treatment** at a **hospital** with similar facilities and a **medical practitioner** with similar experience and qualifications

ww) **Schedule of procedures**
Refers to the document **we** maintain which lists the **surgical procedures we** pay benefits for and classifies them according to their complexity. Please contact **our** Customer Service team for more information.

xx) **Service provider(s)**
Refers to any third-party that **we** appoint to manage claims, or to provide the evacuation or repatriation service, or any other company that assist with the provision of benefit or service under this **policy**..

yy) **Surgical procedure(s)**
Refers to operations or other invasive surgical interventions listed in the **schedule of procedures**.

zz) **Terminal medical condition**
Refers to the conclusive diagnosis of an illness that is expected to result in the death of the **insured person** within twelve (12) months. This diagnosis must be supported by a specialist and confirmed by **our medical practitioner**. Terminal illness in the presence of Human Immunodeficiency Virus (HIV) is excluded.

aaa) **Terrorist act**
Refers to any use of violence by an individual terrorist or a terrorist group to coerce or intimidate the civilian population to achieve a political, military, social or religious goal. Terrorism shall also include any act which is verified or recognised by the relevant Government as an act of terrorism.

bbb) **Treatment(s)**
Refers to **surgical procedures** or medical procedures carried out by a **medical practitioner** for an eligible **medical condition** and this may include:

- **diagnostic procedures**;
- **in-patient treatment**;
- **day-care treatment**;
- **out-patient treatment**.

For avoidance of doubt, any of the above listed **treatment** is subject to the **benefits table** applicable to the **insured person's plan** stated on the **policy schedule.**

ccc) **Visit**
Refers to each separate occasion that the **insured person** meets with a **medical practitioner** and receives a consultation and/or **treatment** for an eligible **medical condition**.

ddd) **Waiting period(s)**
Refers to the period the benefit concerned will not be payable. Please refer to the **benefits table** and/or **policy schedule** applicable to the **insured person's plan**.

eee) **We/us/our/PJICO**
Refers to Petrolimex Insurance Corporation ('PJICO'), being the insurer issuing the **policy**.

fff) **Writing**
Communication/correspondence from the **policyholder** or **us,** or vice versa. This could either be in written correspondences or through email.

ggg) **Year**
Refers to twelve (12) calendar months from when the **policy** began or was last renewed unless **we** have agreed something different.

hhh) **Yearly Maximum limit**
Refers to the overall maximum amount set out in the **benefits table** applicable to the **plan** which **we** will pay for the relevant **policy year**.

Section 4 - What the insured person is covered for

*4.1 What **we** pay for*

This **policy** covers the **insured person** against the cost of **medically necessary** and **eligible treatment** carried out by a **medical practitioner**. **We** will only pay:

(a) for charges actually incurred for items listed in the **benefits table** applicable to the **insured person's plan** subject to the limits shown there. Note: if an **insured person** incurs costs in excess of the limits, the **policyholder** or the **insured person** will have to pay the difference;

(b) charges by the **medical practitioner,** laboratory or other such medical services which are **reasonable and customary**. If the charges made by the **medical practitioner**, laboratory or other such medical services are higher than is **reasonable and customary, we** will only pay the amount which is **reasonable and customary** and the **policyholder** or the **insured person** will have to pay the rest;

(c) provided the costs are not for something excluded by the terms of this **policy**;

(d) for **treatment** incurred during a period for which the **premium** has been paid;

(e) **treatment** of **medical conditions** that existed, and were specifically declared to **us**, prior to inception of this **plan** except where such **treatment** relates to a **medical condition** that has previously been excluded or subject to a moratorium (**waiting period**) by **us** or any previous insurer and such exclusion or moratorium has not expired; or as allowed for by the **plan**. For avoidance of doubt, the **pre-existing condition** exclusion and limitation shall apply to all benefits for an **insured person** unless otherwise stated.

*4.2 **Insured person's plan** benefits*

Where applicable, in applying **annual deductibles** and **co-insurance, we** will subtract the **annual deductible** first and then apply the **co-insurance** to the balance of eligible benefit remaining.

Please refer to the **benefits table** for further information on the availability, benefit levels and **waiting periods** of the **insured person's plan**.

Benefits	**Clarifications**
Overall **Yearly Maximum Limit**	**We** will pay up to the overall **yearly maximum limit** shown for each **insured person** each **policy year.** All benefits paid during the **policy year** will count against the overall maximum limit. Cover does not extend beyond the **area of cover** shown for **insured person's plan** unless he/she is eligible for '**outside area of cover**' benefit.
Area of Cover	This is the geographical area where the **insured person** can choose to receive **treatment**. This is chosen at the time of application.
Outside area of cover	**a)** This is to cover **emergency treatment** which arises suddenly while the **insured person** is outside his/her **area of cover** up to the limit and the area shown in the **benefits table** applicable to the **insured person's plan**, and provided the **insured person's** total number of days stay outside his/her **area of cover** does not exceed the

	number of days that is stated on the **benefits table** applicable to the **insured person's plan.** b) The number of days outside the **insured person's area of cover** would include **treatment** days. If the **insured person** is eligible for this benefit, **we** will pay for the necessary **treatment** up to number of days as specified in the **insured person's benefits table** from the date of first **treatment**. c) **We** can consult the treating **medical practitioner** or **we** can consult **our medical advisers** or **independent medical practitioner** to determine what constitutes **emergency treatment.**. d) In cases of serious emergency treatment where the **insured person** requires immediate **in-patient treatment**, the evacuation service could be available for the **insured person**. Please refer to Section 4.2.4 for more details. e) This benefit does not provide cover for **treatment** for any **medical condition** if the **insured person** has travelled outside the applicable **area of cover** to get **treatment** (whether or not that was the only reason) or for any **treatment** which was, or may have reasonably been, known about before travel commenced. f) Under no circumstance will benefit be payable for any aspect of pregnancy or childbirth. g) **We** will stop paying for **emergency treatment** when the treating **medical practitioner** states that the **insured person's** eligible **medical condition** is stabilised or his/her health status allows him / her to travel back into his/her **area of cover** . **h)** Please note that all **policy** terms**,** conditions, limitations and exclusions, apply to this benefit exactly as for all other benefits under this **policy**.
Annual deductible	Provided the **annual deductible** is applicable to the **insured person's plan** as specified in the **policy schedule**, this amount will be collected by whoever provides the **insured person's treatment** (for direct billing) or deducted from any reimbursement made to the **policyholder** by **us**. The **annual deductible** applies to all benefits unless otherwise stated in the **policy schedule**.

*4.2.1 **In-patient treatment** and **day-care treatment** – general information*

Please refer to the **benefits table** for further information on the availability, benefit levels and **waiting periods** for the **insured person's plan**.

Please also refer to the Section 7 - 'Exclusions and Limitations' for further information on applicable exclusions and limitations.

*Please note: For all non-**emergency** admissions, it is recommended that the **policyholder** / the **insured person** obtain **our** written pre-approval before admission. This is to protect the **policyholder /** the **insured person** from unexpected cost.*

For direct settlement for an **eligible treatment**, the approval **we** give to the service provider will indicate the amount which is **reasonable and customary** for the proposed **treatment**. Please refer to the Section 8 - 'Understanding how to get the best from the **plan**'.

Benefits	Clarifications
Daily Accommodation Charges	Subject to the limits shown in the **benefits table** for the **insured person's plan,** while the **insured person** is admitted as an in-patient or day-patient for an eligible **medical condition**, **we** will pay for the costs of the **insured person's** accommodation in the type of room or up to the limits shown in the **benefits table** applicable to the **insured person**. Wherever the **insured person** receives **in-patient treatment** or **day-care treatment**, if the **hospital** offers several classes for the room type the **insured person** is entitled for, **we** will only pay for the cost of a room of a standard class. This corresponds to the lowest cost room class offered in that **hospital** for that type of room. If the **insured person** stays in a room which is more expensive than the standard room or in a ward that exceeds the limits stated on the **benefits table** applicable to the **insured person**, the **insured person** may have to pay for the difference in room charges. The **policyholder** or the **insured person** may also have to pay for a share of other medical expenses wherever these increase as a result of the room upgrade. Please check with **us** prior to admission to avoid unnecessary out of pocket expenses.
Hospital Charges	**We** will pay for **hospital** charges incurred for **eligible treatment** given between admission and discharge such as: • **diagnostic procedures** • **surgical procedures** • operating theatre charges • nursing care, drugs and dressings • surgeon and anaesthetist charges • **intensive care unit** charges • consultations and physiotherapy while admitted for **treatment** of an eligible **medical condition** and when such **treatment** directly relates to it • radiotherapy and/or chemotherapy • computerized tomography, magnetic resonance imaging, x-rays and other such proven medical imaging techniques • special nursing in **hospital**
Organ transplant	**We** will pay for transplantation of kidneys, heart, liver, lung or bone marrow required as a result of an **eligible medical condition** and

	provided these organ(s) came from a relative (and this would also include from parent(s), parent(s)-in-law, brother(s), brother(s)-in-law, sister(s), sister(s)-in-law, spouse, or child(ren)) or a certified and verified source of donation. The **policy** does not cover the costs of collecting donor organs (including transportation or administration costs) or any expenses incurred by the donor.
Reconstructive surgery	**We** will pay for initial treatment plan for reconstructive surgery and only when it is **medically necessary** and subject to the following: (a) it is carried out to restore function after an **accident** or following surgery for an **eligible medical condition**, provided that the **insured person** has been covered under this **policy** since before the **accident** or surgery happened; and (ii) it must be done at a medically appropriate stage after the **accident** or surgery; and (iii) **we** agree to the cost of the **treatment** in writing before it is done.
Surgical implants	**We** will pay for medical device surgically implanted into the body as part of the **treatment** (excluding any dental implants).
Companion Accommodation	*For Plan A1, Plan A2, Plan B1, Plan B2, Plan C1 and Plan C2* **We** will pay up to the amount shown in the **benefits table** applicable to the **insured person's plan** for companion's accommodation when he/she is staying either in the same hospital room with the **insured person** or at a hotel/motel near the **hospital** within the **area of cover** when the **insured person** is receiving an eligible **in-patient treatment** in the **hospital** within the **area of cover**. This is paid from the **insured person**'s benefit. *For Plan D1 and Plan D2* **We** will pay for the companion's accommodation in the same **hospital** room with the **insured person** within the **area of cover** when the **insured person** is receiving an eligible **in-patient treatment** in the **hospital**. This is paid from the **insured person's** benefit.
Cash Benefit, per night	**We** will pay up to the amount and maximum number of days (where applicable) shown in the **benefits table** applicable to the **insured person's plan** when he/she receives an eligible **in-patient treatment**, within the **area of cover**, provided no cost is borne by **us** for the same admission. 'Cash Benefit' is only payable when no other benefit is claimed for under this **policy** per **in-patient treatment**.
In-patient Treatment for HIV/AIDS *(Applicable to Plan A1, Plan A2, Plan B1, Plan B2, Plan C1 and Plan C2)*	This benefit becomes available when signs or symptoms for HIV / AIDS are present for the first time after the **insured person** is insured with **us** on the **plan** where the **insured person** has been continuously covered under the same plan for the length of **waiting period** applicable to the **insured person's plan**. **We** will pay for eligible claims on expenses up to the limits applicable to the **insured person's plan** for **in-patient treatment** for Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) as a result of occupational accident or blood transfusion up to the limit shown for **insured person's plan** subject to

	the following criteria: (a) Infection with HIV through a blood transfusion, provided that all of the following conditions are met: (i) the blood transfusion was **medically necessary** or given as part of a medical **treatment**; (ii) the blood transfusion was received after **insured person** was insured on this **policy**; (iii) the source of infection is established to be from the **hospital** and the **hospital** is able to trace the origin of the HIV tainted blood; and (iv) the **insured person** does not suffer from thalassaemia major or haemophilia. (b) Infection with HIV which resulted from an **accident** occurring after **insured person** was insured on this **policy**, while the **insured person** was carrying out the normal professional duties of his/her occupation in his/her **principal country of residence,** provided that all of the following are proven to **our** satisfaction: (i) proof of the **accident** giving rise to the infection must be reported to **us** within thirty (30) days of the **accident** taking place; (ii) proof that the **accident** involved a definite source of HIV infected fluids; (iii) proof of sero-conversion from HIV negative to HIV positive occurring during the one hundred eighty (180) days after the documented **accident**. This proof must include a negative HIV antibody test conducted within five (5) days of the **accident.**
Government hospital allowance	**We** will pay up to the amount shown on the **benefits table** applicable to the **insured person's plan** only when the **insured person** receives his/her eligible **in-patient treatment** at the non-private section in a Government Hospital in Vietnam. This benefit is not payable if the **insured person** is entitled for 'Cash Benefit' for the period of his/her **in-patient treatment**. Where the **policy** has an **annual deductible**, the **insured person** has to fulfil the **annual deductible** under this **policy** before this benefit for eligible i**n-patient treatment** is payable.
Pre-hospitalisation and post-hospitalisation treatment	
Pre-hospitalisation treatment	Subject to the limits shown in the **benefits table** for the **insured person's plan, we** will pay for one (1) consultation, prescribed investigation and essential medications by a **medical practitioner** received as an out-patient within ninety (90) days prior to an **in-patient treatment**, where such **in-patient treatment** is **eligible** for cover under the **insured person**'s **plan** and where the need for such **in-patient treatment** arose as a direct result of the medical examination and investigation findings drawn from that consultation.

