BẢO HIỂM HÙNG VƯƠNG

PACIFIC CROSS

TERMS AND CONDITIONS OF HEALTH INSURANCE

CARE SERIES

CARE FIRST - CARE CROSS - CARE ELITE

The product's premium rating methodology and basis were approved by the Ministry of Finance under Official Letter No. 9291/BTC-QLBH dated June 26, 2025.

The Terms and Conditions were issued under the Decision No. 166/2025/QĐ-BHV-TGĐ dated July 30, 2025 by the General Director of Hung Vuong Insurance Corporation.

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ARTICLE 1

DEFINITION

"Insurance Company" or **"Company"** means Hung Vuong Insurance Corporation, licensed under establishment and operation license No. 50GP/KDBH dated May 19 2008, issued by the Ministry of Finance and the amendments.

"Policyholder" means an organization legally established and operating in Vietnam, or an individual who is a resident of Vietnam, aged 18 (eighteen) or above at the time of completing the Insurance Application Form, who has full civil capacity, satisfies the conditions stipulated in these Terms and Conditions, pays the insurance premium, and is accepted by the Company for entering into the Insurance Policy.

"Insured Person" means an individual residing in Vietnam at the time of submitting the Insurance Application Form, who meets the eligibility requirements for Insurable Age and is accepted for coverage by the Company under the Insurance Policy.

"Beneficiary" means the organization or individual designated by the Policyholder to receive insurance benefits under the Insurance Policy. The designation or change of the Beneficiary must comply with the Law on Insurance Business and other relevant legal regulations.

"Dependent" means the Insured Person's legal father, mother, spouse, or children. The Insured Person's children must be aged from 15 (fifteen) days old to 18 (eighteen) years old, calculated from the Effective Date or Renewal Date of the Insurance Policy.

"Insurance Application Form" means a written request for insurance issued by the Company, together with any related documents (if any), completed and declared/ provided by the Policyholder and the Insured Person with all information requested by the Company. The information provided in the form is the basis for the Company to assess risk and determine whether to accept or decline insurance coverage.

"Certificate of Insurance" means the Company's insurance acceptance document, detailing the main information about insurance benefits, and forming an integral part of the Insurance Policy.

"Terms and Conditions" means this Terms and Conditions, which sets out the detailed terms and conditions of insurance participation, rights and obligations of the Policyholder, Insured Person, and the Company. This Terms and Conditions form an integral part of the Insurance Policy.

"Insurance Policy" means the agreement between the Policyholder and the Company. The Insurance Policy includes the Insurance Application Form, Certificate of Insurance, this Terms and Conditions, the Summary of Terms and Conditions, endorsements and riders, and any other agreements made between the parties during the formation and execution of the Insurance Policy. The Insurance Policy may be concluded in written or electronic form.

"Effective Date of the Insurance Policy" means the date on which the Company commences insurance for the Insured Person under the Insurance Policy, as stated on the Certificate of Insurance.

"Renewal Date of the Insurance Policy" means the date following the expiration of the initial Insurance Period, if the Insurance Policy is renewed and accepted by the Company.

"Insurance Period" means the period of up to 1 (one) year starting from the Effective Date of the Insurance Policy, as specified in the Certificate of Insurance.

"Premium Payment Period" means the premium payment period stated in the Insurance Policy or Certificate of Insurance.

"Policy Year" means the period from the first day to the last day of the Insurance Period.

"Insurable Age" means the age of the Insured Person ranging from 15 (fifteen) days old to 70 (seventy) years old, calculated based on the birthday immediately preceding the Effective Date of the Insurance Policy.

"Schedule of Benefits" means the detailed list of insurance benefits under the insurance program(s) applicable to the Insured Person.

"Doctor" means a person who holds a medical qualification and is licensed or legally registered to practice medicine under the laws and regulations of the country in which they practice. A Doctor shall not be the Insured Person/Policyholder or the spouse, parent, child, or sibling of the Insured Person/Policyholder.

"Public Hospital" means a medical facility established and administered by a competent State authority in accordance with the laws of Vietnam.

"Medical Facility" means medical examinations and treatment facilities which is legally licensed and legally operating in compliance with the laws of Vietnam or the laws of the country/territory where the facility is located (if licensing is required by that country/local law), and not including any nursing home, convalescent center, retirement home, rehabilitation facility for drug and alcohol addicts or any similar institution, and must meet the following requirements:

- Be established to provide access to, care for, examination and treatment of people with illnesses, diseases, or injuries;
- Be fully equipped and qualified to perform medical surgeries;
- Have fully conditions for inpatient and patient monitoring

"Illness" means a pathological change in health that differs from a normal state of health, which must be diagnosed by a Doctor, prescribed treatment, and is the direct, independent cause of other factors which affecting the health and leading to medical treatment for the Insured Person.

"Congenital Condition" means any condition is formed in a fetus during the mother's pregnancy, influenced on fetal development, and may be detected prenatally, at birth, or after birth. Congenital Condition may be described by medical authorities by various names such as: congenital disease, congenital anomaly, birth defect and chromosomal abnormality. The determination of a Congenital Condition must be carried out by a Doctor.

"Pre-existing Illness" means any Insured Person's Illness or Injury that has been diagnosed or treated by a Doctor prior to the Effective Date or the most recent reinstatement date of the Insurance Policy.

"Genetic Diseases" means any disease that appears in individuals sharing a common bloodline, or the transmission of pathological conditions from parents to children through parental genes, and/or is passed down from one generation to another within individuals of the same bloodline. The determination of a Genetic diseases must be carried out by a Doctor.

"Special Diseases" includes all types of tumour, cyst and polyp, cancers, stones, hemorrhoids, anal fistula, prostate conditions, respiratory infection, varicose veins, disc herniation, gastritis, duodenitis, gastric ulcer, duodenal ulcer, sinusitis, diabetes, all types of hepatitis, endometriosis, cardiovascular diseases and blood pressure, stroke/cerebrovascular accident, transient ischemic attack, arthritis, carpal tunnel syndrome.

"Maternity Complication" consists of:

- Threatening miscarriage, threatening premature birth;
- Stillbirth in utero;
- Abortion/miscarriage/termination of pregnancy due to genetic diseases/congenital defects of the fetus or to protect the life of the insured mother as requested by the Doctor;
- Hydatidiform mole;
- Ectopic pregnancy;
- Difficult birth;
- Postpartum haemorrhage;
- Retained placenta after giving birth;
- Complications of the above conditions.

"Newborn care" includes routine check-up, vaccinations, appliances, vitamins (Within 30 (thirty) days of delivery or expired Policy Year)

"Room and Board Expenses" means the expenses of the room which the Insured Person stays at a Medical Facility for Medically Necessary treatment, it is not a room with two or more beds that paid by the Insured Person for using entirely. If the Insured Person pays for using entire room, the Room and Board Expenses will be determined by dividing the cost of that room by the number of beds in that room.

In Inpatient Treatment, Room and Board Expenses includes standard meals for patient provided and billed by Medical Facilities.

"Customary and Reasonable Expenses" means necessary expenses under coverage, but not exceed the normal expenses for the treatment of similar Illness/Injury or for similar services and supplies in the geographical area where the expenses are incurred.

"Emergency Expenses" means the expenses for the urgent treatment at the Medical Facility within 24 (twenty-four) hours following an Accident or the disease symptoms that can be life-threatening, health-threatening which required urgent treatment at the emergency room and the medical document has the emergency confirmed by the Medical Facility. If treatment at the emergency room is solely due to outside the Medical Facility's regular service hours, it will be considered as Outpatient treatment.

