Policy Wording

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General Provisions

Contracting Parties

This Policy binds: First party, the Policyholder, the company whose name is indicated on the Insurance Certificate as "Policyholder", hereinafter referred to as the "Policyholder".

And; Second party, Tokojaya Lao Co., Ltd hereinafter referred to, sometimes collectively, as the "Insurer", "We" or "Us".

The declarations of the Policyholder and of the Eligible Employees and Dependents serve as the basis for the Policy. Any references in this Policy to Employees and Dependents that are expressed in the masculine gender shall be interpreted as including the feminine gender whenever appropriate.

Entire Policy and Changes

This Policy, the Schedule of Benefits, the Policy Rider, the Policyholder application and enrollment forms, any amendments or endorsements, and the application forms (if any) of the Insured Persons, make up the entire contract between the parties.

No change may be made to this Policy unless it is approved by the Insurer. A change will be valid only if made by a Policy Endorsement signed by the Insurer, or an amendment of the Policy in its entirety issued by the Insurer. No agent or other person may change this Policy or waive any of its provisions.

Eligibility and Conditions of Coverage

Eligibility (Group policy)

Subject to underwriting, all the Employees of the Policyholder who are Actively at Work and who meet the criteria indicated under "Eligibility and Conditions of Coverage" as indicated below are eligible for insurance.

Eligible Employees

Eligible Employees are active, full-time Employees who work at least twenty (20) hours per week as an Employee for the Policyholder, and can be up to the age of seventy (70) at the time of enrollment. An Eligible Employee may renew coverage through age seventy -five (75). Premium surcharges apply to Insured Persons who are aged sixty (60) and over at the time of enrollment.

Once accepted by the Insurer, each of the Eligible Employees qualifies as an "Insured Employee" who is entitled to the insured benefits. An Insured Employee and his Insured Dependents, once admitted, cannot be excluded from the insured group, except as outlined in the section entitled Cancellation, as long as the Insured Employee is employed by the Policyholder and meets eligibility requirements for Insured Employees under this Policy.

- Insured Persons are eligible to leave the specified coverage area (company location), and will remain eligible for benefits. However, if the Insured Person remains outside of the specified coverage area, the Insurer holds the right to adjust the Insured Person's Premium to reflect new residency.
- Insured Persons who are dropped fromcoverage during the Policy Year cannot be reactivated until the following Policy Year, except in cases where an Eligible Employee is rehired by the Policyholder.

EligiblePrimary Insured (Individual policy)

An Eligible Primary Insured can be up to the age of seventy (70) at the time of enrollment. An Eligible Primary Insured may renew coverage through age seventy-five (75).

Insured Dependents

Provided family coverage has been elected by the Policyholder, coverage under this Policy can be extended to the following family members as Insured Dependents:

- The spouse or domestic partner (same maximum enrollment age limits as Insured Employees).
- Unmarried children up to the age of twenty-one (21).
- Unmarried children up to the age of twenty-four (24) who are full-time students, attend school regularly, and depend solely upon the Insured Employee's support
- Unmarried children up to the age of twenty-four (24) who are physically or mentally incapacitated and depend solely upon the Insured Employee's support.

Dependent children include the Insured Employee's natural children, legally adopted children, and/or step children who depend on the Insured Employee's sole support and who live with the Insured Employee in a customary parent-child relationship.

Benefits for unmarried children who are physically or mentally incapacitated remain in force after the child reaches age twenty-one (21) to age twenty-four (24) as long as proof of the handicap is submitted to the Insurer after the child reaches age twenty-one (21)
periodically thereafter at the Insurer's request.

Dependents are eligible for insurance on the later of (a) the day the Insured Employee becomes eligible, or (b) the day the Insured Employee acquires the first Dependent. Dependents can only be insured if the Insured Employee is insured by the Policy and the Policyholder has elected Dependent coverage for the Insured Employee.

Addition of a New Baby or Legally Adopted Child

Newborn babies, born under a covered pregnancy of an Insured Person are automatically covered under their current Policy during the first fourteen (14) days, up to the amount stated on the Schedule of Benefits. All Deductible and Policy Co-payments will apply. In order to continue the baby's benefits after fourteen (14) days, a member may request coverage for a new baby or legally adopted child, provided all of the following conditions are met:

- Thirty (30) day notification:
  A newborn child shall be accepted for coverage from the date of birth regardless of health, provided written notification has been received within thirty (30) days of the date of birth.

