SUMMARY OF BENEFITS, CONDITIONS AND TERMS COMPREHENSIVE HEALTH CARE INSURANCE PRODUCT

The Flexi Health Insurance Rules (Insurance Rules) set out the terms and conditions of health care insurance and serve as the legal basis for settling insurance claims by Techcom General Insurance Joint Stock Company. In the event of any discrepancy between the Insurance Contract / Insurance Rules / Certificate of Insurance, the order of priority shall be applied in accordance with the following principle: Amendments and supplements executed at the most recent date — Insurance Contract / Certificate of Insurance and appendices attached to the contract — Insurance Rules.

1. Regulations on the Insured Person

- Vietnamese citizens and foreigners legally residing in Vietnam who have full civil legal capacity;
- The parties understand and agree that the eligibility conditions are the primary conditions for the Insured Person to be covered under this Insurance Contract, and that all conditions, exclusions, extensions and/or amendments and supplements, if any, must be complied with;
- Age from 1 to 60 years old, with continuous renewal up to age 65.
- Children from 01 to 06 years old are subject to co-insurance at an 80/20 ratio.
- Not currently undergoing inpatient treatment for any illness or injury (except in the case of a renewed Insured Person).
- Does not have a permanent disability exceeding 50%.
- Has not been and has never been diagnosed with a mental disorder, leprosy, or cancer.
- Has not lost or had their civil legal capacity restricted.
- Does not suffer from any of the following serious medical conditions:
  - ✓ Neurological conditions: Inflammation of the central nervous system (brain) and spinal cord; Parkinson's disease; Other degenerative neurological conditions; Amnesia, coma, cerebral palsy, paralysis.
  - ✓ Respiratory conditions: Pulmonary insufficiency, pneumothorax, chronic respiratory failure; Chronic obstructive pulmonary disease.
  - ✓ Cardiovascular conditions: Cerebrovascular disease / stroke (cerebral hemorrhage, arterial sclerosis); Myocardial infarction.
  - ✓ Sexually transmitted diseases: Syphilis, gonorrhea, HIV/AIDS.
  - ✓ Other serious medical conditions: Liver cirrhosis; Renal failure, renal atrophy, bilateral kidney stones; Hemodialysis; Leukemia; Bone marrow transplant; Systemic lupus erythematosus; Collagen vascular disease (Collagenosis); Tuberculosis; Bone marrow failure.
- In the case of renewal, the insurance company does not agree to insure or accept liability for a permanent disability of 50% or more on the part of the insured.

- In the event that the insured fails to comply with the stated eligibility criteria and conditions, the insurance company reserves the right to terminate the insurance contract and shall bear no liability for the registered insurance benefits.

2. Waiting Period

Insurance benefits will begin to be paid after the following waiting periods from the policy effective date:

- 30 days for treatment of common illnesses and the following respiratory conditions: Pneumonia, Bronchitis, Bronchiolitis, Otitis Media;
- 60 days for maternity complications;
- 90 days for treatment of special diseases (as listed in Appendix 1 – Special Diseases, Insurance Rules) and chronic diseases;
- 365 days for treatment of pre-existing conditions and maternity.

*Pre-existing condition: Any illness or injury of the Insured Person that was diagnosed or treated by a physician prior to the effective date or the (most recent) reinstatement date of the insurance policy; or that showed specific signs/symptoms arising within 36 months prior to the effective date or the (most recent) reinstatement date of the insurance policy, of which the Insured Person was aware or conscious, regardless of whether the Insured Person actually sought examination or treatment.

3. Insurance Benefits

3.1. Main Insurance Benefits

- Death and permanent total disability due to illness and accident;
- Inpatient treatment due to illness and accident, including:

  + Intensive care expenses: Expenses related to patient care in special care units such as ICU (Intensive Care Unit), HDU (High Dependency Unit), and CCU (Coronary Care Unit) during hospitalization;

  + General hospitalization expenses: If the Insured Person is hospitalized, the insurance company will reimburse the Insured Person for medical expenses ordered by a physician or provided by a licensed medical facility, such as:

  a) Medications and pharmaceuticals used during hospitalization;
  b) Standard bandages, splints, and casts;
  c) Laboratory tests;
  d) Electrocardiogram
  e) X-ray therapy, radiotherapy; radium and isotopes;
  f) X-rays;
  g) Intravenous infusions;
  h) Inpatient treatment bed: covers the standard room rate at the medical facility — based on the posted price list and confirmation from the medical facility. Does not cover room reservation fees, VIP rooms, or beds for accompanying family members;
  i) Other reasonable and necessary treatment expenses as prescribed by a physician.