Post hospitalisation treatment	Subject to the limits shown in the **benefits table** for the **insured person's plan, we** will pay for follow-up out-patient consultation and **treatment** following an **eligible in-patient treatment** or day surgery when such consultation is carried out by the in-patient treating **medical practitioner** or a referred **medical practitioner** and provided such consultation or **treatment** occurs within ninety (90) days immediately following the date of discharge from **hospital** for which the **insured person** was confined as an in-patient or the date of the day-care surgery.

4.2.2 ***Out-patient treatment*** *– general information*

Subject to the availability of the benefits for the **insured person** and the limits shown for in his/her **plan** stated on the **benefits table,** an **insured person** is covered for:

- **medical practitioner's** charges for consultations,
- **diagnostic procedures**,
- **prescriptions** (note any prescribed drug or other medication required for more than thirty (30) days should be pre- authorised by **us**),
- computerized tomography, magnetic resonance imaging, positron emission tomography and gait scans received as an out-patient (pre-approval is recommended),
- radiotherapy and/or chemotherapy received as an out-patient,
- kidney dialysis received as an out-patient,
- out-patient **surgical procedures.**

*The reason **we** recommend pre-approval of planned **treatment** is to protect the **policyholder** / the **insured person** from unexpected costs.*

Please refer to the **benefits table** for further information on the availability, benefit levels and **waiting period**s for the **insured person's plan**.

Benefits	Clarifications
Emergency out-patient treatment arising from an **accident**	**We** will pay for **out-patient treatment** required immediately (within twenty-four (24) hours) following bodily injury arising from an **accident**, provided the **insured person** is covered under this **policy** before the **accident** happened. Follow up **treatment** for the same bodily injury will be covered up to thirty (30) days from the date of the **accident.**
Radiotherapy and/or Chemotherapy	**We** will pay for radiotherapy and/or chemotherapy received as part of an eligible **out-patient treatment** at a registered medical facility.
Kidney Dialysis	**We** will pay for kidney dialysis received as part of an eligible **out-patient treatment** at a registered medical facility.
Outpatient **Surgical Procedure**	**We** will pay for any eligible **surgical procedure** received as part of an **out-patient treatment** including one (1) pre-operative surgery consultation within ninety (90) days prior to the date of the **surgical procedure** and one (1) post-surgery consultation within ninety (90) days from the date of the **surgical procedure**.
Primary and Specialist Care *(Applicable only to Plan A1, Plan A2, Plan B1 and Plan B2)*	Subject to the limits shown in the **benefits table** for the **insured person**'s **plan , we** will pay for the **insured person**'s **visit** to any **medical practitioner** for the treatment of an **eligible medical condition**. **We** will pay for the **medical practitioner's** charges for consultations, **prescriptions** and diagnostic tests. Diagnostic tests include and are limited to laboratory, X-ray and ultrasound. Second opinion for the same **medical condition:** pre-approval is recommended Thereafter subsequent opinions and referrals for the same **medical condition**: pre-approval is compulsory.

Computerized tomography, magnetic resonance imaging, positron emission tomography and gait scans	*For Plan A1, Plan A2, Plan B1 and Plan B2* Subject to the limits shown in the **benefits table** for the **insured person's plan, we** will pay for computerized tomography, magnetic resonance imaging, positron emission tomography, and gait scans received as part of an eligible **out-patient treatment**. *For Plan C1, Plan C2, Plan D1 and Plan D2* Subject to the limits shown in the **benefits table** for the **insured person's plan** , this benefit is included if it is part of pre- and/or post-hospitalisation treatments for an eligible **in-patient treatment** or daycare surgery. Hence it is subject to the limits, terms and conditions of the 'Pre-hospitalisation treatment' and/or 'Post-hospitalisation treatment' benefits respectively.
Hormone Replacement Therapy (HRT)	*For Plan A1, Plan A2 and Plan B1* **We** will pay for the consultations and the cost of the implants, injections, patches or tablets when it is medically indicated and resulting from a medical intervention rather than for the relief of physiological symptoms. *For Plan B2, Plan C1, Plan C2, Plan D1 and Plan D2* Subject to the terms and conditions stated in this benefit for Plan A1, Plan A2 and Plan B1, this benefit is included if it is part of post-hospitalisation treatment for an eligible **in-patient treatment** or daycare surgery. Hence it is subject to the limits, terms and conditions of the 'Post-hospitalisation treatment' benefit.
Physiotherapy, occupational therapy and speech therapy	*For Plan A1, Plan A2, Plan B1 and Plan B2* **We** will pay for **treatment** given by a **physiotherapist,** occupational therapist or speech therapist, who is registered to practice where the **eligible treatment** is given. Benefit is payable only following **in-patient treatment** for an **eligible medical condition**, provided that the **insured person** has been covered under the **policy** since before the **in-patient treatment** commenced. **Treatment** given by **physiotherapist,** occupational therapist or speech therapist must be under the medical supervision of a **medical practitioner**. Medical supervision means that the reason for referral, where applicable, has been initiated by the **medical practitioner** who has defined a diagnosis. There must be a clear **treatment** plan from the **physiotherapist,** occupational therapist or speech therapist with an end point and expected outcome. *For Plan C1, Plan C2, Plan D1 and Plan D2* Subject to the terms and conditions stated in this benefit for Plan A1, Plan A2, Plan B1 and Plan B2, this benefit is included if it is part of post-hospitalisation treatment for an eligible **in-patient treatment** or daycare surgery. Hence it is subject to the limits, terms and conditions of the 'Post-hospitalisation treatment' benefit.

4.2.3 Other benefits – general information

Subject to the availability of the benefits for the **insured person** and the limits shown for in this **plan** stated on the **benefits table,** the **insured person** is covered for the additional features under 'Other benefits'.

Please note that all **annual deductible**, **co-insurance,** limitations and terms apply to these benefits exactly as for the main in-patient/day-care and out-patient benefits, depending on whether **treatment** is received as part of an **out-patient treatment**, **in-patient treatment** or **day-care treatment**.

Please refer to the **benefits table** for further information on the availability, benefit levels and **waiting period**s for the **insured person's plan**.

Benefits	Clarifications
Alternative and Wellbeing Medicine	
Alternative Treatment:: Consultation and treatment provided and prescribed by a qualified and registered chiropractor, , dietician, nutritionist, naturopath, acupuncturist, homeopath, physiotherapist and traditional Chinese medicine practitioner *(Applicable to Plan A1, Plan A2, Plan B1 and Plan B2)*	Subject to the limits shown in the **benefits table** for the **insured person's plan, we** will pay for consultations and **alternative treatment** given by a qualified **alternative practitioner** or **physiotherapist** who is registered to practice in the country the **treatment** is given in. Within this benefit and up to the limits applicable to the **insured person's plan**, **we** will also pay for vitamins, supplements, and Chinese traditional medicine when such are prescribed by the **alternative practitioner** or **medical practitioner**. The **insured person** should obtain a non-contra-indication for the use of alternative **treatment** from their treating **medical practitioner** as **we** will not pay for any complications arising from such alternative **treatment** in excess of the limit shown for this benefit. There must also be a clear **treatment** plan from the chiropractor, dietitian, naturopath, acupuncturist, homeopath, **physiotherapist** and traditional Chinese medicine practitioner with an end point and expected outcome. For avoidance of doubt, no benefit shall be payable for any alternative **treatment** arising from any **in-patient treatment**, **day-care treatment** or **diagnostic procedures**.
Wellness Benefit	
Health Screen *(Applicable to Plan A1, Plan A2 and Plan B1)*	Subject to the limits applicable to the **insured person's plan ,** the limit shown for his/her **plan** includes the cost of any eligible consultation needed as part of the screening process.
Vaccinations *(Applicable to Plan A1 and Plan A2)*	Subject to the limits applicable to the **insured person's plan, we** will pay this benefit for necessary vaccinations up to the limit shown for this. Consultation charge made in conjunction with vaccination can be claimed from this benefit where applicable.
Dental Care	
Accidental Damage to Natural Teeth	Subject to the availability of this benefit and the limits shown for the **insured person's plan, we** will pay for the initial **treatment** required immediately (within seven (7) days) following **accidental** damage to natural teeth caused by extra-oral impact when that **treatment** is given by a **dental practitioner,** provided that the **insured person** has been continuously covered under the

	policy since before the **accident** happened. Benefit is not payable if: ▪ the injury was caused by any form of eating or drinking, or • the damage was caused by normal wear and tear, or ▪ the injury was caused when boxing or playing rugby (except school rugby) unless appropriate mouth protection was worn, or ▪ the damage was caused by tooth brushing or any other oral hygiene procedure, or ▪ the injury was caused by any means other than extra-oral impact, or ▪ the damage is not apparent within seven (7) days of the impact which caused the injury**.**
Oral and Maxillofacial Surgery	**We** will reimburse the **reasonable and customary** charges actually incurred for oral and maxillofacial surgery performed by an oral and maxillofacial surgical surgeon for the following procedures: (1) Surgical removal of impacted / un-erupted teeth and buried teeth which are diseased or causing symptoms; (2) Surgical removal of complicated buried roots which are diseased or causing symptoms; (3) Enucleation (removal) of cysts of the jaw; (4) Treatment of cancers (For lesion or lump in the mouth). Necessary Treatment to Temporal Mandibular Joint (TMJ) such as physiotherapy and surgery are covered under the respective benefits of this Plan.
Routine Dental/Preventive Dental Care *(Applicable to Plan A1, Plan A2, Plan B1 and Plan B2)*	**We** will pay eighty (80%) percent of the eligible expenses up to the limit applicable to the **insured person's plan** on the **benefits table** for dental examination, extraction, fillings, scaling/polishing, x-ray, sealant and fluoride treatment.
Restorative Dental Treatment *(Applicable to Plan A1, Plan A2, Plan B1 and Plan B2)*	**We** will pay eighty percent (80%) of the eligible expenses up to the limit applicable to the **insured person's plan** on the **benefits table** after the **insured person** has been covered for the length of the **waiting period** applicable to the **insured person's plan** for root canal treatment, implants, bridgework, crowns, treatment of gum disease, dentures, inlays, onlays.
Optical Care	
Routine Optical Care *(Applicable to Plan A1 and Plan A2)*	**We** will pay the eligible expenses up to the limit applicable to the **insured person's plan** on the **benefits table** for the fees charged for corrective spectacle lenses, contact lenses and associated spectacle frames prescribed by the ophthalmologist or optometrist. This benefit also pays for the eye examinations carried out by an ophthalmologist or optometrist. This benefit does not pay for tinted / reactive lenses, sunglasses, non-corrective contact lenses, lasik / laser eye surgery and/or similar, whether prescribed or not.

Emergency Medical Service and Assistance	
International Emergency Medical Assistance ('IEMA') *(Applicable to Plan A1, Plan A2, Plan B1, Plan B2, Plan C1 and Plan C2.* *For Plan D1 and Plan D2 – this benefit is applicable only if the **insured person** is travelling outside Vietnam)*	This is a worldwide, 24 hours a day, 365 days a year emergency service providing evacuation and repatriation services. If the **insured person** needs immediate **emergency in-patient treatment**, where local facilities are unavailable or inadequate, a phone call to **our** Customer Service team will alert the International Emergency Medical Assistance service. Please note that, for the **insured person's** own protection, calls may be recorded in case of subsequent query or for calls for training or quality monitoring purposes. Emergency evacuation is covered, up to the limit shown, when the **insured person** is away from his/her **principal country of residence**. Evacuation, when **medically necessary**, will always be to the nearest place where appropriate **treatment** can be given. The **insured person** evacuated in an **emergency** will subsequently be returned to his/her **principal country of residence**. Repatriation of mortal remains if the **insured person** is away from his/her **principal country of residence** is included – this may be to the **insured person's principal country of residence** or to their home country. Please note that all **policy** terms, conditions, limitations and exclusions, apply to this benefit exactly as for all other benefits under this **policy**. The entitlement to the evacuation service does not mean that the **insured person's treatment** following evacuation or repatriation will be eligible for benefit. Any such **treatment** will be subject to the terms and conditions of this **plan**. In the event that the evacuation service has been carried out and it is subsequently found out that the evacuation is not for a covered condition, **we** reserve the right to request the **policyholder** to reimburse **us** for the services which **we** have incurred on behalf of the **policyholder**. Please refer to Section 4.2.4 for more details on International Emergency Medical Assistance.
Travel cost (economy fare) for planned eligible **in-patient treatment** (for reimbursement only) *(Applicable to Plan A1, Plan A2, Plan B1, Plan B2, Plan C1 and Plan C2)*	**We** will reimburse a maximum of one (1) return airfare trip on economy class per **policy year** per **insured person** for an eligible **in-patient treatment** subject to the following: (a) it will be to the nearest place outside the **insured person's principal country of residence** where the medical facilities are adequate and is within the **insured person**'s **area of cover**; and (b) the **insured person** has been referred by his/her treating **medical practitioner** for a non-**emergency in-patient treatment** which is not available in **his/her principal country of residence,** and (c) this benefit shall be payable only when written pre-approval from **us** is given. **We** reserve the right to increase this benefit, on a case by case basis, to allow for a longer flight if this can result in a lower in-patient treatment cost. Please contact **us** beforehand. This benefit will also pay for a return airfare trip on economy class for one (1) accompanying person while the **insured person** is evacuated: (a) when the **insured person** is under sixteen (16) years old; or (b) when in the opinion of **our** appointed **medical practitioner**, the need for such accompanying person is **medically necessary**. For avoidance of doubt, the terms and conditions of this **policy** shall also