- Appropriate coverage must apply:
  Should the Insured Employee have a baby or adopt a child while covered under a Single or Couple coverage, then the thirty (30) day written notificationmust also include a request to change coverageto either Single Parent Family or Family coverage so that the child will be covered on the date of birth or legal adoption. Any request received beyond the thirty (30) day notification period shall result in coverage only being effective from the date of notification, if accepted by Us, and a twelve (12) month Waiting Period for Pre-existing Conditions shall apply.
- In the case of an Insured Employee that adopts a child officially and legally after the date of birth of the child, then for a period of twelve (12) months from the date of enrollment, Pre-existing Conditions shall not be covered for the adopted child.

Residency

The residency of the Insured Employee and all Insured Dependents is assumed to be the location of the employer. If any Insured Persons are living in another location, the Insurer must be notified in writing of their full-time residency immediately. Any changes in residency must also be immediately reported to the Insurer.

If any Insured Persons are living full-time in specified areas, the Premiums will be adjusted according to an applicable location surcharge.

Enrollment Procedures

Conditions of Enrollment

To enroll, an Eligible Employee must be actively working (20 hours minimum per week) on the date of enrollment. If the Eligible Employee is not actively working on the date of enrollment, the Insurer must be notified and Eligibility reviewed.

Enrollment Procedures

The Policyholder shall send to the Insurer an Enrollment Form on or before the Effective Date of the Policy or, for Eligible Employees hired by the Policyholder on or before the date such new Eligible Employee is to be covered. If required by the Insurer, the new Eligible Employee shall also prepare and forward a Member Health Statement.

Coverage Changes

Changes in Coverage of Dependents

Any Dependent child born while the Insured Employee is insured will be insured from the date of his birth if the Insured Employee elects Dependent coverage no later than thirty (30) days after birth. Insuring newborn Dependents requires the submission of a completed Enrollment Form to be received by the Insurer.

Changes in coverage cannot be backdated and are effective on the date of notice or a future date as notified by the Policyholder, with the exception of a newborn child, who is covered from the date of birth upon thirty (30) day notification.

Terms and Conditions

Obligation of Truthful Declaration

While concluding the contract, the Insurer has a duty to accurately present to the Policyholder the contents of every provision of the contract. In regards to the Exclusions in particular, We need to make them evident on the Application Form, Certificate or other Insurance Certificates so that the Policyholder can easily notice. Furthermore, We have an obligation to provide a written/ oral explanation of the Exclusions to the Policyholder, without which the Exclusions are not effective.

The Policyholder must declare honestly to us all facts about himself and/or the Insured Persons when required by Us.

If the Policyholder or Insured Persons make an untrue statement on purpose or by grave negligence, and it will directly affect the Insurer's decision whether to accept the risk or not, or whether to charge increased Premiums or not, then We have the right to rescind this contract.

If on purpose, we will bear no liability to pay any benefits for an insurance event which occurs before the date of rescission of the contract. The Premiums will not be refunded.

If by grave negligence and the statement severely affects the occurrence of the insurance event, We will bear no liability to pay any benefits for the insurance event which occurs before the date of rescission of the contract, but return the unearned Premium.

While concluding the contract, if We are already aware of an untrue statement concealed by the Policyholder, We cannot rescind the contract once the insurance event occurs and we are obligated to pay benefits for it.

The right of contract rescission mentioned in this provision shall be extinguished if it has not been exercised within 30 days calculated from the day that we become aware of the rescission reason.

Premium Payment

All coverage under this Policy is subject to the timely payment of Premium, which must be made to the Insurer.

Prior to each Premium Payment Date, the Insurer shall send to the Policyholder a Debit Note and shall also provide a listing of the Insured Employees and Insured Dependents. The Policyholder shall update such list with all changes, as well as identify those Insured Employees who have terminated their employment with the Policyholder, and forward it to the Insurer together with the payment of the total Premium debit stated on or before the Premium Payment Date. If the list shows a Premium credit, the Insurer will credit the Policyholder.

- The Policy and Premium rates shall be for one Policy Year and are continually subject to the terms in force at the time of each renewal date.
- The Insurer may change the Premium payable periodically. However, generally, this Policy will not be subject to any alteration in Premium rates during the Policy Year.
- All Premiums are payable before coverage under this Policy is provided.

Policy and Rate Modifications

Neither the Policyholder nor the Insured Employee has the right to change this Policy or to modify any of its provisions. However, the Insurer has that right. If the Insurer changes or terminates any Policy provisions or changes the Premium charged, the Policyholder will be notified in writing thirty (30) days prior to the effective date of the change. The Policy Year begins on the Effective Date of the Policy as stated on the Insurance Certificate and ends at midnight three- hundred and sixty-five (365) days later.

Continued payment of the appropriate Premium (including payment at changed rates) shall be confirmation of the Policyholder's acceptance of the Policy or Premium change(s) and will result in the continuation of coverage, as modified, without interruption.

The Insurer has the right to change any Premium, or rate basis, on:

- Any renewal date. The Insurer must notify the Policyholder of the change at least 30 days before the Insurer makes the change; or
- At any time the demographics or geographic location of the Policyholder or its Insured Employees change.