Note: In cases where the insured person does not have Special Care benefits, but during the course of treatment incurs expenses for an ICU (Intensive Care Unit), HDU (High Dependency Unit), or CCU (Coronary Care Unit), such expenses will be reimbursed under the General Inpatient benefit.

+ Pre-hospitalization expenses:

The insurance company will pay a one-time benefit for consultations, diagnoses, and tests that are necessary and directly related to the illness or injury of the insured person, which must be performed immediately prior to inpatient treatment, and where such diagnoses directly form the basis for the physician's conclusion that inpatient treatment is necessary.

There is no time limit on consultations and diagnoses that must be performed before the insured person is admitted for inpatient treatment. Determination of pre-admission consultation expenses will be based on the customer's actual medical records; a conclusion/referral for inpatient treatment is required in order for consultation expenses to be reimbursed under the Pre-hospitalization Expense limit.

+ Post-discharge treatment expenses:

The insurance company will cover the discharge prescription and one follow-up treatment immediately after discharge, as prescribed by a physician for the illness or injury for which the insured person received inpatient treatment, including: follow-up consultation fees, laboratory tests, and medication costs, provided they are performed or used within 90 days from the date of discharge.

+ Surgical expenses

Medical expenses related to an inpatient surgical procedure or day surgery as defined, including costs for surgical procedures, the operating room, the surgeon, anesthesia, and routine pre-operative diagnostic and post-operative recovery expenses. Surgery is divided into 2 types:

a) Inpatient surgery: a procedure after which the patient must remain in the hospital for at least 24 hours, reimbursed under the Surgery/year benefit.

b) Day surgery: a procedure after which the patient stays in the hospital for less than 24 hours, reimbursed under the Surgery/day benefit. The maximum total amount payable equals the Surgery/year benefit.

+ Organ transplant expenses:

The insurance company will cover the surgical costs for a heart, lung, liver, pancreas, kidney, or bone marrow transplant performed on the insured person at a hospital.

The organ transplant benefit limit stated above is calculated on a lifetime basis. For example: if in the first year of insurance coverage the customer has already received reimbursement for this benefit and exhausted the limit, this benefit will not be payable in subsequent renewal years.

Costs incurred to obtain the transplant organ and all expenses arising for the organ donor are not covered by insurance.

+ Emergency treatment expenses:

In the event that the insured person is in a critical condition requiring urgent treatment to prevent death or serious long-term or immediate harm to their health, the insurance company will cover

the costs of services rendered at a clinic or emergency room of a hospital or legitimate medical facility immediately following an accident or the onset of an acute illness.

+ Emergency dental treatment due to accident

If the insured person suffers an accident resulting in injury to sound, natural teeth requiring emergency dental treatment at a hospital within twenty-four (24) hours of the accident, the insurance company will reimburse the reasonable and necessary costs of such treatment, up to the sub-limit specified in the Schedule of Benefits.

Natural healthy teeth means teeth that are not dentures, are not decayed, have no more than 2 surfaces filled, are not weakened or loose due to gum disease, and have no missing roots or ongoing root canal treatment.

Treatment of dental accidents does not include dental implants or replacement of dentures.

+ Emergency obstetric treatment due to accident

If the Insured Person suffers an accident that leads to complications related to pregnancy (including miscarriage) and requires emergency treatment, the Insurance Company will reimburse the actual, reasonable, and necessary costs incurred for such treatment, up to the sub-limit specified in the Schedule of Benefits. However, this benefit excludes all costs related to childbirth.

+ Funeral expenses

In the event of the death of the Insured Person, if requested by the Insured Person's family, the Insurance Company will arrange burial at the place of death upon request. Funeral expenses shall cover only the costs of the ceremony and other related services, up to the amount stated in the Insurance Certificate and/or Insurance Policy.

In the event that the Insured Person's family arranges the funeral services independently, the family may submit a claim for reimbursement of the above-mentioned expenses. The claim submission must include: service cost invoices; service contracts, etc.

+ Hospital cash benefit

The Insurance Company will pay the amount stated in the Schedule of Benefits for each overnight inpatient hospital stay, up to the maximum number of nights specified in the Insurance Certificate.

3.2. Optional benefits

- Outpatient treatment for illness, disease, and accident covers the Insured Person for outpatient treatment costs arising from illness, disease, or accident, including:

  + Consultation fees.

  + Doctor-prescribed medication costs.

  + Costs of tests, diagnosis, and treatment ordered by a doctor.

  + Medical devices necessary for the treatment of fractures or injuries (such as bandages and splints) as prescribed by a doctor.