"Ambulance Service" means ambulance service to bring the Insured Person in an emergency due to Illness or Accident to Medical Facility or from one Medical Facility to an other Medical Facility.

"Outpatient Treatment" means the treatment of an Illness or Injury in a legal Medical Facility but not Inpatient Treatment.

"Inpatient Treatment" means medical treatment for which the Insured Person is admitted and stays past 0 (zero) o'clock at a Medical Facility due to medical necessity as prescribed by a Doctor, and shall meet the following conditions:

- Upon admission: admission procedures must be completed and medical records opened;
- Upon discharged: discharge procedures are completed and a discharge paper is provided, the medical record fully notes the treatment process, a receipt/invoice for hospital expenses, a breakdown of expenses for inpatient treatment with full legal signatures and seals of the Medical Facility in accordance with legal regulations;
- The Insured Person must remain physically present at the Medical Facility continuously during the treatment period.

"Dental Treatment" means any treatment for pathological conditions of the teeth and gums or jaw in the case of relating to teeth and performed by the specialist Doctor.

"Post-Hospitalization Treatment" means the follow-up treatment after discharge as requested by the treating Doctor, directly related to the Illness/Injury for which the Insured Person has just received the Inpatient Treatment, and is performed within 90 (ninety) days after discharge. Post-Hospitalization Treatment is not applicable to the Maternity benefit.

"Pre-Hospitalization Treatment" means the most recent treatment which is directly related to the Illness/ Injury of the Insured Person that requires hospitalization for Inpatient Treatment as requested by the Doctor, and is performed within 30 (thirty) days before admission. Pre-Hospitalization Treatment is not applicable to the Maternity benefit.

"Home Nursing" means medical care immediately following discharge from hospital after Inpatient Treatment, provided by a licensed nurse at the accommodation of the Insured Person, and must be certified by the treating Doctor to be Medically Necessary.

"Companion Bed" means a bed for the parent or legal guardian who stays overnight with an Insured Person under 18 (eighteen) years old who is hospitalized for Inpatient Treatment at a Public Hospital.

"Loss of Limb" means loss by physical severance of a hand at or above the wrist or of a foot at or above the ankle.

"Loss of Sight" means the entire and irrecoverable loss of sight.

"One Visit" means one time the Insured Person is examined by a Doctor for diagnosis and treatment, or one follow-up visit at the request of the treating Doctor at the same Medical Facility.

- In the case where multiple Doctors jointly consult on the same patient as per the Medical Facility's regulations, it is counted as one visit/treatment.
- If a patient visits the same specialty multiple times in a day, it is counted as one visit/treatment.
- If a patient visits multiple specialties even if referred by a Doctor at the same Medical Facility on the same day, it is still counted as one visit/treatment.

"Surgery" means to a medical method for treatment of Illness/Injury due to Medical Necessity, including surgical procedures/minor surgeries using appropriate anesthesia or sedation for treatment purposes and are conducted by a qualified and specialized Doctor. Surgeries for diagnostic purposes shall not be considered Surgery under this definition. Surgery under this definition includes:

- Inpatient Surgery: means Surgery performed at a Medical Facility where the Insured Person is hospitalized past 0 (zero) o'clock.
- Day Surgery: means Surgery performed at a Medical Facility that incurs Room and Board Expenses, but the Insured Person does not stay past 0 (zero) o'clock. Medical documents showing same-day treatment such as discharge certificate, medical reports, summary of hospitalization (display admission/discharge dates).
- Outpatient Surgery: means Surgery performed at a Medical Facility that does not qualify as either Inpatient or Day Surgery.

"Cosmetic Surgery" means surgery which is performed principally to improve or enhance the appearance of a person or which the person concerned considers or believes will improve or enhance their appearance and includes any surgery necessary for psychological reasons, adaptation and personal satisfaction in respect of a covered Illness/ Injury.

"Intensive Care Unit (ICU)" means a department or unit within a Medical Facility but not a recovery room or a emergency room that:

- Is established to provide intensive medical care and treatment;
- Is specifically designated for critically ill patients requiring continuous monitoring 24/7 under a Doctor's orders;
- Is equipped with all necessary emergency medical equipment, medications, and emergency facilities for timely intervention.

"Coronary Care Unit (CCU)" means a department or unit within a Medical Facility for the care of patients with heart attacks, unstable angina, cardiac dysrhythmias and other heart conditions requiring continuous monitoring and treatment.

"High Dependency Unit (HDU)" means a specialized post-operative a department or unit care room/area with appropriately qualified medical personel providing close 24/7 patient monitoring.

"Medically Necessary" means medical treatment which meets the following conditions:

- Follow the Doctor's diagnosis; and

- Comply with the medical instructions of modern medicine; and
- Not primarily for the convenience of the patient or the patient's family or the Doctor; and
- Not provided for experimental, diagnostic, research, preventive, or screening purposes; and
- Involve a number of hospitalization days and expenses that are reasonable and customary for the relevant Illness/Injury.

"Accident" means unforeseen sudden event or series of events occurring outside the control of the Insured Person, caused by an external and tangible force on the Insured Person's body within the Insurance Period. Accident is the direct, sole and not related to any other factors, causing in Injury, Permanent total disability or death of the Insured Person.

"Permanent Total Disablement" means disabilities listed in the Disability schedule or bodily injuries caused by an Accident that result the Insured Person to suffer a permanent partial loss of earning capacity due to the severance, loss or inability to use or partial paralysis of a body part that cannot be remedied with current medical conditions.

"Injury" means a bodily injury to the Insured Person caused solely and directly by an Accident.

"Pre-existing Condition" means any Illness, Injury, or condition of the Insured Person that:

- Was examed, diagnosed or treated within 36 (thirty-six) months before the Effective Date of the Insurance Policy; or
- Had signs or symptoms onsetting within 36 (thirty-six) months before the Effective Date of the Insurance Policy.

Medical records, medical history or sign, symptoms documented at Medical Facilities, self-declared information by the Insured Person, or a Doctor's conclusion shall be considered sufficient and legal evidence of a Pre-existing Condition.

"Prescription Drugs" means medications that are Medically Necessary and reasonable for the treatment of an Illness/Injury and are prescribed by a Doctor. The drugs must be listed in the registered list with the Drug regulatory authority, and not include functional foods, medicated cosmetics, cosmetics, minerals, preparations not listed in the Ministry of Health's therapeutic drug formulary, supplement, vitamin. However, the Company may consider reimbursement of supplement, vitamin up to 10% (ten percent) of the total cost of the prescription if the following conditions are met:

- The vitamins and supplements are prescribed by the treating Doctor.
- The prescription must include accompanying treatment medication.

"Hospital Cash" means a cash allowance if the Insured Person is hospitalized for inpatient treatment due to Illness. The Hospital Cash period is determined by the number of days hospitalized as prescribed by a Doctor. The payable amount will be based on the sum insured and the number of days eligible for the Hospital Cash as stipulated in the Insurance Policy/Certificate of Insurance.

"Physiotherapy" means a method of treatment using physical measures to help restore the functions or daily normal activities of the Insured Person at the request of the treating Doctor (other than various massage methods, spa or gait correction practice) and is performed in Medical Facilities.

"Medical Supplies" means supplies prescribed by a Doctor for medical use such as gloves, dressing, masks, nebulizer kits, syringes, cotton, plaster, etc. as well as other consumable used for mechanical devices.