Other Premium Changes

Premium changes due to the following will occur automatically and will be charged from the date the change occurs:

- An increase or decrease in benefits provided under the Policy; or
- Additions, deletions, increases or decreases of an Insured Employee's Dependent's insurance; or
- Addition of a new Insured Person; or
- Termination of an Insured Person

Any such change will be prorated to the Premium payment period of the Policyholder and reflected on the Policyholder's next Debit Note.

Changes in an Insured Person's age are considered changes in the demographics of the Policyholder. Resulting Premium changes will occur and are assessed upon each renewal date.

Duration of Coverage

Benefits are paid to the extent that an Insured Person receives any of the treatments covered under the Schedule of Benefits from the Effective Date of coverage for such Insured Person and up to the date such individual no longer meets the definition of Insured Person.

Alterations

The Insurer may alter any of the terms of this Policy at any renewal date. A copy of the current Policy terms will be sent to the Policyholder and its Insured Employees at such time.

Compliance with the Policy Terms

The Insurer's liability under this Policy will be conditional upon each Insured Person complying with its terms and conditions.

Change of Risk

The Policyholder must inform the Insurer as soon as reasonably possible, of any changes relating to Insured Persons (such as change of address, occupation or marital status) or of any other material changes that affect information given in connection with the application for coverage under this Policy. The Insurer reserves the right to alter the Policy terms or cancel coverage for an Insured Person following a change of risk.

Cancellation

The Insurer reserves the following rights:

- This Policy will be cancelled automatically upon non-payment of the Premium, although the Insurer may at their discretion reinstate the coverage if the Premium is subsequently paid.
- If any Premium due from the Policyholder remains unpaid, the Insurer may in addition defer or cancel payment of all or any claims for expenditures incurred during the period it remains unpaid.
- While the Insurer shall not cancel this Policy because of eligible claims made by any Insured Person, they may at any time terminate an Insured Employee's and/or eligible Dependent's membership of group or subject his/her coverage to different terms if he/she or the Policyholder has at any time:
  - Misled the Insurer by misstatement or concealment;
  - Knowingly claimed benefits for any purpose other than what is provided for under this Policy;
  - Agreed to any attempt by a third party to obtain an unreasonable pecuniary advantage to our detriment;
  - Failed to observe the terms and conditions of this Policy, or failed to act with utmost good faith.
- If the Insurer does cancel this Policy, they shall give thirty (30) days notice.
- Coverage for an Insured Person shall cease immediately upon the Policyholder deleting the Insured Person from the group.
- If agreed by the Insurer, the Policyholder can cancel the Policy by submitting the documents requested by the Insurer before the renewal date. The Insurer will refund the unused Premium after a deduction of 20% for administration fees.

Fraudulent/Unfounded Claims

If any claim under this Policy is in any respect fraudulent or unfounded, all benefits paid and/or payable in relation to that claim shall be forfeited and, if appropriate, recoverable.

Jurisdiction

This Policy is governed by, and shall be construed in accordance with the laws of the Lao PDR

Waiver

Waiver by the Insurer of any term or condition of this Policy will not prevent Us from relying on such term or condition thereafter.

Upon Subscribing to the Policy

The Policyholder shall provide the Insurer with:

- A list of Eligible Employees at work (Enrollment Form), indicating for each person his/her family name, first name, date of birth, family status, city of Residence, nationality (country of citizenship), and salary and job title (if applicable).
- A list of Eligible Employees unable to work on the Effective Date of the Policy, and the reasons why.
- A completed Application Form and any requested Member Health Statements completed by each Eligible Employee. Completed and signed originals must be received before the Effective Date of the Policy.

During the Term of the Policy

The Policyholder agrees to:

- Enroll all new Eligible Employees on their hire date as well as all other Employees who become Eligible Employees. When enrolling Employees, the Policyholder will indicate either the hire date or the date when the Employee became an Eligible Employee.
- Inform the Insurer no later than during thirty (30)days that follows the event, of the name and date of departure of all Insured Employees and/or Insured Dependents that are no longer eligible for coverage under this Policy.
- Submit a completed Enrollment Form for each Eligible Employee.

Denial of Liability

Neither the Insurer nor the Policyholder is responsible for the quality of care received from any institution or individual. This Policy does not give the Insured Person any claim, right or cause of action against the Insurer or Policyholder based on an act of omission or commission of a Hospital, Physician or other Provider of care or service.

Beneficiary

The beneficiary of the health benefit is the insured himself/herself.