  + Physiotherapy costs: costs of treatment using radiation therapy, heat therapy, or light therapy as prescribed by a doctor (other forms of physiotherapy are not covered).

- Dental care (applicable only if the Outpatient treatment benefit is selected): covers the Insured Person for medical costs related to dental care and treatment in the following cases:
  + Dental examination and treatment costs;
  + Examination and diagnosis;
  + Dental scaling and cleaning;
  + Dental fillings using standard materials (including but not limited to: amalgam; composite; fuji; GIC). In cases where the Insured Person undergoes dental fillings using premium materials such as: gold, titanium, porcelain, etc., the Insured Person will be reimbursed for the filling cost at the rate applicable to standard treatment materials at the medical facility (based on the medical facility's fee schedule);
  + Extraction of decayed teeth;
  + Extraction of impacted teeth, teeth covered by gum tissue, or teeth that are unable to erupt;
  + Extraction of tooth roots;
  + Removal of deep calculus (subgingival scaling);
  + Apicoectomy (surgical removal of the root tip);
  + Root canal treatment;
  + Gingivitis, periodontitis.
- Maternity treatment: the following maternity treatment costs will be covered for the Insured Person:
  + Maternity complications and difficult labor: Covers medical costs arising from complications during pregnancy or from obstetric procedures required during delivery.
  + Pregnancy and normal delivery: Covers medical costs arising from a normal delivery, including: prenatal check-ups, delivery assistance, general hospitalization fees, specialist physician fees, pre- and post-natal care for the mother at the hospital, and cosmetic suturing of the incision.
  + Newborn care: Covers medical costs arising from the care of a newborn under 3 months of age in the event that pathological symptoms covered under the insurance policy appear, subject to the benefit limit specified in the Insurance Benefits Schedule.

4. Policy term and premium payment period

- Policy term: 1 year
- Premium payment period: Prior to the insurance effective date

5. Policy termination and premium refund

❖ If either party wishes to cancel the insurance policy, written notice must be provided to the other party at least 30 days before the intended cancellation date.

- For group insurance policies: if the Insured Person is no longer participating in this insurance through the Company/organization named on the policy and the authorized representative requests termination of coverage for that Insured Person, the insurance company will refund the premium on a pro-rata basis corresponding to the remaining days of the policy relative to the total policy period, provided that the Insured Person has not submitted any claims during the policy's effective period.

- For individual and family insurance policies: upon the Insured Person's request, the insurance company will agree to cancel the policy provided that the Insured Person has not submitted any claims during the insurance period, and 80% of the premium for the remaining period will be refunded.
- If the insurance company requests cancellation of the policy, the insurance company will refund the full premium for the remaining period regardless of whether any claims have been submitted.

❖ Contract cancellation within the 7-day consideration period, subject to the following conditions:

- Applicable only to individual/family insurance policies; not applicable to corporate or group insurance policies.
- Applicable only in cases where the customer has a replacement insurance policy with higher benefits than the cancelled insurance policy.

  Note: To ensure eligibility for promotions/gifts from Techcombank/TCGIns, the related insurance policies will not be permitted to be cancelled or unilaterally terminated during the agreed period of validity.

6. The policyholder's obligation to declare information truthfully

- An insurance policy is void in cases where the policyholder or the insurance company engages in fraudulent conduct when entering into the insurance contract.
- If the insured person or their representative makes any claim involving fraud or dishonesty, or if there is any act of deception or scheme to exploit insurance benefits in any way in order to obtain insurance proceeds, the insurance policy shall be governed in accordance with applicable law.

7. Key points to note about the Insurance Program

7.1. Definition of Accident — item 9, section 1 — Definitions in the Flexi Health Insurance Term and Condition:

Any sudden, unforeseen event caused by an external, violent, and visible force during the period in which the Insurance Policy is in effect, which is the direct cause of bodily injury to the Insured Person and occurs against the Insured Person's subjective will.

The risks of Drowning, Inhalation of gas/toxic fumes, and Smoke inhalation are not covered under the policy.

7.2. Definition of Chronic Disease — item 13, section 1 — Definitions in the Flexi Health Insurance Term and Condition:

- A medical condition that, in the opinion of a general practitioner/specialist/consulting physician, is characterized by one of the following:

  + Lasting more than 3 months

  + Likely to leave lasting after-effects

  + Requiring long-term treatment and care.
- Basis for determining a chronic condition: based on the conclusion/diagnosis of a physician or medical history information reflected in the Insured Person's medical records.

7.3. Definition of Pre-existing Condition — item 32, section 1 — Definitions in the Flexi Health Insurance Term and Condition:

Any health condition of the Insured Person that has been diagnosed; or for which symptoms have appeared that would cause a reasonable person to seek medical examination or treatment; or for which a medical professional has concluded that the Insured Person requires treatment, regardless of whether the Insured Person has actually received treatment.