	apply to this benefit.
Maternity Benefits	
Investigation into infertility *(Applicable to Plan A1 and Plan A2)*	**We** will pay for investigation and **treatment** of the cause of infertility. This benefit becomes available and **eligible** claims payable for expenses incurred after the **insured person** has been continuously covered under this benefit for the length of **waiting period** and has effected the annual renewal of that **plan** for the coming **policy year.** This benefit is payable up to the **lifetime limit**, in aggregate, shown for in the **insured person's plan.**
Pre- and Post- Natal Complications *(Applicable to Plan A1, Plan A2, Plan B1 and Plan B2)*	Benefit only becomes available and eligible claims payable for expenses incurred after the female **insured person aged** eighteen (18) years or older has been covered for the length of **waiting period** applicable to the **female insured person's plan** and has effected the annual renewal of that **plan** for the coming **policy year.** This benefit pays for **treatment** of an eligible **medical condition** which is due to, and occurs to, the female **insured person** during the pregnancy prior to the delivery or after the delivery of child. The list of eligible pre- and post-natal complications include the following: • Antiphospholipid syndrome, • Cervical incompetence, • Ectopic pregnancy, • Gestational diabetes, • Hydatidiform mole – molar pregnancy, • Hyperemesis gravidarum, • Obstetric cholestasis, • Pre-eclampsia / Eclampsia, • Rhesus (RH) factor, • Threatened miscarriage, • Post partum haemorrhage, • Retained placental membrane. Under post-natal complications, **we** will only pay for **treatment** received within ninety (90) days following the delivery of child. This benefit does not cover: ▪ the costs of delivery of any child whether such delivery is normal, by caesarean section or by any form of assisted means, or ▪ any complication arising from elective or non-**medically necessary** caesarean section birth, or ▪ if the conception of the child is by **assisted conception/assisted pregnancy**, or ▪ **treatment** of any **medical condition** which is due to, and occurs during, the pregnancy prior to the delivery or after the delivery if the pregnancy was a result of **assisted conception/assisted pregnancy**. While **we** recognise that caesarean section may sometimes be a medical necessity, caesarean section can only be covered under the "Pregnancy and Delivery" benefit for an **insured person** on Plan A1 and Plan A2. For avoidance of doubt, this benefit shall not be payable if the: o delivery of birth is through assisted means, or elective or non-**medically necessary** caesarean birth, and/or o conception of the child is conceived by **assisted conception/assisted**

	pregnancy. Please note: If **we** are not able to determine that a caesarean section is **medically necessary we** will consider it as elective and not **medically necessary**. This benefit will not automatically be upgraded to a higher level of **plan**. In the case of an upgrade in cover this benefit will be restricted to the level of the original **plan** until the female **insured person** has been covered under the upgraded **plan** for a period of not less than twelve (12) consecutive months and has effected the annual renewal of the upgraded **plan.**
Pregnancy and Delivery *(Applicable to Plan A1 and Plan A2)*	Subject to the limits applicable to the **insured person's plan,** benefit only becomes available and eligible claims payable for expenses incurred after the female **insured person** has been continuously covered under this benefit for the length of **waiting period** applicable to the **insured person's plan** and has effected the annual renewal of that **plan** for the coming **policy year.** This benefit is only available for female **insured person aged** eighteen (18) years or older and covers pre-natal care, delivery of baby, and post-natal care up to forty-two (42) days following birth, in aggregate, up to the limit shown for this **plan**. The limit shown is the maximum **we** will pay under this benefit for each: • **policy year**, even if there is more than one pregnancy in that **policy year,** • pregnancy, even if a pregnancy, which is eligible for benefit, falls across the **policy anniversary**, and provided the **policy**, including this benefit, has been renewed for the subsequent **policy year.** For birth through vaginal delivery and **medically necessary** caesarean section, **we** will pay for the delivery costs up to the limit shown for this benefit in the **benefits table**. Any complications arising from such delivery will be paid from 'Pre- and post-natal complications' benefit. For birth through elective or non-**medically necessary** caesarean section, **we** will pay for the delivery costs up to the costs of a normal delivery. The complications arising from such delivery will be paid up to the remainder of the 'Pregnancy and Delivery' limit. Please note: If **we** are not able to determine that a caesarean section is **medically necessary we** will consider it as elective caesarean section and is not **medically necessary**. This benefit will not automatically be upgraded to a higher level of **plan**. In the case of an upgrade in cover this benefit will be restricted to the level of the original **plan** until the female **insured person** has been covered under the upgraded **plan** for a period of not less than twelve (12) consecutive calendar months and has effected the annual renewal of the upgraded **plan**.
New born cover	
New born accommodation *(Applicable to Plan A1, Plan A2, Plan B1 and Plan B2)*	**We** will pay for the child who is less than sixteen (16) weeks old to stay in the **hospital** with the mother (being an **insured person**) while she is receiving **eligible in-patient treatment** at such **hospital**. This is paid from the mother's benefit.

New born cover - acute medical condition	**We** will pay for the **treatment** of acute medical condition, providing there is no underlying **congenital condition** developed in a new born baby including nursing of pre-mature baby (i.e. where birth is prior to thirty-seven (37) weeks gestation) in Neonatal **intensive care unit** (NICU). The common acute medical conditions for new born babies include neonatal jaundice, colic, diarrhoea, constipation, vomiting and ear infection. This benefit is only available if: a) the parent of the new born baby has been covered under this **policy** for three hundred sixty-five(365) consecutive days or more when the baby is born (unless otherwise agreed by **us** in writing); and b) the new born baby must be at least fifteen(15) days old and is added into the insured parent's **policy** between the fifteen(15^{th}) days to the thirty(30) days from the date of birth and **we** have accepted the new born baby's coverage as per the eligibility clause stated in Section 2. This benefit covers **treatment** received by a new born baby during the fifteen (15^{th}) to the t thirty (30) days after birth and this **treatment** is paid from the parent's **policy** (i.e. the parent who meets the criteria stated in the sub-clause (a) mentioned above). After thirty (30) days and provided is received for this new born baby , **treatment** can be covered under the main benefits of the insured baby's **plan**. This benefit excludes any **treatment** begun, or for which the need had arisen, during the first ninety (90) days after birth for any child conceived by assisted means or any form of **assisted conception/assisted pregnancy**. Please see Section 2 for details on 'Eligibility'.

Home Nursing	
Home Nursing	**We** will pay the home nursing charges of a **nurse** at the **insured person**'s home and only when the following conditions are met: (i) after the **insured person's** discharge from **hospital** which he/she had been warded in the **intensive care unit** for an **eligible medical condition**, and (ii) agreed in writing by **us** beforehand that it is **medically necessary** and appropriate, and (iii) it is prescribed by the treating **medical practitioner** for the continued **treatment** for the **eligible medical condition** which the **insured person** was hospitalised for, and (iv) when such services are essential for medical as distinct from domestic reasons. For avoidance of doubt, the charges refer to the fees for the service of the **nurse** incurred for nursing at home. For **terminal medical condition**, this benefit is only payable under 'Hospice and Palliative Care' and subject to the limitations applicable to that benefit.
Local Road Ambulance Transport	This is to pay for a road ambulance for **medically necessary emergency** transport to or between **hospitals.** The **medical practitioner** of the **insured person** will determine if this is medically essential. In the event there is a difference in opinion by **our medical advisers** on the medical necessity for this transfer the **independent medical practitioner** can be appointed to determine whether such transportation was medically appropriate. *(This does not form part of the 'International Emergency Medical Assistance' service)* *Pre-approval is recommended to protect the **policyholder/insured person** for unexpected costs. **We** recommend pre-approval if it is medically safe for the **policyholder** to take the time to call **us**.*
Pre-existing conditions *(Applicable to Plan A1 and Plan A2)*	Subject to the availability of this benefit and the limits shown for the **insured person's plan**, **we** will pay for **treatment** required for **pre-existing conditions** up to the limit shown for **insured person's plan** after the **insured person** has been continuously covered for the length of **waiting period** applicable to the **insured person's plan**, and subject to the following: **Treatment** for **pre-existing conditions** will be paid from this benefit. Unless otherwise agreed by **us**, all **pre-existing conditions** must, in good faith, be declared to **us**, in writing, at the time of application. Please note that it is important that the **insured persons** give **us** full details of any medical history on their application. Failure to declare any **medical condition** of which the **insured persons** should reasonably have been aware may result in **treatment** of that condition being excluded from all future cover with **us** or cancellation of the **policy**. **We** may ask for a medical report, at the **policyholder** or the **insured**

	person's own cost, to clarify the status of any **medical condition**.
Congenital conditions *(Applicable to Plan A1 and Plan A2)*	Subject to the availability of this benefit and the limits shown for the **insured person's plan, we** will pay for **treatment** of **congenital conditions**, after the **insured person** has been continuously covered for the length of **waiting period** applicable to the **insured person's plan**, and subject to the following: All **congenital conditions** must, in good faith, be declared to **us**, in writing, at the time of application. Please note that it is important that the **insured persons** give **us** full details of any medical history on an application. Failure to declare any **medical condition** of which the **insured persons** should reasonably have been aware may result in **treatment** of that **congenital condition** being excluded from all future cover with **us** or cancellation of the **policy.** For the avoidance of doubt, the exclusions below stated in Section 7 – Exclusions and Limitations are still applicable to this benefit: (a) all types of learning disorders, educational problems, behavioural problems, physical development, or psychological development, including assessment or grading of such problems; (b) cosmetic (aesthetic) surgery or **treatment**, (c) any **treatment** which relates to or is needed because of previous cosmetic treatment or reconstructive surgery;

Psychiatric Treatment	
Psychiatric **Treatment** *(Applicable to Plan A1, Plan A2, Plan B1 and Plan C1)*	*For Plan A1 and Plan A2* Subject to the limits applicable to the **insured person's plan,** the limit shown applies to **in-patient treatment**, **day-care treatment** and **out-patient treatment** of psychiatric illnesses in aggregate. All **treatments** given by psychologists, psychotherapists or any individuals other than a registered psychiatrist must be pre-approved by **us**. *For Plan B1 and Plan C1* Subject to the limits applicable to the **insured person's plan,** the limit shown applies to **in-patient treatment** and up to the maximum number of days stated on the **benefits table** applicable to the **insured person's plan** by a psychiatrist.
Purchase or Hire of Equipment, Medical Aids and Durable Medical Equipment; Artificial Limbs	
Artificial limbs *(Applicable to Plan A1 and Plan A2)*	Subject to the limits applicable to the **insured person's plan**, **we** will pay for all the costs associated with fitting artificial limbs, including the artificial limbs, its maintenance, consultations and necessary medical or **surgical procedures**. Benefit is only payable following a surgery or an **accident** for **an eligible medical condition** provided that the **insured person** has been covered under this **policy** since before the **accident** or surgery happened. This benefit is payable once every three (3) **policy years.**
Purchase or hire of Equipment, Medical Aids and Durable Medical Equipment *(Applicable to Plan A1 and Plan A2)*	Subject to the limits applicable to the **insured person's plan**, **we** will pay for instruments or devices or durable medical equipment which are prescribed by the **medical practitioner** as a **medically necessary** aid to the function or capacity such as and limited to compression stockings, hearing aids, speaking aids (electronic larynx), wheelchairs, crutches, corrective splint and orthopaedic supports.
Hospice and Palliative Care	
Hospice and Palliative Care	Subject to the limits applicable to the **insured person's plan,** benefit only becomes available, and eligible claims payable, for expenses incurred after the **insured person** has been continuously covered under his/her chosen **plan** for the length of **waiting period.** This benefit becomes available when the **insured person** is admitted to a specialist palliative care centre or hospice, following diagnosis by, and written confirmation (including medical evidence) from a **medical practitioner** that the **insured person** is suffering from an eligible **terminal medical condition** and its associated **medical conditions.** The benefit should be pre-approved in **writing** by **us** in advance of admission. Once the **insured person** is admitted, all costs of care and any **treatment** related to an eligible **terminal medical condition** will be taken from this benefit and may not be claimed from any other benefit applicable to this **plan**. Any eligible **medical conditions** not related to the **insured person's terminal medical condition** will be

	covered under the **insured person** normal **plan** benefits. **Our medical adviser** will determine whether a **medical condition** is, or is not, related to the **terminal medical condition**. If there is any different opinion of the **treating medical practitioner** and **our medical adviser**, the opinion of **independent medical practitioner** will be obtained and that will be the final decision. This benefit is payable up to the **lifetime** limit shown for this **plan,** in aggregate, for all such conditions. The **insured person** must maintain the same level of cover throughout the palliative or hospice care admission. This means that, if the period of palliative or hospice care falls across a **policy anniversary**, the **policyholder** must pay the **premium** for the subsequent **year** or the benefit will cease at the **policy anniversary**. In the event that the costs of the **insured person's** admission reaches the limit shown for this benefit no further benefit will be payable. Once the limit of this benefit is reached no benefit of any kind will be payable in respect of any **medical condition** for which palliative and/or hospice care has been received.