Arbitration Agreements

The dispute resolution is agreed in contract by the Insurer and Policyholder as either of the two ways below: Should a dispute arise while fulfilling the provisions, it shall be submitted to the Arbitration Commission if negotiations fail between the interested parties. Should a dispute arise while fulfilling the provisions, it shall be submitted to Court if negotiations fail between the interested parties.

Claims

All claims worldwide are subject to Usual and Customary Charges as determined by the Insurer and are processed in the order in which they are received. In order for claims payment to be made, claims must be submitted in a form acceptable to the Insurer. Claim Forms can be obtained from **www.mshchina.com**.

Claims Incurred within the Direct Billing Network

Claims may be submitted to the Insurer directly by the institution or Provider. If the Primary Insured has already paid the institution or Provider, the Primary Insured must submit the claim along with the original receipts (tax invoices

if within Lao P.D.R.), and Claim Form directly to the Insurer. Photocopies will not be accepted. The Insurer will pay the Primary Insured in accordance with the terms of this Policy.

Claims Incurred Outside of the Direct Billing Network

The Primary Insured must submit claims directly to the Insurer. The original receipts (tax invoices if within Lao P.D.R.) must accompany such claims. Photocopies will not be accepted. The Insurer will pay the Insured in accordance with the terms of this Policy.

Releasing Necessary Information

By applying for enrollment, the Primary Insured agrees on behalf of him/herself and his Insured Dependent(s), to let any Physician, Hospital, pharmacy or Provider give the Insurer all medical information determined by the Insurer to be necessary, including a complete medical history and/or diagnosis. The Insurer will keep this information confidential. In addition, by applying for coverage, the Primary Insured authorizes the Insurer to furnish any and all records respecting such Insured Person including complete diagnosis and medical information to an appropriate medical review board, utilization review board or organization and/or to any administrator or other insurance carrier for purposes of administration of this Policy.

Examinations

The Insurer and the Claims Administrator shall have the right and opportunity, through their medical representatives, to examine any person whenever and as often as they may reasonably require within the duration of any claim. The Insured Person shall make available all medical reports and records, and where required, shall sign all authorization forms necessary to give the Insurer a full and complete medical history The Insurer and the Claims Administrator shall have the right and the opportunity to require an autopsy in the case of death, unless forbidden by law or religious beliefs.

Request for Reproduction of Records

The Insurer reserves the right to charge a fee for reproductions of claims records requested by the Primary Insured or his/her representative.

Limitation of Action

With respect to insurance except life insurance, the rights of the Insured Person or the beneficiary to claim for payment of the insurance benefits shall expire if the Insured Person or the beneficiary fails to exercise his/ her rights to claim within two (2) years from the date when the Insured Person or the beneficiary is aware of the occurrence of the insured event.

Coordination of Benefits

When an Insured Person has coverage under another insurance contract, including but not limited to health insurance, Medicare, Medicaid, worker's compensation insurance, automobile insurance (whether direct or third party), and occupational disease coverage, and a service received is covered by such contracts, benefits will be reduced under this Policy to avoid duplication of benefits available under the other contract including benefits that would have been payable had the Insured Person claimed for them. In no event will more than 100% of the Allowable Charge and/or Maximum Benefit for the covered services be paid or reimbursed. It is the duty of the Primary Insured to inform the Insurer of all other coverage. United States citizens who are eligible for USA Medicare benefits must apply for coverage under those benefits for medical and prescription services obtained within the USA. The Insurer has full right of subrogation.

To determine the primary Policy, the following guidelines will be used: This Policy is primary if it covers the claimant as an active Employee.

- If two Policies cover the claimant as an Employee, the Policy that has covered him for the longer period of time is the primary Policy.
- If an Employee is covered as an active Employee under the Policy and as a retired or laid off Employee under another Policy, the Policy that covers him as an active Employee is the primary Policy. The Policy that covers him as a retired or laid off Employee is the secondary Policy.

Subrogation

If an Insured Person has a right of recovery against any person or organization based upon a legal claim (whether or not that claim is asserted), and if the legal action or claim involves medical expenses which the Insurer paid, the Insurer is subrogated to all the rights of recovery against that person or organization. This means that the Insurer is entitled to reimbursement from the person or organization. The Insured Person is required to cooperate with the Insurer. This includes, but is not limited to, the completion and delivery of any pertinent documents the Insurer may request. No Insured Person may settle or otherwise compromise his or her claim for such medical expenses without the written consent of the Insurer. Refusal to honor this paragraph will be grounds for the Insurer to terminate this Policy.

Definitions

Certain words and phrases used in this Policy are defined below. Other words and phrases may be defined where they are used.

Accident - Any sudden and unforeseen event occurring during the Policy Year period, resulting in bodily Injury, the cause or one of the causes of which is external to the victim's own body and occurs beyond the victim's control.