7.4. Expansion of exclusion item 1, section 3 — General Exclusions in the Flexi Health Insurance Term and Condition:

The pre-existing condition exclusion does not apply; instead, the Company applies the waiting periods stated in Section 2 above when paying insurance benefits.

7.5. Extension provision under Point 3, Section II, Part 5 – Claims Settlement Procedure in the Flexi Health Insurance Term and Condition:

The requirement to notify the Insurance Company prior to hospitalization does not apply.

8. List of Special Diseases

Special diseases under the policy rules may be understood to include the following conditions:

a) Neurological diseases: Inflammatory diseases of the central nervous system (brain), systemic atrophies affecting the central nervous system (Huntington's disease, hereditary ataxia, spinal muscular atrophy and related syndromes), extrapyramidal and movement disorders (Parkinson's disease, dystonia, other movement and extrapyramidal disorders), Alzheimer's disease, Apallic syndrome/dementia, epilepsy, coma, cerebral palsy and other paralytic syndromes.

b) Respiratory diseases: Pulmonary insufficiency, pneumothorax, tonsillitis requiring surgical removal, adenoid hypertrophy requiring curettage, sinusitis, deviated nasal septum, asthma; otitis media requiring surgery, nasopharyngeal polyps, turbinate resection.

c) Circulatory diseases: Heart disease, hypertension, idiopathic arterial hypertension, cerebrovascular diseases/stroke and their consequences/sequelae, phlebitis and thrombophlebitis/venous occlusion, varicose veins of the lower limbs, carpal tunnel syndrome, lymph nodes/lymphatic vessels, hemorrhoids.

d) Digestive diseases: Hepatitis A, B, C, liver cirrhosis, liver failure, gallstones, gallbladder disease, gastric and duodenal ulcers.

e) Urinary diseases: Diseases of the glomeruli, renal tubules, kidney and ureteral stones, lower urinary tract stones, renal failure.

f) Endocrine diseases: Thyroid disorders, diabetes mellitus and endocrine disorders of the pancreas, adrenal gland disorders, coma, disorders of other endocrine glands.

g) Tumor diseases: Tumors/growths of all types.

h) Blood diseases: Aplastic anemia, coagulation disorders, neutrophil dysfunction disorders, diseases related to lymphoreticular tissue and the reticulohistiocytic system, bone marrow transplantation.

i) Diseases of the skin and connective tissue: Lupus erythematosus, systemic scleroderma, multiple sclerosis, progressive systemic sclerosis/amyotrophic lateral sclerosis, muscular dystrophy and

complications of these diseases, Pemphigus, psoriasis, chronic allergic urticaria (treated with foreign antigens).

j) Musculoskeletal diseases: Arthritis/polyarthritis, degenerative disease of the spine and vertebral bodies, intervertebral disc herniation, disorders of bone density and structure, gout.

k) Growth hormone deficiency

l) Other diseases: Stones, polyps, cysts, warts, moles of all types, vestibular disorders.

9. Main Exclusions

a) Dental treatment, except for emergency treatment following an accident involving natural teeth. Dentures of all types. This exclusion shall not apply if the Insured Person has enrolled in the "Dental Care" supplementary benefit.

b) All forms of cosmetic treatment, weight management treatment, cosmetic surgery or reconstructive surgery and related consequences, unless such surgery is intended to restore an organ injured in an accident occurring during the insurance period stated in the Insurance Policy;

c) Treatments related to sleep-disordered breathing (including snoring), physical exhaustion, and stress;

d) Tests or treatments related to family planning, abortion for psychological or social reasons, contraception, sexual dysfunction, infertility treatment, sterilization, artificial insemination, treatment for impotence, or gender reassignment, as well as any consequences or complications arising from such treatments.

e) Congenital disabilities, birth defects, genetic diseases or malformations, and hereditary health conditions with signs present from birth.

f) Treatments related to ligament reconstruction and meniscus tears are excluded in the first year of insurance and will be covered from the second year onward, subject to a 30/70 co-payment condition. The insured person bears 30% of the costs as defined under the co-payment provision.

g) Costs related to maternity care, except for maternity complications resulting from an accident. This exclusion shall not apply if the insured person has enrolled in the Maternity Care benefit.

h) Treatment or examination of diseases related to acquired immune deficiency syndrome, AIDS-related complex syndromes, venereal diseases, sexually transmitted diseases, and other related conditions.

i) Treatment of mental illness and psychiatric disorders. However, MSIG will cover medical expenses for the initial consultation if the insured person has enrolled in the Outpatient Treatment benefit, and for acute inpatient treatment cases.

j) Treatment of epidemics declared by competent authorities, tuberculosis, malaria, and leprosy.

k) Treatment or use of medication not prescribed by a physician, treatments not recognized by medical science, and experimental treatments.

l) Treatment outside the territorial scope of the insurance program selected and declared in the insurance policy.

m) And other exclusions as set out in Part 3 – General Exclusions of the Insurance Rules.