"Co-payment" means the percentage of the Customary and Reasonable Expenses of each relevant benefit item must be paid by the Insured Person himself. The Company will consider paying the remaining Customary and Reasonable Expenses of each relevant benefit item based on the Insured Person's benefit details specified in the Benefits Schedule.

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ARTICLE 2

BENEFITS

2.1. Main benefits:

The Company shall pay the Customary and Reasonable Expenses in accordance with the Insurance program of the main benefit of the Insured Person set out in the Benefits Schedule. The Benefits Schedule is referred to Article 2.3.

In all cases, the total reimbursement for main benefit of the Insured Person in a Policy Year shall not exceed the maximum benefit of the insurance program of the main benefit of the Insured Person set out in the Benefits Schedule.

Item	Benfit
Room and Board Expenses in Inpatient Treatment	The Company shall pay the actual incurred expenses for room and board on a daily basis, up to a maximum of 60 (sixty) days per Policy Year. The maximum daily expenses shall be based on the sum insured stated in the Insurance Policy/Certificate of Insurance. If the Insured Person stays in a single room, the Company will reimburse only for the standard single room (*) which has lowest-cost provided by the Medical Facility for that room category. (*) A "standard single room" means a one-bed room with a private bathroom, without a kitchen, dining area, or living room. This definition excludes deluxe, VIP, or luxury rooms.
Daily Doctor's Visit and Specialist Consultation Expenses	Maximum 30 (thirty) visits per Policy Year. The payout amount shall be based on the sum insured stated in the Insurance Policy/Certificate of Insurance.
Intensive Care Unit (ICU), Coronary Care Unit (CCU), High Dependency Unit (HDU) Room Expenses	Maximum 30 (thirty) days per Policy Year. The payout amount shall be based on the sum insured stated in the Insurance Policy/Certificate of Insurance.
Pre-Hospitalization Treatment	Within 30 (thirty) days prior to hospitalization. The payout amount shall be based on the sum insured stated in the Insurance Policy/Certificate of Insurance.

2.1. Main benefits:

Item	Benefit
Post-Hospitalization Treatment	Within 90 (ninety) days after discharge from hospitalization. The payout amount shall be based on the sum insured stated in the Insurance Policy/Certificate of Insurance.
Home Nursing Care	Within 60 (sixty) days after discharge from hospitalization. The payout amount shall be based on the sum insured stated in the Insurance Policy/Certificate of Insurance.
Ambulance Services	Maximum 5 (five) times per Policy Year, reimbursed based on the sum insured. The payout amount shall be based on the sum insured stated in the Insurance Policy/Certificate of Insurance.
Emergency Expenses	Maximum 5 (five) times per Policy Year, reimbursed based on the Sum Insured. The payout amount shall be based on the sum insured stated in the Insurance Policy/Certificate of Insurance.
Miscellaneous Expenses in Inpatient Treatment	Expenses for diagnostic tests, diagnostic imaging as prescribed by a Doctor, prescribed medications, Doctor's expenses, blood, plasma, wheelchair rental within the Medical Facility, medical supplies, surgical instruments and equipment, medical devices placed/implanted inside the body, etc.
Inpatient Surgery Expenses	Includes expenses for surgeons, operating rooms, anesthesia, pre-operative evaluation, and standard post-operative care.
Day Surgery	Maximum 1 (one) time per Policy Year. The payout amount shall be based on the sum insured stated in the Insurance Policy/Certificate of Insurance.

2.1. Main benefits:

Item	Benefit
Cancer Treatment	Covers the expenses of radiotherapy, chemotherapy and targeted therapy (excluding surgical methods) prescribed by a Doctor, not including the medication prescribed for home use, maximum 5 (five) visits per Policy Year.
Organ Transplant	Covers the expenses of kidney, heart, lung, liver and bone marrow transplants for the recipient is Insured Person (up to 50% (fifty percent) for donor and the remaining percentages for recipient, at the option of the Insured Person). The Company does not pay for the expenses of acquiring an organ. This benefit is a lump sum maximum per organ per lifetime and the Company shall not pay any other benefits under the Insurance Policy related to the Insured Person's organ transplant.
Periodic Hemodialysis	Actual medical expenses for hemodialysis and peritoneal dialysis on a day-care basic as prescribed by a Doctor for treatment of chronic kidney failure due to Illness, maximum 30 (thirty) visits per Policy Year.
Companion Bed	The Company covers actual expenses incurred for the extra bed in the same room for a parent or legal guardian staying overnight with the Insured Person under 18 (eighteen) years old, maximum 30 (thirty) days per Policy Year. The maximum payable amount per day shall be based on the sum insured specified in the Insurance Policy/Certificate of Insurance. The total payout amount for Hospital Cash, Companion Bed, and Room and Board Expenses under Inpatient treatment shall not exceed the maximum limit of the Room and Board Expenses benefit under Inpatient Treatment.

2.1. Main benefits:

Item	Benefit
Hospital Cash:	In case the Insured Person is hospitalized, the Company shall pay a daily allowance, maximum 30 (thirty) days per Policy Year. The daily allowance amount shall be based on the sum insured specified in the Insurance Policy/Certificate of Insurance. The total payout amount for Hospital Cash, Companion Bed, and Room and Board Expenses under Inpatient treatment shall not exceed the maximum limit of the Room and Board Expenses benefit under Inpatient Treatment.
Financial Support for Cancer Diagnosis:	The Insured Person will be reimbursed for this benefit if diagnosed with end-stage cancer but excluding thyroid cancer. The payout amount will be based on the sum insured and the remaining months of the Policy Year. This benefit shall not be applied in the next renewal year if it has already been claimed.
24-Hour Emergency Assistance Services and Emergency Medical Evacuation Service:	Medical information and assistance services for the Insured Person.
Additional Travel Costs (Post-Evacuation)	Expenses for one economy-class air ticket to return the Insured Person to their country of residence.
Repatriation of Mortal Remains	Expenses for transporting the Insured Person's mortal remains to their home country or place of residence.
Accidental Dental Injury	Expenses for Emergency dental treatment within 7 (seven) days of the accident for loss or damage to natural healthy teeth.

2.2. Optional benefits:

Optional benefits may only be purchased at the time of submitting the Insurance Application Form for the Insured Person, or at the time of renewing the Insurance Policy. These benefits cannot be canceled during the Policy Year unless the insurance for the Insured Person or the entire Insurance Policy is canceled.

In all cases, the total payout amount for each type of optional insurance benefit for the Insured Person within a Policy Year shall not exceed the maximum benefit limit of the Insured Person's insurance program for that specific optional benefit as stated in the Schedule of Benefits.