Active Service/Actively at Work - An Employee will be considered in Active Service on any day if he/she is then performing in the customary manner all the regular duties of his/her employment as performed or were capable of being performed on the last regularly scheduled work day.

Activities of Daily Living (ADL) - Activities of Daily Living are those activities normally associated with the day-to-day fundamentals of personal self-care, including but not limited to: walking, personal hygiene, sleeping, toilet/continence, dressing, cooking/ feeding, medication and transferring (getting in and out of bed).

Acupuncture - Treatment of a medical condition, which is covered under the terms of this Policy, by needles provided by or ordered by a licensed Physician as defined in this Policy.

Acute Care - Medically Necessary, short-term care for an Illness or Injury characterized by rapid onset, severe symptoms, and brief duration, including any intense symptoms, such as severe pain.

Admission - Means the period from the time that an Insured Person enters a Hospital, Extended Care Facility or other approved health care facility as an Inpatient until discharge.

Air Ambulance - Means an aircraft specially equipped with the necessary medical personnel, supplies and Hospital equipment to treat life-threatening Illnesses and/or Injuries for persons whose conditions cannot be treated locally and must be transported by air to the nearest medical center that can adequately treat their conditions. This service requires Pre-authorization. A commercial passenger airplane does not qualify as an Air Ambulance.

Allowable Charge - Means the fee or price the Insurer determines to be the Usual and Customary Charge for health care services provided to Insured Persons which are covered under the Policy. The Insured Person is responsible for the payment of any balance over the Allowable Charge. All services must be Medically Necessary.

Ambulatory Surgical Center - Means a facility which: (a) has as its primary purpose to provide elective surgical care; and (b) admits and discharges a patient within the same working day; and (c) is not part of a Hospital. Ambulatory Surgical Center does not include: (1) any facility whose primary purpose is the termination of pregnancy; (2) an office maintained by a Physician for the practice of medicine; or (3) an office maintained by a Dentist for the practice of Dentistry.

Attention Deficit Disorder (ADD) - Attention Deficit Disorder is a biologically based condition causing a persistent pattern of difficulties resulting in one or more of the following behaviors: inattention; hyperactivity; impulsivity.

Attention Deficit Hyperactivity Disorder (ADHD) - Is a problem with inattentiveness, over-activity, impulsivity, or some combination of these. For these problems to be diagnosed as ADHD, they must be out of the normal range for the child's age and development.

Bereavement Counseling - Counseling of a terminally ill or deceased member's family by a licensed counselor, psychiatrist, psychologist, or pastor. Benefits for Bereavement Counseling are eligible for coverage only under the Outpatient Treatment, Mental Health benefit of this Policy.

Birth Center - Means a facility which: a) is mainly a place for the delivery of a child or children at the end of a normal pregnancy; b) and meets one or both of the following tests: (1) it is licensed as a Birth Center under the laws of the jurisdiction where it is located; and/or (2) it meets all the following requirements: (i) it is operated in accordance with the laws of the jurisdiction whereit is located; (ii) it is equipped to perform all necessary routine diagnostic and laboratory tests; (iii) it has trained staff and equipment required to properly treat potential emergencies of the mother and of the child; (iv) it is operated under the full-time supervision of the Physician or a Registered Nurse (R.N.); (v) it has at all times a written agreement with at least one Hospital in the area for immediate acceptance of a patient in the event of a complication; (vi) it maintains medical records for each patient; (vii) and it is expected to discharge or transfer each patient within 48 hours after the delivery.

Catastrophic Illnesses:

1. Cardiovascular diseases - Includes coronary artery disease, congenital heart disease, chronic pulmonary heart disease, myocardial infarction, and aortic aneurysm.

2. Neurological conditions - Includes stroke, brain aneurysm, Alzheimer's disease, Parkinson's disease, Syringomyelia, and Multiple Sclerosis.

3. Hematologic diseases - Includes leukemia, lymphoma, aplastic anemia, ITP, and hemophilia.

4. Pulmonary diseases - Includes chronic obstructive pulmonary disease, and primary pulmonary hypertension.

5. Digestive diseases - Includes liver cirrhosis, and severe hepatitis.

6. Autoimmune diseases - Includes systemic lupus erythematosus, systemic scleroderma, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex Syndrome (ARCS), and all diseases caused by and/or related to the HIV virus.

7. AIDS - Acquired Immune Deficiency Syndrome (AIDS) and all diseases caused by and/or related to the HIV virus.

8. Others - Includes all cancer, major organ failure/ transplants, cystic fibrosis, Peutz-Jeghers syndrome, and III-degree burns.

Chronic Condition - An Injury, Illness or condition, which may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by recurrences requiring continuous or periodic care as necessary; or which has had continued treatment for three months or more.