No.	INSURANCE PACKAGES	AN TÂM	AN KHANG	AN THỊNH	AN PHÚC	AN VƯỢNG
	MAIN INSURANCE BENEFITS					
1	**Death or permanent total disability due to accident or illness**	**60,000,000**	**100,000,000**	**200,000,000**	**300,000,000**	**500,000,000**
2	**Inpatient treatment due to illness and accident**	**60,000,000**	**100,000,000**	**200,000,000**	**300,000,000**	**500,000,000**
2.1	Special care expenses (treatment costs in ICU, HDU, HDU, CCU special care units)	Not applicable	3.750.000	15.000.000	15.000.000	25.000.000
2.2	Inpatient cost per day (maximum 100 days/year) (medically necessary expenses prescribed by a physician – including room and board charges)	3.000.000	5.000.000	10.000.000	13.500.000	17.500.000
2.3	Pre-hospitalization treatment costs (per year)	2.200.000	2.500.000	4.000.000	5.500.000	7.500.000
2.4	Post-hospitalization treatment costs (per year)	2.200.000	2.500.000	4.000.000	5.500.000	7.500.000
2.3	Surgical costs / year (Including day surgery cost limit)	60,000,000	100,000,000	200,000,000	300,000,000	500,000,000
2.4	Day surgery costs	5.500.000	6.875.000	12.000.000	17.000.000	25.000.000
2.5	Organ transplant surgery (lifetime limit)	Not applicable	12.500.000	55.000.000	85.000.000	125.000.000
2.6	Emergency treatment (urgent care)	8.200.000	11.000.000	16.800.000	22.000.000	30.000.000
2.7	Emergency dental treatment due to accident	8.200.000	11.000.000	16.800.000	22.000.000	30.000.000
2.8	Emergency maternity treatment due to accident	8.200.000	11.000.000	16.800.000	22.000.000	30.000.000
2.9	Funeral expenses	2.500.000	3.125.000	4.500.000	5.500.000	7.500.000
2.10	Daily hospital cash benefit – maximum 100 nights/year	93.000	135.000	180.000	210.000	250.000
2.11	Hospital guarantee of payment – Inpatient	√	√	√	√	√
	Premium – Core benefits	**1.480.000**	**2.250.000**	**3.460.000**	**4.800.000**	**6.260.000**
	OPTIONAL BENEFITS					
3	**Outpatient treatment benefits for illness, disease, and accident (annual)**	**10,000,000**	**12,500,000**	**15,000,000**	**20,000,000**	**25,000,000**
3.1	Maximum limit per outpatient visit	1.200.000	1.500.000	1.800.000	2.400.000	3.000.000
3.2	Hospital guarantee of payment – Outpatient			√	√	√
	Premium – Outpatient	**1.040.000**	**1.215.000**	**1.620.000**	**2.290.000**	**3.040.000**
4	**Dental care (annual)**	**1.400.000**	**2.500.000**	**2.750.000**	**5.000.000**	**6.250.000**
4.1	Limit per dental treatment, including: *- Dental scaling* *- Tooth fillings using conventional materials such as amalgam/composite…* *- Tooth extraction due to pathological causes such as decay/gum coverage/impaction/root issues…* *- Apicoectomy surgery; removal of dental calculus;* *- Root canal treatment* *- Gingivitis, periodontitis*	560.000	1.000.000	1.100.000	2.000.000	2.500.000
4.2	Hospital cash benefit – Dental			√	√	√
	Insurance premium – Dental	**540.000**	**760.000**	**850.000**	**1.265.000**	**1.585.000**
5	**Maternity (per year):** ▪ *Childbirth (Normal delivery/Cesarean section/Difficult delivery);* ▪ *Maternity complications;* ▪ *Routine prenatal check-ups/antenatal examinations;* ▪ *Newborn care* ***No sub-limit applies to Maternity Benefits***	**Not applicable**	**10.000.000**	**20.000.000**	**30.000.000**	**40.000.000**
5.1	Guarantee of Payment – Maternity		√	√	√	√
	Insurance Premium – Maternity		**1.755.000**	**3.290.000**	**5.590.000**	**6.410.000**