There are 4 (four) separate categories of Optional benefits:

a) Outpatient benefit: includes the following covered benefit items:

Item	Benefit
Outpatient Treatment (Non-Surgery)	Doctor's expenses, diagnostic tests, imaging as prescribed by a Doctor, Prescription Drugs, Medical Supplies, and other related expenses.
Outpatient Treatment (With Surgery)	Surgical Doctor expenses, operating room expenses, anesthesia or analgesia expenses, laboratory testing, diagnostic imaging, medical supplies expenses, surgical instruments and equipment expense, prescription drugs as prescribed by the Doctor, and other related expenses.
Expense for Physiotherapy, Chiropractic in Outpatient Treatment	Maximum 30 (thirty) days per Policy Year, The payout amount shall be based on the sum insured stated in the Insurance Policy/Certificate of Insurance.
Free Health Check-up (maximum one time/Policy Year)	If no reimbursed claims occurred in the previous Policy Year, the Insured Person is entitled to a free annual health check-up at domestic Medical Facilities. The payout amount shall be based on the sum insured stated in the Insurance Policy/Certificate of Insurance.
Free Basic Screening Package (maximum one time/Policy Year)	The cost shall be paid if no reimbursed claims occurred in the previous Policy Year. The Insured Person is entitled to a basic health

a) Outpatient benefit:

Item	Benefit
Free Basic Screening Package (maximum one time/ Policy Year)	screening package including: Abdominal Ultrasound, Urinalysis, Complete Blood Count (CBC), Lipid Profile, Electrocardiogram (ECG), Liver Enzyme Test, Lung X-ray.
Vaccination (maximum one time/Policy Year)	Vaccination costs are reimbursed for the Insured Person. The payout amount shall be based on the sum insured stated in the Insurance Policy/Certificate of Insurance. The Company covers 60% (sixty percent) of the total cost.
Cancer Screening Package (maximum one time/Policy Year)	Cancer screening costs are reimbursed for the Insured Person. The payout amount shall be based on the sum insured stated in the Insurance Policy/Certificate of Insurance. The Company covers 60% (sixty percent) of the total cost.

b) Maternity benefit

Item	Benefit
Maternity Benefit	Expenses for prenatal examinations; normal delivery or cesarean section due to medical nescessity; and treatment for newborns related to Illness arising within 30 (thirty) days after birth, provided that the mother remains hospitalized (not including expenses for hygiene items, personal supplies, baby food, physiological jaundice, vaccinations, preventive check-ups and medications and screening tests, or treatment for Congenital Diseases, Genetic Disorders, and maternity complications treatment).

b) Maternity benefit

Item	Benefit
Newborn Care	Periodic health check-ups, vaccinations, medical devices, vitamins (Within 30 (thirty) days from the date of birth or during the expired Policy Year).
Mother Care	Postnatal follow-up visits (Within 30 (thirty) days from the date of childbirth or during the expired Policy Year, maximum 2 (two) visits per Policy Year).
Financial Support	Maximum 5 (five) days per delivery. The Company provides financial support during the period the Insured Person is hospitalized for childbirth at a Medical Facility.
Maternity Gift (per delivery)	Applicable when the Insured Person gives birth at a Public Hospital in Vietnam, excluding private-service departments. The gift is a cash amount specified in the Insurance Policy/Certificate of Insurance.

c) Dental benefit

Co-payment of 20:80 (The Company shall insure and pay 80% (eighty percent) of the reasonable and customary expenses. The Insured Person shall be responsible for 20% (twenty percent), applicable to the following cases:

- Examination, X-rays
- Treatment of gingivitis, periodontitis.
- Root-end resection, subgingival calculus removal (deep cleaning below the gumline).
- Tooth filling.
- Root canal treatment.
- Extraction of diseased tooth (including surgery).

The Company will cover the full cost of the benefit as specified in the Insurance Policy/Certificate of Insurance for the following case:

- Tooth cleaning (maximum 2 (two) times/Policy Year).

d) Personal Accident benefit

This benefit is only applicable to Insured Persons aged from 15 (fifteen) days old to 70 (seventy) years old.

If the Insured Person sustains an Accident occurring while the personal accident insurance of the Insured Person is in effect, and such Accident shall within 180 (one hundred and eighty) calendar days of the Accident be the sole and direct cause of:

- death; or
- total and irrecoverable loss of use of one eye or one limb; or
- total and irrecoverable loss of use of both eyes or more than two limbs; or
- total and irrecoverable loss of use of one eye and one limb; or
- Permanent Total Disablement.

then the Company shall pay Personal Accident benefits in accordance with the Benefits schedule for Personal Accident Insurance as specified below, in which the benefits are expressed as a percentage of the Insured Person's Personal Accident sum insured:

Death due to Accident	100%
Total and irrecoverable loss of use of one eye or one limb	50%
Total and irrecoverable loss of use of both eyes or more than two limbs	100%
Total and irrecoverable loss of use of one eye and one limb	100%
Permanent Total Disablement	100%
Burial and Funeral Expense	VND 5,000,000

In all cases, the total amount payable in respect of all losses caused by any and all Accidents occurring during a Policy Year shall not exceed 100% (one hundred percent) of the sum insured for personal accident in respect of the Insured Person in the Policy Year in which the Accident occurred.

2.3. Schedule of Benefit

2.3.1. Inpatient Benefit

The table below lists the benefits and sub-limits applicable to this benefit (Unit: VND).

The Company will apply a co-payment for Insured Persons aged 0 (zero) to 3 (three) years. The Insured Person will be responsible for 40% (forty percent) and the Company will cover 60% (sixty percent) of the treatment costs for both Inpatient Benefit and Outpatient Benefit.

PLAN	CARE FIRST			CARE CROSS			CARE ELITE	
	CF1	CF2	CF3	CC1	CC2	CC3	CE1	CE2
Maximum Benefit/Policy Year	100 million	250 million	500 million	1 billion	2 billion	5 billion	10 billion	20 billion
Coverage Area	Vietnam			Worldwide (*)				
1. Room and Board Expenses (Maximum 60 days/Policy Year)	600,000 /day	1,250,000 /day	2,500,000 /day	4,000,000 /day	6,000,000 /day	7,000,000 /day	8,000,000 /day	9,000,000 /day
2. Daily Doctor's Visit and Specialist Consultation Expenses (Maximum 30 visits/Policy Year)	500,000 /visit	1,000,000 /visit	1,500,000 /visit	3,000,000 /visit	4,000,000 /visit	5,000,000 /visit	6,000,000 /visit	7,000,000 /visit
3. Intensive Care Unit (ICU), Coronary Care Unit (CCU), and High Dependency Unit (HDU) Room Expenses (Maximum 30 days/Policy Year)	1,200,000 /day	2,500,000 /day	5,000,000 /day	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
4. Pre-Hospitalization Treatment (Within 30 days before admission)	3,000,000 /Policy Year	6,000,000 /Policy Year	10,000,000 /Policy Year	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
5. Post-Hospitalization Treatment (Within 90 days after discharge)	3,000,000 /Policy Year	6,000,000 /Policy Year	10,000,000 /Policy Year	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
6. Home Nursing Care (Within 60 days after discharge)	3,000,000 /Policy Year	6,000,000 /Policy Year	10,000,000 /Policy Year	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
7. Ambulance Services (Maximum 5 times/Policy Year)	5,000,000 /Policy Year	10,000,000 /Policy Year	15,000,000 /Policy Year	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full