Complications of Pregnancy - Means: (a) when pregnancy is not terminated, conditions that require Hospital confinement, whose diagnoses are distinct from pregnancy but are adversely affected by or are caused by pregnancy, such as: (1) acute nephritis; (2) nephrosis; (3) cardiac decompensation; (4) missed abortion; and (b) when pregnancy is terminated; (1) ectopic pregnancy that is terminated; or (2) spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of Pregnancy will not include false labor; occasional spotting; physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum; and similar conditions associated with the management of a difficult pregnancy that do not constitute a nosologically distinct Complication of Pregnancy.

Congenital Condition - Means any heredity condition, birth defect, physical anomaly and/or any other deviationfrom normal development present at birth, which may or may not be apparent at that time. These deviations, either physical or mental, include but are not limited to, genetic and non-genetic factors or inborn errors of metabolism.

Covered Expenses - Means the Usual and Customary Charges incurred by an Insured Person, while covered under this Policy, for Medically Necessary services, treatments or supplies described under the provisions of the Policy, Schedule of Benefits, and Policy Rider.

Credible Coverage - Credible Coverage refers to the time an insurance applicant has spent covered under a health insurance plan directly prior to the inception of this Policy. In order to be considered Credible Coverage for the purposes of this Policy, the previous health insurance plan must have provided coverage commensurate, in terms of benefit type and scope, with the health benefits in force under this Policy. For example, a dental benefits only plan will not be judged commensurate with a medical benefits plan. Prior coverage must be substantially the same as coverage under this Policy.

The prior coverage must be of at least 12 months consecutive duration, and a maximum lapse of 30 days between the prior coverage and the commencement of this Policy is allowed. The previous insurer must provide documentation adequate to establish the requirements described herein.

Critical Condition - An immediate life threatening or perilous Illness or condition due to an Accident or natural causes, which requires urgent specialized treatment without delay.

Custodial Care - Includes: (1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who,

as determined by the individual's attending Physician, has reached the maximum level of recovery; and (2) in the case of an institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him to live outside an institution; and (3) rest cures, Respite Care and home care provided by family members. Upon receipt and review of a claim, the Insurer or an independent medical review will determine if a service or treatment is Custodial Care.

Day-care Treatment - Treatment received while an Insured Person occupies a Hospital bed or is charged for Hospital accommodations, but does not remain overnight.

Deductible - Whether the Individual Annual Deductible, or the Family Annual Deductible as set forth in the Schedule of Benefits means the amount of covered Allowable Charges payable by the Primary Insured during each Policy Year before the Policy benefits are applied. Such amount will not be reimbursed under the Policy. The Deductible is not considered part of the Policy Year Out-Of-Pocket Co-payment Maximum.

Dependent - Means the Primary Insured's legally recognized spouse or domestic partner; and/or unmarried children up to the age of twenty-one (21), or twenty-four (24) if a full-time student and they reside at home and are financially dependent on the Primary Insured. (See Eligibility and Conditions of Coverage section)

Drug Abuse - Means a mental and/or physical condition wholly or partly due to taking any drug, substance or solvent unless solely arising from a prescription issued on medical authority and taken strictly in accordance with medical advice.

Durable Medical Equipment - Means orthopedic braces, artificial devices replacing body parts and other equipment customarily and generally useful to a person only during an Illness or Injury and determined by Insurer to be Medically Necessary.

Effective Date - The date shown on the Payment List issued by the Enrollment Department on which an Insured Person was included under this Policy.

Eligible Employee - Means an Employee of the Policyholder that meets all of the Eligibility criteria under this Policy.

Eligibility - Means the requirements an Insured Person must meet at all times in order to be Insured Person under this Policy. (See Eligibility and Conditions of Coverage section)

Emergency - Defined as an injury or illness that is acute, poses an immediate risk to a person's life or long term health and requires immediate medical intervention which the Insured Person secures after the onset of such condition (or as soon thereafter as care can be made available, but in any case not any later than twenty-four (24) hours after the onset).

Emergency Dental Treatment - Cost of Emergency treatment necessary to restore or replace sound natural teeth where the damage is a direct consequence of the Accident. Initial treatment must be obtained within 30 days of the Accident.

Emergency Medical Evacuation - In the event of a life threatening emergency, when appropriate treatment is not available locally, this Policy provides Emergency Medical Evacuation to the closest medical facility capable of providing the required care. Should treatment be available locally but the Insured Person chooses to be treated elsewhere, transportation expenses shall be the responsibility of the Insured Person. In the event of such emergency, the Emergency Assistance Company must be contacted in advance in order to approve and arrange such Emergency Medical Evacuation. The Emergency Assistance Company, on behalf of the Insurer, retains the right to decide the medical facility to which the Insured Person shall be transported. If the Insured Person chooses not to be treated at the facility and location arranged by the Emergency Assistance Company, then transportation expenses shall be the responsibility of the Insured Person. All emergency medical transportation must be arranged, in advance, with the Emergency Assistance Company, whose contact details are located on the back of the Insurance Card. Failure to arrange transportation as indicated will result in non-payment of transportation costs.