4.2.4 INTERNATIONAL EMERGENCY MEDICAL ASSISTANCE ('IEMA')

*1)Can an **insured person** be repatriated to his/her **principal country of residence** or **area of cover** for **treatment**?*

There may be reasons why an **insured person** would prefer to return to his/her **principal country of residence** or any country within the **insured person's area of cover** for **treatment** which does not involve an **emergency** admission. In this case, the **insured person** will be covered by the benefits of his/her **plan** on return to his/her **principal country of residence** or **area of cover** and can claim in the usual way. The cost of returning to the **insured person's principal country of residence** or **area of cover** in these circumstances will be his/her responsibility.

*2)What if **t**he **insured person** is taken ill but the local medical facilities are not adequate to treat the **insured person**?*

Should the **insured person** be injured or become ill suddenly and need immediate **emergency in-patient treatment** then the **evacuation or repatriation service** will become available to the **insured person.** For **insured persons** insured on Plan D1 and Plan D2, the **evacuation or repatriation service** is applicable only if he/she is outside Vietnam.

The exclusions in other parts of this **policy** document do not apply to the **evacuation or repatriation service** but will apply to **treatment** in the **insured person's principal country of residence**, home country or any country to which the **insured person** has been evacuated. If the **insured person** need the **evacuation or repatriation service,** the **insured person** must contact **our** Direct Billing Support Team so that immediate help or advice can be given over the phone.

Arrangements may then be made for **our** appointed **medical practitioner** to see the **insured person** and to move him/her or bring him/her back to his/her **principal country of residence** if necessary. If **our** appointed **medical practitioner** thinks it is necessary then the **evacuation or repatriation service** will be carried out under medical supervision.

The full rules relating to the **evacuation or repatriation service** can be found in the following items 3 and 4.

3)Specific terms relating to the overseas evacuation or repatriation service

3.1)The overseas **evacuation or repatriation service** is available to provide the following services only when the arrangements are made by **us**:

(a) the **insured person** must already been warded in a **hospital**;

(b)Transferring the **insured person** by air ambulance, regular airline or any other method of transport **we** consider appropriate. **We** will decide the method of transport and the date and time.

(c) If the **insured person** is admitted to **hospital** then, if in the opinion of **our** appointed **medical practitioner** the medical facilities in the **hospital** are not suitable or adequate, the **insured person** will be evacuated to the nearest place where appropriate services are available.

(d) Cover for the reasonable and necessary transport and additional accommodation costs for another person, who must be **age** eighteen (18) years or over, to accompany the **insured person** if he/she is under **age** eighteen (18) years (or in other cases where **we** believe that the **insured person's medical condition** makes it appropriate) while he/she is being moved.

(e) Cover for the reasonable additional travelling and accommodation costs incurred in returning to the **principal country of residence** any family members covered by a **Care Plus policy** who is accompanying the **insured person** on the overseas journey.

(f) Bringing the **insured person's** body back to a port or airport in his/her **principal country of residence** or his/her home country, if the **insured person** dies outside of his/her home country, except if he/she die in the circumstances shown in the below item 4.2(b).

4)The overseas evacuation or repatriation service will not be available for the following:

(a) Any **medical condition** which does not prevent the **insured person** from continuing to travel or work and which does not need immediate **emergency in-patient treatment**.

(b) Any costs incurred which arise from, or are directly or indirectly caused by a deliberately self-inflicted injury, suicide or an attempt at suicide.

(c) Any costs incurred which arise from or are in any way connected with, alcohol abuse, drug abuse or substance abuse.

(d) Any costs incurred as a result of engaging in or training for any sport for which the **insured person** receives a salary or monetary reimbursement, including grants or sponsorship (unless the **insured person** receives travel costs only).

(e) Treatment of injuries sustained from base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 10 metres, trekking to a height of over 2,500 metres, bungee jumping, canyoning, hang-gliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste.

(f) Moving the **insured person** from a ship, oil-rig platform or similar off-shore location.

(g) Any costs that **we** do not approve beforehand.

(h) **Treatment** costs other than for the necessary **treatment** administered by the international assistance company appointed by **us** while they are moving the **insured person.**

(i) Any unused portion of the **insured person's** travel ticket, and that of any accompanying person, will immediately become **our** property and the **policyholder** must give it to **us**.

(j) Any costs incurred such as but not limited to a result of nuclear, biological or chemical contamination, war (whether declared or not), act of foreign enemy, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons.

(k) Any costs incurred when the **insured person** is on a leisure trip and he/she is travelling to a country or area that the UK Foreign and Commonwealth Office (www. https://www.gov.uk/foreign-travel-advice) lists as a place which they either advise against:

- all travel to; or
- all travel on holiday or non essential business

*5)**We** will not be liable in respect of the **overseas evacuation or repatriation service** for:*
(a)Any failure to provide the **overseas evacuation or repatriation service** or for any delays in providing it, unless the failure or delay is caused by **our** negligence including that of the international assistance company **we** have appointed to act of **us**), or of agents appointed by either party.

(b)Failure or delay in providing the **overseas evacuation or repatriation service** if:
by law the **overseas evacuation or repatriation service** cannot be provided in the country in which it is needed; or
the failure or delay is caused by any reason beyond our control e.g. strikes and flight conditions.

Important :
For avoidance of doubt, **we** will not pay for any **evacuation or repatriation service** if the **policyholder** or the **insured person** have not obtained pre-approval from **us**.

All cases must be assessed by **our** Customer Service team, to be deemed necessary for **evacuation or repatriation service**, and all arrangements must be made by **our** Customer Service team in order to ensure that related costs are covered by the **service**.

If an **insured person** makes his/her own arrangements (except for local burial / cremation at the place of death), its costs will not be covered. Entitlement to the **service** does not mean that the **insured person's treatment** following **evacuation** or repatriation will be eligible for benefit. Any such **treatment** will be subject to the terms and conditions of **insured person's plan**.

Direct Billing support team_An **insured person** can contact **our** Direct Billing support team at the hotline on the membership card at any time of the night or day, seven (7) days a week, fifty-two (52) weeks of the year to arrange the **insured person's** admission guarantee to any of **our Global Directory of Hospitals**.

When in contact with **our** Direct Billing support team, the **insured person** will need to state that he/she is an **insured person** of a **Care Plus plan** and give their policy number.

Please note that if there is any query about Care Plus product, please do not hesitate to contact **our** hotline number stated on the membership card or in Section 11.

Section 5 – Treatment of Pre-existing conditions

As with all insurance policies the **plan** is there to cover the **policyholder** for costs arising from an unforeseen event. For healthcare insurance this means the cost of **treatment** resulting from an unexpected illness or **accident**.

For this **policy**, the **pre-existing condition** exclusion applies to all benefits, unless otherwise stated on the **benefits table** and/or **policy schedule** applicable to the **insured person's plan**.

Some **pre-existing conditions** may require medical attention after the **policy commencement date**.

Based on **our** medical knowledge and experience **we** may sometimes, for those **pre-existing conditions**, consider the medical attention required after the **policy commencement date** a foreseen event. As the purpose of this **policy** is to cover the **insured person** against the costs of unexpected illness or **accident we** will assess claims for **pre-existing conditions** differently. **Our** definitions are very important to read as they will affect the way **we** will pay the claims, if any, so **we** recommend the **policyholder** take some time to read and understand them.

We will assess a **medical condition** associated with a **pre-existing condition** as a **pre-existing condition**.

We will determine that a **medical condition** is associated with a **pre-existing condition** when this **pre-existing condition** is commonly recognised as a risk factor, however small, or if it is directly or indirectly related to such **medical condition**. To determine whether a **medical condition** is associated with a **pre-existing condition** or not will depend on what is provided in the claims document and related documents such as medical reports, medical literature, medical research or the advice by the **independent medical practitioner**.

For example,

If the **insured person** has the following **pre-existing condition**:	**We** will not pay for **treatment** of the following associated **medical conditions**:
have been diagnosed with diabetes	• Ischaemic Heart Disease/Coronary Artery Disease, • Cataract, • Diabetic retinopathy, • Diabetic renal disease, • Diabetic neuropathy, • Stroke, • Glaucoma, • Cardiac Arrhythmia. As well as diabetes
are currently undergoing **treatment** for raised blood pressure (hypertension)	• Ischaemic Heart Disease/Coronary Artery Disease • Stroke, • Hypertensive renal failure, • Heart Attack, • Cardiac Arrhythmia. As well as raised blood pressure
are under investigation, having **treatment** or undergoing monitoring as a result of a Prostate Specific Antigen (PSA) test	• Any disorder of the prostate.

Please do not hesitate to contact **our** Direct Billing and Claim support team to check whether a **treatment** will be eligible for cover before receiving **treatment** and incurring costs, if it is medically safe for the **policyholder** to take the time to contact **us**.

In some circumstances the **policyholder** may have joined on different terms to those described above and **he/she** will find those terms on the **policy schedule**. For example, if the **policyholder** have joined from another insurer **we** may have transferred the medical underwriting terms from the previous **policy** for **medical conditions** that existed prior to the **policyholder** joining that **policy**.

Section 6 - Important information about Insured person's plan

*6.1. **Our policy** on changing the level of cover or moving to another **plan***

We will not allow an **insured person** to upgrade or downgrade their level of cover except at each **policy anniversary** and only then when requested, in **writing** to do so. **We** reserve the right to refuse any request to upgrade or amend cover. **We** will not pay upgraded benefit levels for **treatment** of any **medical condition** which arose or should reasonably have been foreseen by the **insured person** prior to the upgrade becoming effective. The **insured person** is required to declare any such **medical condition** to **us** when requesting the upgrade. Where such a **medical condition** is, or becomes, apparent, benefits for such a **medical condition** will be restricted to the level of cover that would have been applicable to such a **medical condition** prior to the upgrade.

For any illness or injury or **medical condition** occurring, contracted or sustained at any time on or after the effective date of a downgrade, notwithstanding that such illness or injury or **medical condition** may be a direct or indirect result of a **medical condition** or **accident** occurring, contracted or sustained during the preceding **policy years**, **our** liability shall be restricted to the limits applicable to the downgraded or lower **plan**

In any event, final acceptance of any amendment by **us** and particularly the application of upgraded benefits (must be confirmed by **us** in **writing**) will only be made at the next renewal following such a request. Neither amendments nor upgrades can be made during the **policy year**. Upgrades will not be accepted for cancer care, after initial diagnosis, under any circumstances.

Dependant child(ren) cannot stay on the **policy** after the **policy anniversary** following their twenty-first (21st) birthday. However, cover for the **dependant** child(ren) on the **policy** may be renewed up to twenty-five (25) years old provided that they are unmarried and unemployed. For the **policy** to be re-issued to the **dependant** child(ren) as the **policyholder**, they will not be required to submit further evidence of insurability provided there is no change in the **plan** and the **dependant** child(ren) has/have been continuously insured under the **policy** without any break in cover.

*6.2 What happens if an **insured person** changes their **principal country of residence***

The **policyholder** must complete the prescribed form if an **insured person** changes their **principal country of residence** even if they are staying in the same **area of cover** as **we** may not be able to continue cover due to any breach of a law and/or regulation and/or sanctions.

Where an **insured person** moves to a **principal country of residence** outside the current **area of cover** and provided **we** can continue to cover such an **insured person**, **we** will change the **insured person's plan** and issue an **endorsement** accordingly within thirty (30) days from the date **we** receive the information of change of country of residence from the **policyholder**. A pro-rata **premium** adjustment will be made.

If the **policyholder** does not tell **us**, **we** can refuse to pay benefits.

*6.3 What happens if **policyholder** or **we** wish to cancel the **policy***

The **policyholder** may cancel the **policy** at any time by giving **us** no less than thirty (30) days' notice on an Amended Form from the intended date of cancellation in **writing**. This is an annual contract and **we** will not refund **premium**s if any claim, however small, has been made in the current **policy year**. If the **policyholder** has decided to pay the annual **premium** in non-annual payment instalments (non-annual instalment of **premium** is applicable only to group policy and it is also subject to **our** agreement at the time of quotation or at renewal), the remaining instalments for the **policy** will continue to be due unless **we** (in **our** sole discretion) agree to waive the remaining instalments. In the event that **we** agree to make a refund, **we** will only refund seventy percent (70%) **premium**s of the pro-rata **premium**. (The pro-rata **premium** is calculated from the effective date of cancellation to the remaining period for the **policy year**) basis from the end of the Gregorian calendar month in which cancellation takes effect and provided the **policyholder** have returned to **us** the **policy** documents including the membership card(s). If there is any **premium** refund, **we** will refund the **policyholder** within thirty (30) days from the date **we** receive the notice of cancellation.

We can terminate cover under this **policy** for the respective **insured person** immediately when **we** know if there is a breach of any regulation and/or law and/or economic sanctions. **We** reserve the right to terminate cover for all **insured persons** at the same time when the cover for the **policyholder** is terminated. **We** will refund the pro-rated **premium** from the date of termination to the expiry of the **policy year**, provided there is no claim incurred in the **policy**.