2.3.1. Inpatient Benefit

PLAN	CARE FIRST			CARE CROSS			CARE ELITE	
	CF1	CF2	CF3	CC1	CC2	CC3	CE1	CE2
8. Miscellaneous Inpatient Expenses: Expenses for diagnostic tests, diagnostic imaging as prescribed by a Doctor, prescribed medications, Doctor's expenses, blood, plasma, wheelchair rental within the Medical Facility, medical supplies, surgical instruments and equipment, medical devices placed/implanted inside the body, etc.	6,000,000 /Policy Year	15,000,000 /Policy Year	30,000,000 /Policy Year	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
9. Inpatient Surgery Expenses: Expenses for surgeon, operating room, anaesthetist, pre-surgical assessment and normal post-surgical care	50,000,000 /Policy Year	125,000,000 /Policy Year	250,000,000 /Policy Year	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
10. Cancer Treatment: (Maximum 5 visits/Policy Year) Expenses for radiotherapy, chemotherapy and targeted therapy (excluding surgical methods) prescribed by a Doctor. This benefit does not cover medication prescribed for home use	50,000,000 /Policy Year	125,000,000 /Policy Year	250,000,000 /Policy Year	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
11. Organ Transplant: (1 organ/lifetime) Covers the cost of kidney, heart, lung, liver and bone marrow transplants for the recipient Insured Person (up to 50% for donor and the remaining percentages for recipient, at the option of the Insured Person) The Company does not pay for the cost of acquiring an organ This benefit is a lump sum maximum per organ per lifetime and no other policy benefits are payable by Company in respect of Insured Person's organ transplant	50,000,000 /Policy Year	125,000,000 /Policy Year	250,000,000 /Policy Year	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full

2.3.1. Inpatient Benefit

PLAN	CARE FIRST			CARE CROSS			CARE ELITE	
	CF1	CF2	CF3	CC1	CC2	CC3	CE1	CE2
12. Companion Bed: (Maximum 30 days/Policy Year) An extra bed in the same room for a parent or legal guardian accompanying an insured child under 18 years old	500,000 /day	800,000 /day	1,000,000 /day	1,500,000 /day	2,000,000 /day	2,500,000 /day	3,000,000 /day	3,500,000 /day
13. Periodic Hemodialysis (Maximum 30 times/Policy Year)	25,000,000 /Policy Year	50,000,000 /Policy Year	75,000,000 /Policy Year	150,000,000 /Policy Year	250,000,000 /Policy Year	350,000,000 /Policy Year	400,000,000 /Policy Year	500,000,000 /Policy Year
14. Day Surgery time (One time/Policy Year)	5,000,000 /Policy Year	10,000,000 /Policy Year	15,000,000 /Policy Year	30,000,000 /Policy Year	50,000,000 /Policy Year	70,000,000 /Policy Year	80,000,000 /Policy Year	100,000,000 /Policy Year
15. Emergency Expenses (Maximum 5 visits/Policy Year)	1,700,000 /visit	3,500,000 /visit	4,000,000/ visit	6,000,000 /visit	8,000,000 /visit	10,000,000 /visit	15,000,000 /Policy Year	20,000,000 /Policy Year
16. Hospital Cash: (Maximum 30 days/Policy Year) The total payout amount for Hospital Cash, Companion Bed, and Room and Board Expenses under Inpatient treatment shall not exceed the maximum limit of the Room and Board Expenses benefit under Inpatient Treatment	100,000 /day	300,000 /day	500,000 /day	1,000,000 /day	1,500,000 /day	1,700,000 /day	2,000,000 /day	2,300,000 /day
17. Financial Support for Cancer Diagnosis: The Insured Person will be reimbursed for this benefit if diagnosed with end-stage cancer but excluding thyroid cancer. The payout amount will be based on the Sum Insured and the remaining months of the Policy Year. This benefit is not renewable if already claimed	N/A	N/A	N/A	5,000,000 /month	7,000,000 /month	10,000,000 /month	15,000,000 /month	20,000,000 /month
18. 24-Hour Emergency Assistance Services and Emergency Medical Evacuation Service	Include	Include	Include	Include	Include	Include	Include	Include

2.3.1. Inpatient Benefit

PLAN	CARE FIRST			CARE CROSS			CARE ELITE	
	CF1	CF2	CF3	CC1	CC2	CC3	CE1	CE2
19. Additional Travel Costs: (Post-Evacuation) One economy-class air ticker to return the Insured Person to their country of residence	N/A	N/A	N/A	5,000,000 /Policy Year	5,000,000 /Policy Year	5,000,000 /Policy Year	5,000,000 /Policy Year	5,000,000 /Policy Year
20. Repatriation of Mortal Remains	N/A	N/A	N/A	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
21. Accidental Dental Injury: Emergency dental treatment within 7 days of the accident for loss or damage to natural healthy teeth	N/A	N/A	N/A	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full

(*) Worldwide coverage, excluding the United States, Canada, Hong Kong, Singapore, Japan, and Switzerland.

Note: *The total payout amount under the coverage area shall not exceed the Sum Insured (the maximum limit of Inpatient Treatment within the Policy Year)*

2.3.2. Outpatient Benefit

The table below lists the benefits and sub-limits applicable to this benefit (Unit: VND).

The Company will apply a co-payment for Insured Persons aged 0 (zero) to 3 (three) years. The Insured Person will be responsible for 40% (forty percent) and the Company will cover 60% (sixty percent) of the treatment costs for both Inpatient Benefit and Outpatient Benefit.

PLAN	CARE FIRST			CARE CROSS			CARE ELITE	
	CF1	CF2	CF3	CC1	CC2	CC3	CE1	CE2
Maximum Benefit/Policy Year	10 million	25 million	50 million	100 million	200 million	500 million	1,0 billion	2,0 billion
Coverage Area	Vietnam			Worldwide (*)				
22. Outpatient Treatment (non-surgery): Expenses for doctor, diagnostic tests, diagnostic imaging as prescribed by a Doctor, Prescription Drugs, medical supplies, and other related expenses	1,000,000 /visit	2,000,000 /visit	5,000,000 /visit	7,000,000 /visit	15,000,000 /visit	40,000,000 /visit	50,000,000 /visit	60,000,000 /visit
23. Outpatient Treatment (With surgery): Surgical Doctor expenses, operating room expenses, anesthesia/analgesia expenses, laboratory testing, diagnostic imaging, medical supplies expenses, surgical instruments and equipment expenses, prescription drugs, and other related expenses	2,000,000 /visit	5,000,000 /visit	7,500,000 /visit	10,000,000 /visit	20,000,000 /visit	50,000,000 /visit	60,000,000 /visit	70,000,000 /visit
24. Expense for Physiotherapy, Chiropractic in Outpatient Treatment: (Maximum 30 days/Policy Year)	100,000 /day	200,000 /day	300,000 /day	500,000 /day	1,000,000 /day	2,000,000 /day	5,000,000 /day	10,000,000 /day
25. Free Health Check-up (One time/Policy Year) The cost shall be paid if no claimable insurance event occurred in the preceding Policy Year	N/A	N/A	N/A	2,000,000	2,000,000	5,000,000	5,000,000	5,000,000
26. Free Basic Screening Package (One time/Policy Year) The cost shall be paid if	500,000	750,000	1,000,000	N/A	N/A	N/A	N/A	N/A

2.3.2. Outpatient Benefit

PLAN	CARE FIRST			CARE CROSS			CARE ELITE	
	CF1	CF2	CF3	CC1	CC2	CC3	CE1	CE2
no reimbursed claims occurred in the previous Policy Year. The Insured Person is entitled to a basic health screening package including: Abdominal Ultrasound, Urinalysis, Complete Blood Count (CBC), Lipid Profile, Electrocardiogram (ECG), Liver Enzyme Test, Lung X-ray								
27. Vaccination (One time/Policy Year) The Company pay 60%	500,000	750,000	1,000,000	1,500,000	2,000,000	3,000,000	4,000,000	5,000,000
28. Cancer screening package (One time/Policy Year) The Company pay 60%	500,000	750,000	1,000,000	1,500,000	2,000,000	3,000,000	3,000,000	3,000,000

(*) Worldwide coverage, excluding the United States, Canada, Hong Kong, Singapore, Japan, and Switzerland.