Employee - A person who is in Active Service on a full time basis at least twenty (20) or more hours per week with the employer. It does not mean a person in casual employment. Employees who are on a leave of absence may be considered eligible under this Policy, however, the Insurer must be informed immediately, and the Insurer reserves the right to determine whether or not such Employees may continue coverage under this Policy.

Enrollment Effective Date - Means the date upon which an Insured Person's coverage will become effective under this Policy, as determined by the Policyholder or otherwise.

Experimental and/or Investigational - Means any treatment, procedure, facility, equipment, drug, drug usage, device, or supplies not recognized as accepted medical practice by the Insurer.

Extended Care Facility - Means a nursing and/or Rehabilitation center approved by the Insurer that provides skilled and Rehabilitation services to patients who are discharged from a Hospital or who are admitted in lieu of a Hospital stay. The term Extended Care Facility does not include nursing homes, rest home, health resorts, homes for the aged, infirmaries or establishments for domiciliary care, Custodial Care, care of drug addicts or alcoholics, or similar institutions.

Force Majeure - Means a force impossible to foresee, avoid or overcome by objective situation.

HIV - Acquired Immune Deficiency Syndrome (AIDS) and all diseases caused by and/or related to the HIV virus.

Home Country - The Home Country of any Insured Person under this Policy is deemed to be the country from which the Insured Person holds a passport. In the event that a citizen of the United States holds more than one passport, the United States shall be deemed the Home Country.

Homeopathy - A system of alternative medicine that seeks to treat patients by administering small doses of medicines that would bring on symptoms similar to those of the patient in a healthy person. For example, the homeopathic treatment for diarrhea would be a miniscule amount of a laxative.

Home Health Care Agency - Means an agency or organization, or subdivision thereof, which: a) is primarily engaged in providing skilled nursing services and other therapeutic services in the Insured Person's home; b) is duly licensed, if required, by the appropriate licensing facility; c) has policies established by a professional group associated with the agency or organization, including at least one Physician and one registered graduate Nurse (R.N.), to govern the services provided; d) provides for full-time supervision of such services by a Physician or by a Registered Nurse (R.N.); e) maintains a complete medical record on each patient; and f) has a full-time administrator.

Home Health Care Plan - Means a program: a) for the care and treatment of an Insured Person in his home; b) established and approved in writing by his attending Physician; and c) Certified, by the attending Physician, as required for the proper treatment of the Injury or Illness, in place of Inpatient treatment in a Hospital or in an Extended Care Facility.

Hospice - Means an agency which provides a coordinated plan of home and Inpatient care to a terminally ill person and which meets all of the following tests: a) has obtained any required state or governmental license or Certificate of Need; b) provides service 24-hours-a-day, 7 days a week; c) is under the direct supervision of a Physician; d) has a Nurse coordinator who is a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.); e) has a duly licensed social service coordinator; f) has as its primary purpose the provision of Hospice services; g) has a full-time administrator; and h) maintains written records of services provided to the patient.

Hospital - Means and includes only Acute Care facilities licensed or approved by the appropriate regulatory agency and/or Insurer as a Hospital, and whose services are under the supervision of, or rendered by a staff of Physicians who are duly licensed to practice medicine, and which continuously provides twenty-four (24) hour a day nursing service under the direction or supervision of registered professional Nurses. The term Hospital does not include nursing homes, rest home, health resorts, and homes for the aged, infirmaries or establishments for domiciliary care, Custodial Care, care of drug addicts or alcoholics, or similar institutions.

Insurance Card - The document provided to the Primary Insured and Insured Dependents, which outlines the Policy benefits, name of the Policyholder, Insured Persons, and endorsements, if any. On this card, Insured Persons will find benefit information, as well as contact information for submitting claims and emergency medical assistance. Insured Persons may in certain circumstances have two (2) Insurance Cards.

Insurance Certificate - Is a certificate issued by the Insurer showing the name of the Policyholder, Policy Effective Date, as well as other pertinent information. Illness - Means a bodily disorder or infirmity for all Insured Persons.

Injury - A medical condition of an Insured Person caused by, arising out of, or resulting from an unforeseen force or event external to that Insured Person.

Inpatient - Means a person admitted to an approved Hospital or other health care facility for a Medically Necessary overnight stay.

Insured Dependent - Means a Dependent of a Primary Insured who is enrolled for and is entitled for coverage under this Policy and for whom the required Premium has been paid.