*6.4 When the terms of the **policy** might change*

We have the right to change all or any part of the **policy** from any **policy anniversary. We** will provide the **policyholder** thirty (30) days' notice from the **policy anniversary** and will send the details of the changes to the address **we** have for the **policyholder** on **our** records.

We may also change **premium**s if costs (e.g. medical inflation), regulations or benefit changes make this necessary and provided that these changes are approved by Vietnam Ministry of Finance. In the event that **we** are required by law to make a change during the **policy year we** will be obliged to do so before the next renewal date.

We can apply the underwriting terms to the **policy** at any time if a **medical condition** that should reasonably have been declared at **policy commencement date** or at the time the **policyholder** request an upgrade to the **plan (** if requested) comes to **our** attention.

6.5 Joining and Renewing

(a) All **pre-existing conditions** must, in good faith, be declared to **us**, in **writing** at the time of application. Please also note that there may be cases which **we** may need to decline the entire application in view of the person's **pre-existing conditions**.

We will tell the **policyholder** in **writing** on or by the date the **policy** starts any special terms which apply to it. **We** can refuse to give the **policyholder** cover and will tell the **policyholder** if **we** do so.

(b) Adding or removing of an **insured person**

If the **policyholder** wants to add an **insured person** to an existing **policy**, the **policyholder** must complete the Proposal Form for the person to be insured.

If the application is approved, **we** will then update and issue the **policy schedule** accordingly. All applications for adding **insured persons** are subject to **our** acceptance. Any addition of an **insured person** during the **policy year** must be due to a special event such as marriage or new born baby.

If **we** do accept an addition of an **insured person** during the **policy year**, a pro-rata **premium** adjustment will applied and PJICO will issue the **policy schedule** after **premium** is received for that

newly included **insured person**. payment. The additional **insured person's policy anniversary** will be the same as that of the original **policy** issued to the **policyholder**.

If the **policyholder** wants to remove an **insured person** from an existing **policy**, the **policyholder** must complete the Amended Form. For an **insured person** who has been removed, no **premium** refund will be made if he/she has incurred a claim in the **policy**. If there is no claim, PJICO will refund seventy percent (70%) of the pro-rata **premium**. (The pro-rata **premium** is calculated from the effective date of termination to the remaining period for the **policy year**) The effective date of termination is based on the date **we** receive the notice of termination in **writing**, or from the requested date of termination (if the requested date of termination is a later date from the date **we** receive the instruction to terminate the **insured person**). No benefit shall be payable for the **insured person** with effect from the termination date of the **insured person** or **policy.**

The membership cards issued to the **insured person** being removed from the **policy** must be returned to **us.**

(c) Only those people listed in the **policy schedule** are considered **insured persons** of this **policy**. All cover applicable to an **insured person** ends if the **policyholder** decide to end the cover.

(d) The **policy** is for one **year** unless **we** have agreed something different. At **policy anniversary** provided the **plan** the **policyholder** are on is still available, the **policyholder** have a right to continue this **policy** on the terms and conditions applicable at that time by paying the **premium** applicable at the time of renewal. This shall not apply in the event that the **policy** expires, or is terminated or cancelled in accordance with the terms of this **policy** and the **policyholder** should subsequently wish to reapply for insurance cover under this **policy** as a new policy and all applicable **waiting period** will apply. If **we** are unable to renew the **policy** at any **policy anniversary**, **we** will provide the **policyholder** thirty (30) days' notice from the **policy anniversary** and will send the details to the address **we** have for the **policyholder** on **our** records.

(e) **Premium** rates are not guaranteed and the **premium** payable at **policy anniversary** shall be determined at each **policy anniversary** based on the premium rates approved by Vietnam Ministry of Finance based on the attained **age** of each **insured person**, the **premium** rates then in effect, and any other factors which may materially affect the risks insured. The **policyholder** must pay the **premium** when it is due, and the **premium** paid shall not be less than the **premium** amount stated in the renewal notice. Any renewal notice **we** sent to the **policyholder** is for his/her information only and does not prejudice the **policyholder's** liability to pay the renewal **premium** before the premium due date. **We** will decide the amount at the start of each **policy year** and tell the **policyholder** how much it is. The **policyholder** can pay it in the way **he/she** has agreed with **us**. It is hereby agreed and declared that the total **premium** due must be paid and actually received in full by **us** on or before the inception date of the coverage under the **policy**, Renewal Certificate, Cover Note or **endorsement**. The premium payment mode must follow the current regulations stipulated by the Vietnam Government.

In the event that the total **premium** due is not paid and actually received in full by **us** on or before the inception date referred to above, then the **policy** shall be deemed to be cancelled immediately and no benefits whatsoever shall be payable by **us**. Any payment received thereafter shall be of no effect whatsoever on the cancellation of the **policy** and the **premium** shall be returned to the **insured person.**

(f) **We** can change all or any part of the **policy** including the **benefits table** or these terms and the changes will only apply to the **policyholder** when **he/she** renew unless **we** are obliged by law to apply any change with immediate effect.

If the changes are regulated from the law, the changes will take effect immediately, regardless whether the **policyholder** or **insured person** has received the details of the changes.

6.6 General Conditions

(which apply to the whole **policy** and to be observed by the **policyholder** and all the **insured person s** covered under the **policy**)

It is important part of **our** contract that the **policyholder** observe the following General Conditions and they are, where their nature permits, conditions precedent to the right to recover from **us**:

(a) If any **insured person** breaches any of the terms of the **policy** or makes, or attempts to make, any dishonest claim, **we** can:

- refuse to make any payment; and
- refuse to renew the **policy**; or
- impose different terms to any cover **we** are prepared to provide; or
- terminate the **policy** and all cover under it immediately.

(b) The **policyholder** must make sure that whenever **policyholder /** an **insured person** are required to give **us** information all the information **policyholder /** an **insured person** give is true, accurate and complete. If it is not then **we** can cancel the **policy** or apply different terms of cover.

(c) The **policyholder** or the **insured person** or his/her representatives shall co-operate fully with **us** and **our** medical team (including the independent appointed **medical practitioner**) and the **policyholder**, the **insured person** or his/her representatives will fully and faithfully disclose all material facts and matters which the **policyholder** and/or the **insured person** knows or ought to know and will, upon request, execute any document to empower **us** to obtain the relevant information, at the **policyholder** or the **insured person's** expense from any **medical practitioner** or **hospita**l or clinic or other source.

(d) The **policy** will not provide compensation cover other than on a proportionate basis if the **policyholder** or the **insured person** has any other insurance in force or is entitled to indemnity from any other source in respect of the same injury or illness.

(e) It is hereby declared that as a condition precedent **our** liability, the **policyholder** and the **insured person** have agreed that any personal information in relation to the **policyholder** provided by or on behalf of the **insured person** to **us** may be held, used and disclosed to enable **us** or individuals/organizations associated with **us** or any independent third party (within or outside Vietnam) to:

(i) process and assess the **insured person's** application or any matter arising from the **policy** and any other application for insurance cover, and/or

(ii) provide all services under the **policy**.

(f) The **policyholder** must write and tell **us** if **policyholder** (or any **insured person**) change address. The **policyholder** is acting on behalf of any **insured person** covered by the **policy** so **we** will send all correspondence about the **policy** to **policyholder's** address.

(g) For the purposes of determining **premium**s payable, the **insured person's age** shall be deemed to be his/her attained **age** counted to the date of applying or renewing, and any **premium** tables or other material **we** provide in this connection shall be read accordingly. If the **age** of the **insured person** has been misstated and the **premium** paid as a result thereof is insufficient, any claim payable under this **policy** shall be prorated based on the ratio of the actual **premium** paid to the correct **premium** which should have been charged for the original policy commencement date of the **insured person**. Any excess **premium**, which may have been paid as a result of such misstatement of **age**, shall be refunded without interest. If at the correct **age**, the **insured person** would not have been eligible for cover under this **policy**, no benefit shall be payable and the actual **premium** paid shall be refunded without interest. If a claim has been paid in respect of the **insured person** who was not eligible for cover under this **policy**, the **policyholder** are required to repay **us** on demand the amount

of the claim and **we** reserves the right to off-set any **premiums** paid by the **policyholder** against the amount of the claim.

(h) **We** shall not be bound to take notice of any trust, charge, lien, assignment or other dealing with or relating to this **policy**, but the payment by **us** to the **policyholder**/**insured person**, his/her nominee or legal representative, as the case may be, of any compensation or benefit under the **policy** shall in all cases be an effectual discharge to **us.**

(i) If there is a dispute between the **policyholder** and **us, we** have a complaints procedure, set out in Section 9 – 'If any problems arise', which the **insured person** must follow so that **we** can resolve any dispute.

(j) This **policy** is governed by and interpreted according to the laws of Vietnam.

(k) The terms of the **policy** cannot be changed nor claims approval given by any verbal communication between the **policyholder** and **us**. Any changes, approvals, or other statements relating to the **policy** must be confirmed, in **writing,** by **us**. **We** are not bound by any verbal commitment not confirmed by **us** in **writing**.

(l) Cover under this **policy** for the respective **insured person** shall also automatically terminate on the earliest occurrence of any of the following events:

i. the date the **policy** is terminated;
ii. the date the **insured person's** coverage is terminated;
iii. death of such **insured person**;
iv. non-payment of **premium** for this **policy**;
v. if there shall be any misrepresentation, non-disclosure or fraud on the part of the **policyholder** and/or **insured person.**

We reserve the right to terminate cover for all **insured persons** at the same time when the cover for the **policyholder** is terminated.

Except for the sub-section (ii) there shall be no **premium** refund on termination for the **policy**. For sub-section (ii), please refer to Section 6.5(b).

(m) **We** and other service providers will not provide cover or pay claims under this **policy** if doing so would expose **us** or the service provider to a breach of international economic sanctions, laws or regulations, including but not limited to those provided for by the European Union, United Kingdom, United States of America or under an United Nations resolution. If a potential breach is discovered, where possible **we** will advise the **policyholder** in writing as soon as **we** can.

(n) On the description provided for each of the **alternative treatment** mentioned under the '**alternative treatment**' definition, PJICO is not responsible for the availability and the reliability of the information quoted from www.nih.gov.

(o) The cost for the **independent medical practitioner's** consultation and any other charges imposed by the **independent medical practitioner** shall be paid by the party (and this refers either to the **policyholder/insured person** or **PJICO)** who requested for the **independent medical practitioner's** services**.**

Section 7 – Exclusions and Limitations

7.1 The following tests, investigations, treatments, items, conditions, activities and their related or consequential expenses are excluded from this **policy** and **we** shall not be liable for:

(a) **pre-existing condition** as defined, including any treatment and complications arising from the **pre-existing condition** and its associated **medical conditions** unless **we** had agreed otherwise in **writing** that there was no need for the **policyholder** / the **insured person** to tell **us**;

(b) any **surgical procedure** which is not listed in the **schedule of procedures;** unless it is proven that the surgical procedure which is not listed has been established as being effective and is not experimental;**..**

(c) any charges for treatment related to and/or of **congenital conditions** unless if allowed for by the **insured person's plan** stated on the **benefits table**;

(d) any treatment which offers temporary relief of symptoms rather than dealing with the underlying **medical condition**;

Please note **we** will not refuse to pay for other forms of curative treatment after an effective treatment has been recommended by the treating **medical practitioner**. However, **we** will not pay for **treatment** that is only offering temporary relief of symptoms where there is no cure or where the **insured person** refuses to undergo an effective and available treatment for whatsoever reasons but **we** will pay for temporary relief of symptoms when such treatment falls under "Hospice and Palliative Care" benefit and if this benefit is allowed for by the **insured person's plan**.

(e) normal pregnancy or childbirth unless this is specifically included in the **insured person's plan** stated on the **benefits table**. Caesarean section and any complications thereof is covered under 'Pregnancy and Delivery' benefit and would be subject to the limit shown there if allowed for by the **insured person's plan** stated on the **benefits table**;

Under the 'Pre- and post- natal complications' benefit, **we** will pay for **treatment** of a **medical condition** which is due to and occurs during the pregnancy. However **we** will not pay for such **treatment** if the pregnancy was a result of assisted means or any form of **assisted conception/assisted pregnancy** or elective**/**non-**medically necessary** caesarean section.