2.3.3. Maternity Benefit

The table below lists the benefits and sub-limits applicable to this benefit (Unit: VND).

PLAN	CARE FIRST			CARE CROSS			CARE ELITE	
	CF1	CF2	CF3	CC1	CC2	CC3	CE1	CE2
Maximum Benefit/Policy Year	10 million	15 million	20 million	30 million	50 million	60 million	80 million	100 million
Coverage Area	Vietnam			Worldwide (*)				
29. Maternity Benefit: Expenses for prenatal examinations; normal delivery or cesarean section due to medical necessity; treatment for newborns related to illness arising within thirty (30) days after birth, provided that the mother remains hospitalized	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
30. Newborn Care: (Within 30 days from the date of birth or within the expired Policy Year) Routine health check-ups, vaccinations, equipment, and vitamins	2,500,000	3,750,000	5,000,000	7,500,000	12,500,000	15,000,000	20,000,000	25,000,000
31. Mother Care: (Maximum 2 times/Policy Year) (Within 30 days after delivery or within an expired Policy Year) Postnatal follow-up visits	N/A	N/A	N/A	1,000,000 /visit	1,500,000 /visit	2,000,000 /visit	2,500,000 /visit	3,000,000 /visit
32. Financial Support: (Maximum 5 day/Delivery) The Company provides financial support during the period the Insured Person is hospitalized for childbirth at a Medical Facility	N/A	N/A	N/A	500,000 /day	750,000 /day	1,000,000 /day	1,500,000 /day	2,000,000 /day
33. Maternity Gift (Per delivery) Applicable when the Insured Person gives birth at a Public Hospital in Vietnam, excluding private-service departments	500,000	1,000,000	1,500,000	2,000,000	3,000,000	5,000,000	6,000,000	7,000,000

(*) Worldwide coverage, excluding the United States, Canada, Hong Kong, Singapore, Japan, and Switzerland.

2.3.4. Dental Benefit

The table below lists the benefits and sub-limits applicable to this benefit (Unit: VND).

Dental Benefit will apply co-payment. The Insured Person shall pay 20% (twenty percent) and the Company shall cover 80% (eighty percent) of the eligible treatment expenses.

PLAN	CARE FIRST		CARE CROSS			CARE ELITE	
	CF2	CF3	CC1	CC2	CC3	CE1	CE2
Maximum Benefit/Policy Year	3 million	5 million	7.5 million	10 million	20 million	30 million	40 million
Coverage Area	Vietnam			Worldwide (*)			
34. Dental Treatment: Examination, pathological dental X-rays, treatment of gingivitis, periodontitis, apicoectomy (deep subgingival tartar removal), pathological tooth filling, root canal treatment, extraction of pathological tooth (including surgery)	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
35. Tooth cleaning (Maximum 2 times/Policy Year) Company pay 100%	500,000 /visit	500,000 /visit	1,000,000 /visit	2,000,000 /visit	3,000,000 /visit	4,000,000 /visit	5,000,000 /visit

(*) Worldwide coverage, excluding the United States, Canada, Hong Kong, Singapore, Japan, and Switzerland.

2.3.5. Personal Accident Benefit

Sum Insured: From VND 20,000,000 to VND 10,000,000,000.

Children aged 0 (zero) to 18 (eighteen) are eligible to purchase this product only when enrolled together with their parent(s). The sum insured for the child's Personal Accident Benefit is limited to a maximum of 20% (twenty percent) of the Personal Accident Benefit sum insured of the parent(s). If the parents have different sum insured levels, the child's coverage will be based on the higher sum insured amount.

Insurance event	Benefit
Death due to Accident	100% Sum insured
Total and irrecoverable loss of use of one eye or one limb	50% Sum insured
Total and irrecoverable loss of use of both eyes or more than two limbs	100% Sum insured
Total and irrecoverable loss of use of one eye and one limb	100% Sum insured
Permanent Total Disablement	100% Sum insured
Burial and Funeral Expenses	VND 5,000,000

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ARTICLE 3

WAITING PERIOD

The Company has no liability to pay any benefit for insured events occurring within the below specified periods, including the case where the date of admission is within these periods but the date of discharge is beyond these periods (collectively called Waiting Period).

a) Accident: no waiting period applied;
b) For treatment of Special Diseases and their complications; Maternity Complication: 90 (ninety) days from the Effective Date of the Insurance Policy;
c) For treatment of other Illnesses: 30 (thirty) days from the Effective Date of the Insurance Policy;
d) For damages of ligament and meniscus: 90 (ninety) days from the Effective Date of the Insurance Policy. Treatment occurs after the above 90 (ninety)-day period will be covered by the Company on a 30:70 Copayment basis (the Insured Person pays 30% (thirty percent) of the Customary and Reasonable Expenses);
e) For Maternity benefit: 270 (two hundred and seventy) days from the Effective Date of the Insurance Policy;
f) For Dental benefit: 90 (ninety) days from the Effective Date of the Insurance Policy;
g) Pre-existing Illnesses (if accepted by the Company for coverage): A maximum waiting period of 1 (one) year applies.

The Company may consider waiving the Waiting Period for the Insured Person under specific circumstances, as stipulated in the Insurance Policy or Certificate of Insurance.

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ARTICLE 4

EXCLUSIONS

4.1. Exclusions applicable to Main and Optional Benefits

The Company has no liability to pay the main benefit and the additional medical benefit in the following circumstances and/or arising from the following causes:

a) Insured person conducts of suicide, self-inflicted Injury, regardless of any mental status or intentionally fails to take necessary actions to avoid risk occurrence;
b) Sexual transmitted diseases and their complications and sequelae; HIV testing and treatment of HIV related Illnesses including Acquired Immune Deficiency Syndrome ("AIDS"), AIDS Related Complex and/or any mutation, derivation, or variation thereof;
c) Pre-existing Illness, Pre-existing Injuries, Congenital Conditions unless expressly disclosed and accepted for coverage by the Company;
d) Conditions, diseases caused by or treatments related to addiction or abuse of drugs, tobacco, alcohol, or any other addictive or psychoactive substances;
e) Contraception, sterilization, miscarriage, abortion, and pre-/post-natal care (except for abortion covered under Maternity complications benefits), infertility treatment, subfertility treatment, and artificial insemination;
f) Cosmetic surgery, beauty-related treatments, beauty enhancements, and complications arising from such surgeries and treatments; skin-related treatments such as folliculitis (acne), melasma, freckles, skin tags, moles, hyper/hypo/dyspigmentation; and other elective surgeries;
g) Routine health check-ups, medical assessments, vaccinations, immunotherapy, and screening tests (unless specifically covered under the insurance plan);
h) Treatment of refractive eye conditions, vision examination, treatment for medical conditions related to contact lens use, treatment for strabismus by any method; hearing aids or hearing restoration;
i) Experimental medical technologies, procedures, therapies; unorthodox medical treatments; new treatment drugs, pharmaceuticals, stem cell therapies not yet approved by competent authorities;
j) Treatment, surgery for diseases or group of diseases: mental illness, psychological disorders, personality disorders, disorders related to sleep, depression, epilepsy, autism, attention deficit hyperactivity disorder (ADHD), mental and physical developmental disorders, communication disorders, behavioral disorders, dementia, Alzheimer's disease; Asthenia, neurasthenia, spinal degeneration, disc degeneration, joint degeneration;
k) Nursing care, convalescence, rehabilitation, physiotherapy (excluding physiotherapy covered under Outpatient treatment benefit, if applicable);

4.1. Exclusions applicable to Main and Optional Benefits

l) Non-Western medical treatments such as folk medicine, traditional medicine, acupuncture, steam healthcare centers, spas, naturopathic clinics, fitness centers, even if these facilities are registered as a Medical Facility;
m) Any treatment requested by the Insured Person that is not Medically Necessary as prescribed by a Doctor, treatment that does not meet the definitions in these Terms and Conditions; examinations, tests, diagnostic imaging without a conclusive diagnosis of Illness or Doctor's conclusion that no treatment is necessary;
n) Treatments related to weight loss, weight gain, weight management programs or bariatric surgery;
o) Treatments or preventive care aimed at relieving common symptoms related to aging, menopause, perimenopause, or precocious puberty; treatment of sexual dysfunction; or gender reassignment treatment including surgery, hormone therapy, psychotherapy, and similar services;
p) Costs of renting, purchasing, maintaining, repairing, or replacing devices, orthopedic aids, rehabilitation equipment, prosthetic devices (such as dentures, artificial limbs, intraocular lenses...); replacement material, artificial implants (such as artificial heart valves, artificial blood vessels, stents, artificial bone/cartilage/joint/tendon, patches, grafts, balloons, spinal discs, pacemakers...), surgical knives, external support devices (such as crutches, wheelchairs, hearing or vision aids, prescription glasses, cardiac support devices...), cosmetic orthopedic devices, and other similar medical support devices;
q) Costs for cosmetic products, dietary supplements, tonics, vitamins, minerals, or nutritional additives for dieting or special dietary purposes;
r) Injuries resulting from war (whether declared or undeclared), civil war, terrorism, riots, rebellion, or any war-like events; strikes or demonstrations;
s) The Insured Person participates in hazardous sports or recreational activities such as skydiving, aerial acrobatics, mountaineering, car/motorbike/bicycle racing, horse racing, hunting, boxing, scuba diving, bungee jumping, or similar high-risk sports or recreational activities;
t) The Insured Person is concluded by a Competent authority to have committed or participated in criminal acts or other legal violations, except for unintentional violations.

4.2. Exclusions applicable to Personal Accident Benefits

The Company has no liability to pay the Personal Accident Benefit for any loss of the Insured Person in the following circumstances and/or arising from the following causes:

a) Intentionally self-inflicted Injury, suicide or attempted suicide despite being in any status;
b) Use of alcohol, drugs, narcotics, stimulants, solvents or medicines unless using as prescribed by a treating Doctor;
c) All forms of poisoning, intoxication, or contamination;
d) Pregnancy, childbirth, abortion, or postnatal conditions;
e) Human Immunodeficiency Virus ("HIV") and/or any HIV-related illnesses including Acquired Immune Deficiency Syndrome ("AIDS"), AIDS-related complex, and/or any mutations, evolutions, or variations thereof;
f) Radioactive contamination, chemical contamination;
g) Injuries arising from or contributed by any physical or mental defect or infirmity of the Insured Person which is not previously declared or is excluded from insurance by the Company;
h) Training for or participation in professional sports, any racing (excluding walking, jogging, or swimming), dangerous sports or activities including hunting, horse riding, any form of motor vehicle trialing, roller-skating, skating, skiing, snowboarding, skateboarding, skydiving, parachuting, parasailing, paragliding, hang-gliding, flying or riding in any vehicle or device for aerial navigation (other than as a fare-paying passenger on a commercial aircraft of a duly licensed scheduled airline), boarding or traveling in a hot air balloon, caving, rock or mountain climbing (With or without the use of ropes or other equipment), bungee jumping, scuba diving or diving with the use of compressed air, boxing, martial arts, wrestling, rugby, polo;
i) Injuries sustained while serving as a member of a ship's crew or flight crew or as an airline personnel; or while serving in the military, police, or armed forces;
j) Injuries resulting from terrorism, declared or undeclared war, invasion, act of foreign enemy, hostilities, civil war, military uprising, insurrection, rebellion, revolution, military or usurped power, riot, civil commotion;
k) Participation in fights, involvement in any unlawful activities or legal violations, or resisting arrest by Competent authorities;
l) The Insured Person is concluded by a Competent authority to have committed or participated in criminal acts or other legal violations, except for unintentional violations.

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ARTICLE 5

OTHER TERMS AND CONDITIONS

5.1. Coverage Area

The Insured Person shall be covered within the Coverage Area as specified in the Insurance Policy/Certificate of Insurance.

5.2. Premium

5.2.1. The first premium in respect of the Insured Person is calculated based on the Plans of the Insured Person, the age of the Insured Person on the Effective Date of the Insurance Policy, the Insurance Period, the information of the Insured Person is declared on the Insurance Application Form, the applicable premium table and the discount applied (if any).

5.2.2. The renewal premium in respect of the Insured Person can be changed and is calculated based on the Plans of the Insured Person, the age of the Insured Person on the Renewal Date of the Insurance Policy, the claim history of the Insured Person, the applicable premium table, and the discount applied (if any).

5.2.3. "Short Period Rate" means the rate calculated in accordance with the formula below for the Insurance Period or the period of time in which the Insured Person has been insured less than 12 (twelve) months in the Policy Year.

The period of insurance or the period of time in which the Insured Person has been insured in the Policy Year	Short Period Rate
0 (zero) month or less than one (1) month	25% of annual premium
1 (one) month or less than 2 (two) months	40% of annual premium
2 (two) months or less than 3 (three) months	50% of annual premium
3 (three) months or less than 4 (four) months	65% of annual premium
4 (four) months or less than 5 (five) months	75% of annual premium
5 (five) months or less than 6 (six) months	80% of annual premium
6 (six) months or less than 7 (seven) months	85% of annual premium
7 (seven) months or less than 8 (eight) months	90% of annual premium
From 8 (eight) months or more	100% of annual premium

5.3. Rights and Obligations of the Policyholder and the Insured Person

5.3.1. Rights and Obligations of the Policyholder and the Insured Person:

a) Request the Company to explain the insurance terms and conditions; issue the Insurance Policy/Certificate of Insurance.

b) Request the Company to pay insurance claim to the Beneficiary or the Insured Person as agreed in the Insurance Policy upon occurrence of insured event.

c) In case the Company intentionally provides false information in order to enter into an Insurance Policy, the Policyholder has the right to unilaterally terminate the Insurance Policy; the Company must compensate the Policyholder for damages arising from the provision of false information.

d) Other rights as prescribed by law.

5.3.2. Obligations of the Policyholder and the Insured Person:

a) Pay the premium in full, according to the term and method as agreed in the Insurance Policy and in accordance with the law.

b) Declare fully and truthfully all details related to the Insurance Policy at the request of the Company Declare truthfully and fully the contents in the Insurance Application Form or any other form provided by the Company.

c) Immediately notify the Company when there is the change of contact address, email address telephone number of the Policyholder. The Company shall not be responsible for any failure of communication due to the change of contact address, email address, telephone number of the Policyholder but the Company has not been notified.

d) Notify circumstances that may increase risks or increase the Company's liability during the execution of the Insurance Policy. Immediately notify the Company when there is the change in occupation of the Insured Person. The Company reserves the right not to pay benefits for any expenses and/or loss arising from or related to the change in occupation of the Insured Person without the Company's written consent.

e) Notify the Company of the occurrence of insurance event as agreed in the Insurance Policy, provide complete and honest claim documents.

g) Other obligations as prescribed by law.