(f) treatment begun, or for which the need had arisen (as per the diagnosis by the treating **medical practitioner** or the **independent medical practitioner**), during the first ninety (90) days after birth for any child conceived by artificial means or any form of **assisted conception/assisted pregnancy**;

(g) treatment directly related to surrogacy whether the **insured person** is acting as surrogate, or is the intended parent;

(h) foetal surgery. By this **we** mean treatment given or undertaken on a foetus while in the womb;

(i) termination of pregnancy or any consequences of it, except where eligible under the 'Pre- and post-natal complications' benefit;

(j) contraception, investigations into and treatment of infertility, treatment designed to increase fertility (including treatment to prevent future miscarriage), investigation into

miscarriage and **assisted conception/assisted pregnancy**, sterilisation (or its reversal) or any consequence of any of them or of any treatment for them;

(k) treatment of impotence or any consequence of it;

(l) treatment of, or related to, sexual dysfunction or any consequence of it;

(m) treatment of sexually transmitted diseases;

(n) gender re-assignment operations or any other surgical or medical treatment including psychotherapy or similar services which arise from, or are directly or indirectly associated with gender re-assignment;

(o) treatment of any **medical condition** which arises in any way from Human Immunodeficiency Virus (HIV) infection and Acquired Immune Deficiency Syndrome (AIDS) unless allowed for by the **insured person's plan** stated on the **benefits table;**;

(p) treatment of obesity (Body Mass Index ((BMI)) equal to 30 or above) or any **medical condition** which arises from, or is related to, obesity in any way;

(q) costs incurred for, or related to, any kind of bariatric surgery, regardless of the reason the surgery is needed, the fitting of a gastric band or creation of a gastric sleeve;

(r) the removal of fat or surplus tissue from any part of the body whether or not it is need for medical or psychological reasons;

(s) the costs of collecting donor organs or tissue or any administration costs or the cost of donor search even if such transplants are allowed by the terms of this **policy**;

(t) any form of **treatment** by any of the following: the **policyholder**, or the **insured person,** or a family member who are the parent(s), parent(s)-in-law, brother(s), brother(s)-in-law, sister(s, sister(s)-in-law, spouse or child(ren) of the **policyholder** or the **insured person**;

(u) treatment which arises from or is directly or indirectly caused by a self-inflicted injury or an attempt at suicide;

(v) parenting or other teaching classes; courses/program/classes on ante-natal or cessation of alcohol or smoking or drugs or substance; all types of classes/courses/programs;

(w) any costs relating to the treatment of nicotine or smoking dependence, including nicotine replacement therapy; or treatment which arises from or is in any way connected with misuse or over dosage or excessive use of alcohol, medicine, any kind of substance;

(x) any treatment to correct refractive defects of the eyes such as long or short-sightedness or astigmatism, unless allowed for by **insured person's plan**; laser/lasik eye surgery;

(y) all types of learning disorders, educational problems, behavioural problems, physical development or psychological development, including assessment or grading of such problems; treatment for developmental delay such as dyslexia, dyspraxia, autistic spectrum disorder, attention deficit hyperactivity disorder (ADHD), and speech or language problems;

(z) preventive (i.e. prophylactic) treatment;

(aa) any costs incurred as a consequence of treatment that is not eligible under the **policy**, including increased treatment costs;

(bb) any additional **hospital** charges for a non-standard single room or ward that exceeds the limit stated on the daily accommodation charges stated on the **insured person's benefits table** or room upgrade, luxury menu items, menu items not included as standard, visitors meals;

Please note: the **policyholder** may choose to upgrade the room or menu items, however, **we** will only pay for the reasonable charges for a standard single room and the **policyholder** will be responsible for paying any additional charges;

(cc) treatment to relieve symptoms commonly associated with any bodily change arising from any physiological or natural cause such as aging, menopause, or puberty and which is not due to any underlying disease, illness or injury;

(dd) vaccinations, routine or preventive medical examinations or preventive screening, including routine follow-up consultations, unless allowed for by the **insured person's plan** stated on the **benefits table**;

(ee) the costs of providing or fitting any external prosthesis or orthosis or appliance or medical aids or durable medical equipment unless allowed for by the **insured person's plan** stated on the **benefits table**;

(ff) out-patient treatment including drugs or dressings except those defined as **prescriptions**, and where the **policy** provides the 'General Practitioner and Specialist Care' benefit;

(gg) orthodontics, periodontics, endodontics, preventative dentistry, and general dental care including fillings, no matter who gives the treatment unless allowed for by the **insured person's plan** stated on the **benefits table**;

(hh) claims if the **insured person** has travelled outside his/her **area of cover** to get **treatment** (whether or not that was the only reason) or travelled against medical advice even if it is within the **area of cover**;

(ii) treatment incurred as a result of engaging in or training for any sport for which the **insured person** receives a salary or monetary reimbursement, including grants or sponsorship (unless the **insured person** receives travel costs only);

(jj) treatment of injuries sustained from base jumping, cliff diving, flying in an unlicensed aircraft or as a learner, martial arts, free climbing, mountaineering with or without ropes, scuba diving to a depth of more than 10 metres, trekking to a height of over 2,500 metres, bungee jumping, canyoning, hang gliding, paragliding or microlighting, parachuting, potholing, skiing off piste or any other winter sports activity carried out off piste;

(kk) treatment specifically excluded by the terms, including the associated **medical conditions**, shown on the **policy schedule** or **endorsement** for the **insured person**; any charges for items not listed in the **benefits table** applicable to the **insured person's plan**;

(ll) any charges which is incurred for social or domestic reasons (such as travel or home help costs) or for reasons which are not directly connected with treatment;

(mm) any charges for treatment incurred during a period for which the **premium** due has not been paid;

(nn) any charges from health hydros, spas, nature cure clinics, fitness centres even if it is registered as a **hospital**;

(oo) any claim or part of a claim in respect of which the **policyholder/**the **insured person** have to pay e.g. **annual deductible** and/or **co-insurance**. In this case **we** will only pay the balance of the claim after **we** have deducted the amount for **annual deductible** and/or **co-insurance** ;

(pp) any charges made by **medical practitioner, hospital**, laboratory or any such medical services which are not **reasonable and customary**;

(qq) any administration costs or reports of any kind (unless otherwise advised by **us**) or any other charges of a non-medical nature in connection with the provision and/or performance of medical supplies and/or services;

(rr) all bank or credit charges when the claims payment is made in a currency other than Vietnam Dong;

(ss) costs of treatment rendered and drugs or medicine prescribed by a **medical practitioner** that is not related to the treatment provided to the **insured person**;

(tt) claims for any supplements or substances which are available naturally. This includes vitamins, minerals, and organic substances except where prescribed under 'alternative treatment' benefit;

(uu) nutritional supplements including to special formula and cosmetic products even if medically recommended or prescribed or acknowledged as having therapeutic effects;

(vv) psychiatric treatment unless allowed for by the **insured person's plan** stated on the **benefits table**

(ww) cryopreservation; implantation or re-implantation of living cells or living tissue, whether autologous or provided by a donor;

(xx) treatment which is not considered **medically necessary** or which may be considered as a matter of personal choice;

(yy) **in-patient treatment** for a **medical condition** which can be properly treated as an out-patient;

(zz) genetic tests, nor any counselling made necessary following genetic tests, even when those tests are undertaken to establish whether or not the **insured person** may be genetically disposed to the development of a **medical condition** in the future. This is because such tests are carried out for purposes of establishing whether a **medical condition** might develop and not for the treatment of a **medical condition**;

(aaa) standard toiletries, shampoos, soaps, toothpastes, mouthwash, lotions, moisturiser, cleansers, shower gels, contraceptives, proprietary headache and cold cures, with or without prescriptions, nor do **we** pay for telephone calls;

(bbb) all types of sleep disorder, snoring, insomnia, obstructive sleep apnoea, or sleep study tests

(ccc) investigations or treatment of loss of hair;

(ddd) all forms of acne;

(eee) ear or body piercing and tattooing or treatment needed as a result of any of these;

(fff) treatment whilst staying in a **hospital** for more than ninety (90) continuous days for permanent neurological damage or if the **insured person** is in a persistent vegetative state.

We define persistent vegetative state as a condition of profound no responsiveness, with no sign of awareness or consciousness or a functioning mind, even if the person can open their eyes and breathe unaided, and the person does not respond to stimuli such as calling their name, or touching. This state must have remained for at least four (4) weeks with no sign of improvement or there could be no recovery;

(ggg) any cost or service or treatment incurred in a country that is sanctioned by the United Nations (UN) and / or United States of America (USA) and / or European Union (EU) at the time of treatment. Details of these countries can be obtained by calling **our** Customer Service team.

7.2 Special terms apply in the following cases:

The following tests, investigations, treatments, items, conditions, activities and their related or consequential expenses are excluded from this **policy** and **we** shall not be liable for:

(a) cosmetic (aesthetic) surgery or treatment;

(b) any treatment which relates to or is needed because of previous cosmetic treatment**/** reconstructive surgery;

(c) special nursing in **hospital** unless **we** have agreed in **writing** or by beforehand that it is necessary and appropriate;

(d) in-patient rehabilitation except when:
- it is carried out by a **medical practitioner** specialising in rehabilitation; and
- it is carried out in a rehabilitation **hospital** or unit; and
- the **treatment** could not be carried out on an out-patient basis, and a
- the costs have been agreed, in **writing** by **us** before the rehabilitation begins.

We will not pay for in-patient rehabilitation for more than twenty-eight (28) days except in cases such as in severe central nervous system damage caused by external trauma. For cases such as in severe central nervous system damage caused by external trauma, **we** will not pay for in-patient rehabilitation for more than one hundred eighty (180) days.

(e) the use of any drug which has not been established as being effective or which is experimental or within clinical trials. This means they must be licensed by the European Medicines Agency if the **insured person** is receiving treatment in Europe, or the US Food and Drug Administration (FDA) if the **insured person** is receiving treatment anywhere else in the world, and be used within the terms of that license. However **we** will pay if, before the treatment begins, it is established that the **treatment** is recognised as appropriate by an authoritative medical body and the costs are **reasonable and customary**; ;

(f) treatment which has not been established as being effective or which is experimental. For established **treatment,** this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficiently evidenced in published medical journals for specific purposes to be considered proven safe and effective therapies.

7.3 **We** will not pay for any treatment, or for International Emergency Medical Assistance, if they are needed as a result of event including such as but not limited to nuclear contamination, biological contamination or chemical contamination, while engaging in or taking part in war(whether declared or not), act of foreign enemy, illegal or criminal activities, invasion, civil war, riot, rebellion, insurrection, revolution, overthrow of a legally constituted government, explosions of war weapons. This includes treatment needed as a result of the

insured person exposing himself/herself to needless peril, such as going to a place of unrest as an active onlooker or a spectator.

Please note, for clarity: There is cover for treatment required as a result of a **terrorist act** providing that **terrorist act** does not result in nuclear, biological or chemical contamination.

7.4 **We** may not pay the full eligible expenses if **we** have not been informed within thirty (30) days. All the completed claims form, original invoices and all the documents stated in Section 8.2.2 should be submitted within ninety (90) days^ of the **treatment** being received, unless this may not be possible in the case of force majeure. For any claim that is submitted after twelve (12) months^ without the case of force majeure, the claim will not be payable even if the claim is eligible.

^The ninety(90) days and twelve (12) months mentioned in this sub-clause 7.4. is counted based on the date of discharge by the **hospital for in-patient treatment or day-care treatment,** while for **out-patient treatment**, it is counted based on the date of treatment received.

7.5 **We** will not pay upgraded benefit levels for treatment of any **medical condition** which arose or should reasonably have been foreseen by the **insured person** prior to the upgrade becoming effective. Where such a **medical condition** is or becomes apparent, benefits for such a **medical condition** will be restricted to the level of cover that would have been applicable to such a **medical condition** prior to the upgrade.

Section 8 - Understanding how to get the best from the plan

The following notes deal with some specific aspects and commonly asked questions relating to the cover. Please contact **us** for advice on any aspect of the **policy** that the **policyholder** do not understand.

*8.1 Before **the** **insured person** goes for treatment*

8.1.1 What to do before receiving in-patient treatment or day-care treatment

- Before receiving any planned **in-patient treatment** or **day-care treatment** recommended by the **insured person**'s **medical practitioner**, the **policyholder**/the **insured person** or the treating **hospital** should contact **our** Direct Billing and Claim support team to obtain **our** authorisation for such **insured person's** proposed **treatment**.

- **We** will confirm, in **writing** to the **policyholder**/the **insured person** and/or the **hospital,** the extent of the cover for the proposed **treatment** and the amount **we** are prepared to pay for it. In the unlikely event that there is any difference between **our** confirmed level of cover and what is requested by the **hospital** when such **insured person** is discharged, the **policyholder**/the **insured person** must make arrangements to pay this when the **insured person** is leaving the **hospital**.

8.1.2 Pre-approval

The reason that **we** recommend pre-approval of planned **treatment** is to protect the **policyholder**/the **insured person** from unexpected costs. When issuing confirmation of cover in this way, **we** will confirm the following:

- the planned **treatment** is eligible under the **policy**
- the planned **treatment** is **medically necessary**
- the planned **treatment** is within **reasonable and customary** costs
- the planned **treatment** cost falls within the remaining benefit limit of the **insured person's plan**

The **policyholder** should seek **our** written pre-approval for the following **treatment** and services:

In-patient and day-care

- all in-patient and day-care admissions
- all non-**emergency** tests, diagnostics, **treatment**, surgery and other medical services
- all in-patient maternity services
- all in-patient dental services
- local road ambulance transport
- special nursing in **hospital** and/or any nursing at home after discharge
- reconstructive surgery
- hospice and palliative care

Out-patient

- non-**emergency** computerized tomography, magnetic resonance imaging, positron emission tomography, x-rays, gait scans and internal diagnostics such as, but not limited to, endoscopy, colonoscopy, gastroscopy and other such scans
- **prescriptions** covering consumables for thirty (30) days or more
- second opinion for the same **medical condition**
- any out-patient services requested on a direct billing basis

Failure to obtain pre-approval may prevent **us** from settling all or part of any claim. In the event that **we** are obliged to pay for any item not covered by **our** confirmation, **we** will recover that amount from the **policyholder**/the **insured person**. In any event any cost that is not directly related to **treatment** will be borne by the **policyholder**/the **insured person**.

Where it is mentioned in Section 4 in this **policy** that pre-approval is compulsory, PJICO or our **appointed service provider** will provide the pre-approval letter within twenty-four (24) hours from the time **we** receive the request if **we** receive all the complete information.

Where it is not possible for PJICO or **our service provider** to provide the pre-approval because of incomplete information, the **insured person** could still submit the claim for reimbursement to PJICO for their review. The claims will be assessed based on the terms and conditions of this **policy** and according to the **benefits table** applicable to the **insured person's plan**.

8.1.3 In-patient and direct billing

All non-**emergency in-patient treatment** should be approved by **us** or by **our service provider**, in **writing** prior to admission to the **hospital**. The **insured person** can take advantage of direct billing facilities for eligible **in-patient treatment** within **our Global directory of hospitals**. The **insured person** should confirm with the **hospital** that it has received **our** written authorisation before he/she undergoes **treatment**. If it has not, the **insured person** must contact **us** immediately.

Where the **insured person** receives **treatment** for a **medical condition** that is not covered within the terms of the **policy**, the **insured person** remains liable for the costs of such **treatment**, which must be settled in full upon request. Failure to act accordingly will result in the immediate termination of cover for that **insured person** and **we** will refund the pro-rated **premium** from the date of termination to the expiry of the **policy year**, provided there is no claim incurred in the **policy**.

In the event that **we** are obliged to pay for any item not covered by **our** confirmation **we** will recover that amount from the **policyholder**/the **insured person**. In any event any cost that is not directly related to **treatment** will be borne by the **policyholder**/the **insured person**.

8.1.4. Decisions about the treatment

We do not decide whether the **treatment t**he **insured person** receives is given on an in-patient, day-care or out-patient basis. This is decided by the attending **medical practitioner**. **We** will not usually question this unless, in the opinion of **our medical adviser** , it would have been more appropriate for **treatment** to have been given differently.

If there is any differences in the opinion of the treating **medical practitioner** and **our medical advisers**, the opinion of **independent medical practitioner** shall prevail.

8.1.5 Schedule of procedures

In this **policy** document **we** refer to a **schedule of procedures** which is a document that lists the proven **surgical procedures** for which **we** pay benefit and classifies them by complexity. Each of the

procedures is also given a code number for administrative purposes. There are in excess of 1,000 procedures listed, of which about 250 are commonly performed on a daily basis. This document is written in medical language and it is intended for use by **medical practitioners** and **us** to assess the eligibility of proposed **treatment** and the claim. The schedule is regularly updated to include new, proven, procedures and is retained by **us**.

8.1.6 Second opinion

We can ask an **independent medical practitioner** to advise **us** about the medical facts relating to a claim or to medically examine the **insured person** concerned in connection with the claim and provide **us** with a report. The **insured person** must co-operate with the **independent medical practitioner**. This is needed only very rarely and **we** use this right only where there is uncertainty as to the nature or extent of the **medical condition** and/or **our** liability under the **policy**. In the event of any differences between **our** medical team and the attending **medical practitioner**, the **independent medical practitioner's** opinion shall prevail.

8.1.7 If the insured person need treatment

If the **insured person** needs **treatment**, the **insured person** will need to call **our** Direct Billing and Claim Support team on the number shown on the reverse of their membership card.

If the **medical practitioner** of the **insured person** recommends hospitalisation or a major out-patient procedure then call **our** Direct Billing and Claim Support team to confirm that the **insured person** is entitled to benefit.

Any bills, together with the completed claim form, should be sent to:

South Asia Services Liability Ltd. Co
8th Floor, 208 Nguyen Trai, Dist 1, Ho Chi Minh City
Tel: (+848) 39256780

8.1.8 Emergency treatment

If the **treatment** requires an **emergency** admission; the **insured person** may not be able to contact **us** beforehand. Do, however, ask somebody to contact **us** as soon as possible and make sure that, when the **insured person** is admitted to **hospital**, the **hospital** is given the **insured person's** membership card and proof of identity so that they can contact **us** straight away.

*8.2While the **insured person** is having treatment*

8.2.1 Insured Person identifying himself / herself

In any event, if the **insured person** is receiving **treatment** in any part of **our hospital** within **our global directory of hospitals**, the **insured person** must always identify himself/herself as an **insured person** to ensure that his/her **eligible treatment** enjoys the advantages of **our** negotiated rates. Failure to do this may expose the **insured person** to additional costs which the **insured person** will have to bear.

Please note that **we** can recover from the **policyholder** or the **insured person** any ineligible expenses it has incurred on behalf of that **insured person** under this **policy**.

8.2.2 Claim documents for reimbursement claims

For reimbursement claims, the **policyholder/insured person** can pay the medical expenses first but should notify PJICO within thirty(30) days of the **treatment** being received. If the **policyholder/insured person** does not notify **us** within thirty(30) days, the **policyholder/insured person** may have to bear the percentage of the eligible expenses as per the following table:

Number of days which the **policyholder/insured person** notify PJICO or **our service provider**	Percentage on the eligible expenses to be paid by the **policyholder/insured person**
Within 30 days of the **treatment** received	Nil
Within 31 to 60 days of the **treatment** received	10%
Within 61 to 90 days of the **treatment** received	20%
Within 91 to 365 days of the **treatment** received	30%
More than 365 days	100% - the entire claim will not be payable by PJICO.

All reimbursement claims require a claim form which can be obtained at **our** website or by calling **our** Direct Billing and Claim Support team at the number shown on the reverse of the membership card.

The **policyholder/insured person** must make sure it is filled in and signed by themselves and the **medical practitioner** treating the **insured person** and send back to **us** as quickly as possible, giving **us** all the information **we** request.

A fully completed claim form will ensure that the claim will be processed promptly. An incomplete or unsigned claim form may delay settlement of the claim and in some cases may lead to the claim form being returned to the **policyholder** or the **insured person** for completion.

For more details on what is to be submitted, please refer to the handbook given to the **policyholder**. It may be necessary for **us** to obtain additional medical information from the attending **medical practitioner**. In such cases **we** will provide a medical information form which has to be completed by the **medical practitioner** who treated the **insured person**. If the **medical practitioner** does not respond quickly to such a request the claim may be delayed or rejected.

We do not pay for medical reports.

For **treatment** where the **insured person** is seeking **our** pre-approval, such approval must be received from **us**, in **writing** prior to **treatment** commencing. The **insured person** will receive a claim number which must be stated in the **insured person's** subsequent claim.

Please note that, for reimbursement claims, all claims must be submitted within twelve (12)months of the **treatment** being received.

The claim documents issued outside Vietnam in any language other than Vietnamese must be translated to Vietnamese with the legal translator's name and certification and the translated document n must be attached to the original documents. The translator must sign with his/her full name and declare that he/she will be responsible for the correct translation to Vietnamese language. . The cost of the translation is paid by **policyholder/insured person.**

Where to send the claims

Any bills, together with the completed claim form, should be sent to:

South Asia Services Liability Ltd. Co
8 Floor, 208 Nguyen Trai, Dist 1, Ho Chi Minh City
Tel: (+848) 39256780

8.2.3 Currency

The values in the **benefits table** are in Vietnam Dong ('Dong').

Premiums must be paid in Vietnam Dong.

Claim reimbursement will be paid in the same currency which **premiums** have been paid by the **policyholder** unless **we** have previously agreed otherwise in **writing**. If **we** agree to reimburse to the **insured person** in a different currency, **we** will confirm this in **writing.** Reimbursement of eligible expenses other than in Vietnam Dong is also subject to the foreign exchange regulations stipulated by Vietnam Government. For eligible expenses on **in-patient treatment** or **day-care treatment**, **we** will reimburse using Vietcombank spot rates prevailing on the date of discharge from the **hospital**. For eligible expenses for out-patient treatment, **we** will reimburse using Vietcombank spot rates prevailing on the date of the out-patient treatment.. Any exchange costs incurred will be payable by the **insured person** and will be subtracted from any payment made to the **insured person** in respect of such a claim.

We shall not be liable for any bank charges or credit charges or foreign exchange differences.

Note: For the section 8.2.4 and 8.2.7, this is an overall summary, the policyholder would need to refer to the rest of the policy terms and conditions. .

8.2.4What we expect from the insured person

a) To pay **premiums** fully, according to the time limits and mode agreed upon in this **policy** (please refer to Section 6.6(g) for the details).
b) To declare in good faith all the details related to this **policy** at the request of PJICO including **pre-existing conditions** and **congenital conditions** (please refer to Section 5 and Section 6.5(b) for details).
c) Inform PJICO prior to receive any treatment where pre-approval is required (please refer to Section 4 and Section 8 for details).
d) Inform PJICO if there is any material fact that may increase the risk or result in additional responsibilities during application for this policy. The **policyholder** must write and tell **us** if the **policyholder** (or any **insured person**) change address in writing. The **policyholder** is acting on behalf of any **insured person** covered by the **policy** so **we** will send all correspondence about this **policy** to the **policyholder's** address (please refer to Section 6 for details).
e) Notify PJICO of any claim as per the terms and conditions of this **policy**. In the case where the costs exceed the benefit limit or it is not **reasonable and customary**, the **policyholder/ insured person** will have to pay PJICO the difference (please refer to Section 6 and Section 8 for details).
f) To submit all the requested information stated in Section 8 and handbook for **our** assessment for claims.
g) The **policyholder** and/or the **insured person** or his/her representatives shall co-operate fully with **us** and **independent medical practitioner.** The **policyholder**, the **insured person** or their legal representatives will fully and faithfully disclose all material facts and matters which the **policyholder** and/or the **insured person** knows or ought to know and will, upon **our** request, execute any document to empower **us** to obtain the relevant information, at the **policyholder** or the **insured person's** own expense they obtain from any **medical practitioner** or **hospital** or clinic or other source (please refer to Section 6.5(b) and Section 6.6(c) for details).
h) Reimburse PJICO the amount of compensation paid by PJICO if compensation had been paid related to a person who is not eligible to be covered under this **policy** and PJICO has the right to collect any **premium** for the insurance that the **insured person** has paid (please refer to Section 6 and Section 8 for details) .
i) The payment of any claim does not discharge **policyholder / insured person's** obligations on the fulfilment of the terms and conditions under this **policy** (please refer to Section 8 for details);
j) The **policyholder/insured person** must fulfil all other obligations according to the law of Vietnam.

8.2.5 Our rights

a) if the **policyholder** or any **insured person** breaches any of the terms and conditions of this **policy** or makes, or attempts to make, any dishonest claim, PJICO ca n refuse to refund **premium** or to pay any claim or to refuse to renew the **policy** or impose different terms to any cover we are prepared to provide or to terminate the **policy** and all cover under it immediately (please refer to Section 6.6(a) and Section 8 for details).
b) Collect **premiums** as stipulated in this **policy** contract (please refer to Section 6.5(e) and Section 6.6.(g) for details).
c) Request the **policyholder** to fully and honestly give information relating to the inception of this **policy**. Failure to declare any **medical condition** of which the **policyholder** or the **insured persons** should reasonably have been aware may result in changes to the terms and conditions

of the **insured person** under this **policy** or result in the cancellation of this **policy** (please refer to Section 6.6(c) for details).

d) Decline to pay the claim to the **policyholder** or the **insured person** for cases which is outside the scope of this **policy** or is part of the exclusions/limitations of this **policy** (please refer to Section 5 and Section 6 for details).

e) Decline to pay the insurance reimbursement if PJICO did not receive notice from the **policyholder/insured person** within thirty (30) days and the claims within twelve (12) months from the date of treatment, unless in the case of force majeure. (please refer to Section 7.4 and Section 8.2.2 for details).

f) Recover from the **policyholder** and/or the **insured person** when **we** have paid the claim before **we** discover the dishonesty/incorrect misrepresentation (please refer to Section 6.6(a) and Section 8.2.5 for details) ;

g) Retain and , use the personal information relating to the **policyholder** / **insured person** to PJICO or individuals / organizations/service provided appointed by PJICO or any independent third party (within or outside Vietnam's territory) to:
   • process and assess the **insured person's** application or any matter arising from the **policy** and any other application for insurance cover, and/or
   • provide all services under the **policy**.
   (please refer to Section 6.6(e) for details).

h) Refuse to pay the ongoing costs of continuing, or similar treatment, even where **we** have previously paid for this type of or similar treatment, if it is subsequently noted that the claim is not an eligible treatment (please refer to Section 8 for details).

i) **We** and other **our service provider**s will not provide cover or pay claims under this **policy** if doing so would expose **us** or the service provider to a breach of international economic sanctions, laws or regulations, including but not limited to those provided for by the European Union, United Kingdom, United States of America or under an United Nations resolution. If a potential breach is discovered, where possible we will advise the policyholder in writing as soon as **we** can (please refer to Section 2 and Section 6.6(m).

j) Refuse to pay upgraded benefit levels for treatment of any **medical condition** which arose or should reasonably have been foreseen prior to the upgrade becoming effective. Where such a **medical condition** is, or becomes, apparent, benefits for such a **medical condition** will be restricted to the level of cover that would have been applicable to such a **medical condition** prior to the upgrade (please refer to Section 6.1, Section 6.4 and Section 7.6 for details).

k) The **policyholder/insured person** must tell **us** on the claim form if they think any of the costs covered under this **policy** can be claimed from anyone else or under another insurance policy.