5.4. Rights and Obligations of the Company

5.4.1. Rights of the Company

a) Collect the premium as agreed in the Insurance Policy

b) Request the Policyholder to provide complete and truthful information relating to the conclusion and execution of the Insurance Policy;

c) Cancellation or unilateral termination of the Insurance Policy;

d) Refuse to pay benefits to the Beneficiary or the Insured Person in the event of not falling within the scope of insurance or in case of exclusion of insurance as specified in this Terms and Conditions;

e) Other rights as prescribed by law.

5.4.2. Obligations of the Company

a) Clearly and fully explain to the Policyholder the insurance benefits, insurance terms and conditions; the rights and obligations of the Policyholder and the Insured Person;

b) Issue the Insurance Policy/Certificate of Insurance to the Policyholder;

c) Pay insurance claim to the Beneficiary or the Insured Person when the insured event occurs as agreed in the Insurance Policy;

d) Explain the reason for denial of claim payment in writing;

e) To retain and archive the Insurance Policy records in accordance with applicable laws;

f) To maintain the confidentiality of information provided by the Policyholder and the Insured Person, except where disclosure is required by competent state authorities or with the consent of the Policyholder and/or the Insured Person;

g) Other obligations as prescribed by law.

5.5. Claims

5.5.1. Claim must be submitted to the Company within 1 (one) year of the insured event. The time when a force majeure event or other objective obstacle occurs is not counted in this period. The Policyholder or the Insured Person, at his own expense, must submit the following documents to the Company:

- Claim form according to the Company's form with complete information;
- Treatment-related documents: prescription, test results, imaging results, surgery report (in case of surgery), discharge paper, medical examination booklet or medical record with diagnoi s and treatment applied. The Company reserves the right to request for the originals for inspection;
- Legitimate documents related to the payment of expenses: original receipts, original or electronic copy of valid financial invoices, and detailed list of expenses. These original documents (if available) will be kept by the Company as the basis for claim payment;

- Statement of the Insured Person about the Accident, driving license, police report (in case of traffic Accident), confirmation of the company/organization employing the Insured Person (in case of Accident at work);
- Copy of passport or document/data recording immigration information in case of claim for medical expenses or Accident arising/occurring outside the territory of Vietnam. The Company has the right to request the original for verification;
- Death certificate/death extract, relevant records and medical reports in case of death due to Accident;
- Relevant reports and medical records in the case of Permanent Total Disablement, the disablement assessment result of the board of medical examiners accepted by the Company.

Any claim submitted after the above-mentioned period will not be accepted by the Company

5.5.2 If required documents are in a language other than Vietnamese or English, the Insured Person and the Policyholder must bear the cost of translating and authenticating such documents before submitting them to the Company together with the originals.

5.5.3. The Company will process the claim within 15 (fifteen) working days from the date of receipt of all required documents. In case of further investigation, the Company reserves the right to prolong the time but not exceed 90 (ninety) days from the date the Company receives all required documents.

5.6. Payment of Benefits

5.6.1. All benefits will be paid to:

- The Insured Person or the authorized person of the Insured Person; or
- Parent or the legal guardian of the Insured Person if the Insured Person is under 18 (eighteen) years old.

5.6.2. In case of death of the Insured Person, the benefit will be paid to the Beneficiary.

5.6.3. The Company has no liability to pay any benefit in any event where the date of admission is before the Effective Date of the Insurance Policy of the Insured Person but the date of discharge is after or on the Effective Date of the Insurance Policy of the Insured Person.

5.7. Change of Benefit of the Insured Person

Benefits of the Insured Person can only be changed upon renewal of Insurance Policy. The Policyholder must send the request for change of benefit of the Insured Person to the Company atleast 7 (seven) days prior to the Renewal Date of the Insurance Policy. The Company shall assess the risk and has the right to accept or reject this request. If the Company accepts, the change will take effect from the Renewal Date of the Insurance Policy, provided that the Policyholder fully pays the new Renewal Premium as requested within the Premium Payment Period.

5.8. Supplement Insured Person to the Policy

5.8.1. The Policyholder may submit Insurance Application Form to request for supplementing Insured Person under the Insurance Policy at any time while the Insurance Policy is in effect or during the Premium Payment Period. The Company will underwrite the Insurance Application Form and has the right to accept or reject this request. The requested person will become the Insured Person of the Insurance Policy only upon written confirmation of the Company.

5.8.2. The premium in respect of the requested person will be calculated in accordance with the Short Period Rate.

5.9. Renewal of Policy

The Insurance Policy will be automatically renewed annually on the day following the end of the Insurance Period if the Insured Person satisfies the age requirement for renewal as prescribed and the Policyholder fully pays the required renewal premium within the Premium Payment Period, except in the following cases:

- The Company refuses to renew or agrees to renew with conditions and notifies the Policyholder in writing at least 30 (thirty) days prior to the end of the Insurance Period;
- The Policyholder declines the conditional renewal as notified by the Company and submits a written request not to renew the Insurance Policy before the renewal date.

Upon renewal, the Policyholder shall pay the premium at the rate applied by the Company at the time of renewal.

5.10. Cancellation of Insurance Policy

5.10.1. The Policyholder may request to cancel the insurance of an Insured Person or cancel the Insurance Policy with written notice to the Company.

5.10.2. The Company has the right to cancel the insurance of an Insured Person at any time with written notice to the Policyholder in any of the following cases or events:

a) False declaration of the date of birth of that Insured Person;

b) Misstatement or misrepresentation, whether by mistake or intentionally, of the Pre-existing Condition, the physical or mental condition of that Insured Person;

c) Concealing or failing to disclose any material information or facts regarding the Pre-existing Condition, the physical or mental condition of that Insured Person;

d) Misstatement of the occupation or failing to notify the change of occupation of that Insured Person to the Company;

e) That Insured Person changes occupation where the occupation after the change has higher level of risk than the occupation before the change and the Company does not accept to continue insurance, or the additional premium requested by the Company to continue to insure that Insured Person after the change of occupation is not fully paid by the Policyholder within the required period;

f) Being dishonest in claim request;

g) That Insured Person's time in Vietnam is less than 183 (one hundred and eighty-three) days in a Policy Year.

5.10.3. When the insurance of an Insured Person is cancelled, all benefits of such Insured Person under the Insurance Policy shall terminate on the effective date of such cancellation of insurance. The Company will refund the Policyholder the premium paid for that Insured Person for the Policy Year, less the Short Period Rate for the period of time the Company insured that Insured Person in the Policy Year before the cancellation of insurance. However, no such refund shall be paid if any claim of such Insured Person during the Policy Year has been paid or is payable.

5.10.4. When the Policy is canceled, all benefits of all Insured Perons under the Policy shall be canceled on the effective date of cancellation of the Insurance Policy. The Company shall apply Article 5.10.3 above to calculate the refund amount to the Policyholder for each Insured Person in the Insurance Policy.

5.11. Termination of Insurance Policy

The Insurance Policy will be terminated automatically from the time of expiration of the Premium Payment Period of the Insurance Policy in case the Policyholder fails to fully pay the premium or fails to pay the premium by the time agreed upon in the Insurance Policy, unless otherwise agreed by the parties.

5.12. Dispute resolution

Disputes arising from the Insurance Policy, if not resolved through negotiation, will be resolved at a competent Court of Vietnam and in accordance with Vietnamese law. The time limit for filing a lawsuit is 3 (three) years from the time the dispute arises.

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