If another insurance policy is involved **we** will only pay for the excess of the amount recovered from such other insurance policy (please refer to Section 6.6.(d) for details).

l)Other rights according to the law of Vietnam.

m) If the **age** of the **insured person** has been misstated and as a result thereof is insufficient, any claim payable under this **policy** shall be prorated based on the ratio of the actual **premium** paid to the correct **premium** which should have been charged for the original **policy commencement date** of the **insured person** (please refer to Section 6.6(g) for details).

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8.2.6 What insured person/policyholder expect from us

a) Explain terms, conditions, rights and obligations of policyholder to policyholder;

b) Provide **policyholder** their **policy schedule**, policy contract , **membership card** after the **policyholder** has signed the policy contract;

c) Pay eligible claims with completed documents to **insured person** within fifteen (15) working days;

d) Provide the reason , in writing, the reason why PJICO consider the claim as an ineligible treatment.

e) Notify, in writing, to the **policyholder/insured person** for any changes to the benefits, **premiums** and terms and conditions of this **policy** before the changes are effective (please refer to Section 6.4 and Section 6.5 or details)

f) PJICO will inform , in writing, any communication relating to the coverage, terms and conditions to the **insured person's policy.** PJICO is not bound by any verbal commitment. (please refer to Section 1.4, Section 6.6(k) and Section 10)

g) Keep any information given by **policyholder/insured person** as confidential, unless PJICO is asked to disclose such information by any individual/organization co-operating with PJICO or any independent third party or authority (please refer to Section 10 for details).

h) **We** shall not be bound to take notice of any trust, charge, lien, assignment or other dealing with or relating to this policy, but the payment by **us** to the **policyholder/insured person**, his/her nominee or legal representative, as the case may be, of any compensation or benefit under the **policy** shall in all cases be an effectual discharge to **us** (please refer to Section 6.6(h)).

i) Other obligations according to the law of Vietnam.

8.2.7 Insured person/Policyholder's right

a) Request PJICO to explain terms, conditions, rights and obligations of **policyholder**; issue policy contract and membership card.

b) Unilaterally terminate the **policy** according to the terms and conditions (please refer to Section 6.6 for details)

c) Ask PJICO to pay benefits to **insured person** according to the terms and conditions of this **policy** and also, based on the **benefits table** applicable to the **insured person's plan**.

d) Be assisted in direct billing when having an **eligible in-patient treatment** at **hospital** listed in the **Global Directory of Hospitals**.

e) Request PJICO to refund excess **premium** if the **age** of the **insured person** has been misstated for the original **policy commencement date** and the **premium** paid is more than what is required based on his/her correct **age**.

Please refer to Section 6.6(g) for details..

f) Other rights according to the law of Vietnam.

8.2.8 Specific claims conditions

(a) The payment of any claim does not discharge **policyholder** / **insured person's** obligations on the fulfilment of the terms and conditions under this **policy**; and

(b) **We** are not obliged to pay the ongoing costs of continuing, or similar **treatment**, even where **we** have previously paid for this type of or similar **treatment**, if it is subsequently noted that this claim is not an **eligible treatment.**

Section 9 - If any problems arise…

We have a process for dealing with complaints to ensure they are heard. The **policyholder/insured person** are welcome to contact **us** on the details below to talk to a Team Leader ~~or Manager~~ about the **policyholder/insured person**'s complaint.

24/7 hotline: 1900 54 54 55

Email: care.pjico@petrolimex.com.vn

Alternatively, the **policyholder** can write to:

PJICO Insurance Corporation Head Office
21st, MIPEC Tower, 229 Tay Son street, Dong Da district, Hanoi City, Vietnam

We will make every possible effort to resolve complaints to the **policyholder's** satisfaction.
This **policy** is governed by and interpreted according to the laws of Vietnam. If there is any dispute related to this **policy** where there is no agreement between the **policyholder** and **PJICO,** either the **policyholder** or **PJICO** hase the right to ask the Vietnam Governmental Authorities to solve it. The **policyholder** or PJICO has up to three (3) years from the time of the dispute to raise this to the Vietnam Governmental Authorities, thereafter, neither can the **policyholder** or PJICO can have this legal recourse.

Section 10 - The customer charter

As a valued customer the **policyholder** have important rights and entitlements. The **policyholder** is entitled to expect:

Courtesy. The requirements will always be dealt with promptly, considerately and courteously. No customer query is too trivial or too much trouble to sort out.

Helpful advice and guidance. **We** will help the **policyholder**, if he/ she have any doubts, to understand the terms of the contract and any other factors which affect the cover. They will help the **policyholder** to make proper use of the cover should the **policyholder** need to make a claim.

Confidential handling of policyholder's personal details and affairs wherever possible. Any medical details **we** require will always be kept confidential as much as possible. **We** may be required to provide information regarding claims the **policyholder** make, or have made in the past, or other details the **policyholder** have given **us,** to the sponsor or employer or a government department if they are paying for all or part of this **policy** or are entitled by law to require this of **us**. No liability will be accepted by **us** for any outcome resulting from the provision of such information to any of the aforementioned parties.

Advance notification of change in cover. Essential changes to the terms of the cover (including benefits, **premium**s and the **policy** document) will be notified to the **policyholder**, in **writing**, in advance of the date from which the changes take effect.

Professional and efficient service. All requests for assistance and any claims the **policyholder** submit will be considered impartially (without any bias or preference) in accordance with the benefits and **policy** document of **insured person's plan.**

For further information contact the office, details of which can be found on Section 11 in this **policy** document.

Section 11 – Contact for PJICO Office, Customer Service Team, Direct Billing and Claims Support

Section 12 – Benefits Table

Section 13 – Group Plan

This section only applies to the **policyholder** if the **policy** has been issued under a **group plan** and the **employer** has agreed to pay the **premiums** on the **policyholder** behalf and the **dependants** if they are eligible for cover under this **policy**.

The **employer** is eligible for a **group plan** subject to the following criteria:

(a) the **group plan** meets the following definition:

- it is formed by a business with a valid business license number that operates a minimum of six(6) months per year on a regular basis and maintains a legitimate employer/employee relationship. A group cannot be formed for the sole purpose of obtaining health insurance. A minimum of three(3) **employees** is required to form a group plan; and

(b) **we** confirm in writing that a **group plan** is in-force.

Unless otherwise stated, the following section replaces the equivalent wording outlined in the previous sections of this **policy** document.

If the **policyholder** have taken out this **policy** as part of a group:

- the **policyholder** may be entitled to additional **concessions** and/or benefits to those recorded in this **policy**, or
- the **policyholder** may have terms and conditions that are variations to this **policy** document.

If this is the case, details of those **concessions** and/or benefits and/or variations to the terms of this **policy** document will be recorded on the **policy schedule** or **renewal certificate** (whichever is later). In the event there is a conflict between the **concessions** and/or benefits recorded on the **policy schedule** or **renewal certificate** (whichever is later) and those recorded in this **policy** then the **policy schedule** or **renewal certificate** (whichever is later) will prevail.

*Eligibility - this replaces paragraph 2.2 to 2.4 of the **policy***

To be eligible for cover under this **policy**, and unless otherwise accepted by **us** in writing and shown in the **policy schedule,** an **insured person** must be:

(a) an **employee** of the **policyholder**, **aged** between eighteen (18) and sixty-five (65) years (inclusive), unless otherwise agreed by **us** in **writing**, **actively at work** on his/her **eligibility date.** Where an **employee** is not **actively at work** on his/her **eligibility date**, he/she will become eligible for coverage as soon as he/she becomes **actively at work.**

(b) **dependant(s)** of the **employee**, **aged** between fifteen (15) days to sixty-five (65) years (inclusive), unless otherwise agreed by **us** in **writing**, being able to perform all the **activities of daily living** on the **employee's eligibility date,**

subject to the **employee** being covered, are eligible for coverage under this **policy** as determined and agreed with **us** prior to **policy commencement date** or **policy anniversary**, whichever date is applicable.

For a **dependant** who cannot perform all **activities of daily living** on the **employee's eligibility date**, he/she becomes eligible for coverage only when he/she can perform all **activities of daily living**.

Please note:

(i) cover for the **eligible dependants** must be insured on the same **plan** as the **employee**,

(ii) Child(ren) who are eligible under this **policy** cannot stay on the **policy** after the **policy anniversary** following his/her twenty-first (21) birthday. However, his/her cover may be renewed up to the **age** of twenty-five (25) years old provided he/she is unmarried and is still a full time student.

When a new **insured person** becomes eligible, the **policyholder** must write to **us** within thirty (30) days from the **eligibility date** of that **insured person** to apply for his/her cover. If the application is approved, **we** will then update the membership listing and issue an **endorsement to this policy** accordingly.

Continuation of Cover

If this **policy** has been issued as part of an **employer** provided **group plan** and this is shown on the **policy schedule** or **renewal certificate**, and if:

- the **insured person** who is an **employee** resigns from his or her employment or his or her employment contract is terminated or is otherwise no longer eligible for cover under the **employer's** contract with us; or
- **we** or the **employer** end the arrangement which this **policy** is part of,

this **policy** ends immediately.

We may offer the **policyholder** a replacement **policy** determined by **us** at **our** discretion in accordance with **our** transfer rules applying at the time the **employee** ceases to be eligible for cover under the **employer's** contract with us or the arrangement **we** have with the **employer** ends. **We** may review the benefits, **concessions**, terms and conditions and the **premium** payable may be reviewed. **We** will write to the **policyholder** advising that this **policy** has been cancelled and give the **policyholder** the opportunity to continue the cover.

*Adding or removing an **insured person** – this replaces paragraph 1 and 2 of Section 6.5(b) of the policy*

<u>For policy issued on 'Fully Medical Underwritten (FMU)' basis</u>

If the **policyholder** wants to add an **insured person** to an existing **policy**, the **policyholder** must complete the Proposal Form for the person to be insured.

For policy issued on 'Medical History Disregarded (MHD)" basis
If the **policyholder** wants to add an **insured person** to an existing **policy**, the **policyholder** must complete the Amended Form.

For removal of insured person(s) from an existing policy
The **policyholder** must complete the Amended Form.

Paying premiums – this replaces Section 6.6(g) of the policy

Premium rates are not guaranteed and the **premium** payable at **policy anniversary** shall be determined at each **policy anniversary** based on the attained **age** of each **insured person**, the **premium** rates then in effect, and any other factors which may materially affect the risks insured.

The **employer** must pay the **premium** when it is due, and the **premium** paid shall not be less than the **premium** amount stated in the renewal notice. Any renewal notice **we** send to the **policyholder** or the **employer** is for information only and does not prejudice the **employer's** liability to pay the renewal **premium** when it is due. **We** will decide the amount at the start of each **policy year** and tell the **policyholder** how much it is. The **employer** can pay it in the way the **employer** has agreed with **us**. It is hereby agreed and declared that the total **premium** due must be paid and actually received in full by **us** on or before the **premium** due date.

In the event that the total **premium** due is not paid and actually received in full by **us** on or before the **premium** due date referred to above, then the **policy** shall be deemed to be cancelled immediately and no benefits whatsoever shall be payable by **us**. Any payment received thereafter shall be of no effect whatsoever on the cancellation of the **policy**.
Definition
The following definitions apply to the **policy:**

actively at work:
refers to an **employee** who is actually at work on the **policy commencement date** and performing each and every duty of his/her present occupation on a customary and fulltime basis. An **employee** shall also be deemed actively at work if he/she is on annual leave and is not absent from work due to illness, injury, or other form of disability. If an **employee** is not actively at work on the **policy commencement date**, he/she will not be covered.

activities of daily living:
refers to a **dependant partner** or **dependant** child(ren) (who is eligible for cover under the group scheme) and who can perform all the following activities^:
-Dressing: The ability to put on, take off, secure, and unfasten all garments and as appropriate, any braces, artificial limbs, or other surgical appliances;
- Feeding: The ability to feed one's self once food has been prepared and made available;
-Mobility: The ability to move indoors from room to room on level surfaces;

-Toileting: The ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
-Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
-Washing: The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.

^This criteria of performing all the activities of daily living apply to a **dependant** who is **aged** three (3) years old and above i.e.it does not apply to a **dependant** between **aged** fifteen (15) days old to two (2) years old.

eligibility date: means the date or period stated in the policy schedule and/or endorsement on which an **insured person** becomes eligible for cover under this policy

employee: means an **insured person** who is in direct employment with the **employer** and is **actively at work** on the date he/she is eligible for cover under this **policy**.

employer: means the legal entity in Vietnam that employs the **employee** and that is responsible for the payment of **premiums** under this **policy.**

group anniversary date: The date the **premiums** for the group are reviewed. The first group anniversary date will be twelve (12) months after the start date of the group scheme and at each twelve (12)-months period thereafter. For the purpose of interpreting the **policy**, all references to **policy anniversary** will be defined to mean the group anniversary date.

group: it is formed by a business with a valid business license number that operates a minimum of six(6) months per year on a regular basis and maintains a legitimate employer/employee relationship. A group cannot be formed for the sole purpose of obtaining health insurance. A minimum of three(3) **employees** is required to form a group plan.