Insured Employee - Means the person who is Actively at Work and employed by the Policyholder on a full time basis, or who is otherwise eligible on his own behalf and not as a Dependent to be insured under this Policy, as agreed to between the Policyholder and the Insurer. Insured Employees may also be referred to as “members” throughout this Policy.

Insured Person - Means a Primary Insured or his Insured Dependents enrolled for and entitled to coverage under this Policy and for whom the required Premium has been paid.

Late Entrant - Means an Insured Person who becomes insured more than thirty (30) days after he is eligible.

Lifetime Maximum - Means the payment specified in the Schedule of Benefits, which is the maximum amount payable by the Insurer over the course of an Insured Person’s lifetime, regardless of changes in coverage of benefit plan.

Maternity Care - The cost of prenatal care, delivery, Medically Necessary C-sections, and postnatal treatment subject to the specific limit. Any complications related to pregnancy including Cesarean section will be treated as Maternity Care and will be subject to the specified limits.

Maximum Benefit - Means the payment specified in the Schedule of Benefits, which is the maximum amount payable by the Insurer regardless of the actual or Allowable Charges.

Medical Emergency Services - Mean services provided in connection with an “Emergency”.

Medical Exclusion - Means specific provisions excluding coverage for conditions or Illnesses for the life of this Policy. Exclusions are imposed when the Policy is issued as a condition for the issuance of coverage. Medical Exclusion or Exclusions, if issued as a condition for the issue of coverage, form a part of this Policy.

Medically Necessary - Means those services or supplies which are provided by a Hospital, Physician or other approved medical Provider that are required to identify or treat an Illness or Injury and which, as determined by Insurer, are:

1. Consistent with the symptom, or diagnosis and treatment of the condition, disease or Injury; and
2. Appropriate with regard to standards of accepted professional practice; and
3. Not solely for the Insured Person’s convenience, the Physician’s convenience or any other Provider’s convenience; and
4. The most appropriate supply or level of service, which can be provided. When applied to an Inpatient, it further means that the medical symptoms or condition require that the services or supplies cannot be safely provided as an Outpatient; and
5. Is not a part of or associated with the scholastic education or vocational training of the patient; and
6. Is not Experimental or Investigative.

Nurse - Means a person licensed as a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.)
by the appropriate licensing authority in the areas
which he or she practices nursing. Out-Of-Pocket Co-payment Maximum - The Policy Year Out-Of-Pocket Co-payment Maximum is the maximum amount the Insured Person will pay in Policy Co-payments for Covered Expenses during any one Policy Year. The Policyholder may also elect to have no Policy Year Out-of-Pocket Co-payment Maximum.

Outpatient - Means services, supplies or equipment received while not an Inpatient in a Hospital, or other health care facility, or overnight stay. This term does not include home visits by a Physician. Payment List - A document issued by the Enrollment Department, which lists all Insured Persons who are designated by the Policyholder to be insured for coverage, and the applicable Premiums to be paid for such Insured Persons.

Per Claim Deductible - The designated Deductible as found on the Schedule of Benefits will be applied per office visit for each time medical services, including consultations and follow-ups, are received.

Physician - Means any person who is duly licensed to practice medicine, osteopathy or podiatry and who is acting within

the scope of that license. This term does not include: (1) an intern; or (2) a person in training.

Policy - Means the agreement between the Insurer and the Policyholder. The Policy includes this document, the Insurance Certificate, the Schedule of Benefits, the Policy Rider, any application and enrollment forms, any Member Health Statements, the last issued Insurance Cards, and any amendments, endorsementor modification made in accordance with the Policy and any Riders or endorsements purchased by the Policyholder.

Policy Co-payment - Means the sharing of Allowable expenses after the satisfaction of the Deductible amount by the Insurer and the Insured Person. The Insured Person pays the percentage set forth in the Schedule of Benefits.

Policy Effective Date - Means the date that this Policy first takes effect, without regard to renewals thereafter.

Policy Year - Means the period of time (usually one year) in which coverage is effective under this Policy.

Policyholder - Means an employer or other group that: a) has applied for coverage and is named as the Policyholder on the Insurance Certificate; and b) is providing a group insurance plan for its Employees under this Policy.

Pre-authorization - Pre-authorization is a process by which an Insured Person obtains written approval for certain medical procedures or treatments, from the Insurer (see the back of your Insurance Card) prior to the commencement of the proposed medical treatment. Certain medical procedures will require the Pre-authorization process to be followed. For full information on how to obtain Pre-authorization and relevant contact information, refer to the Pre-authorization section and also your Insurance Card.

Pre-existing Condition - Means any Illness or Injury, physical or mental condition, for which an Insured Person received any diagnosis, medical advice or treatment, or had taken any prescribed drug, or where distinct symptoms were evident prior to the Effective Date.

Preferred Provider Organization (PPO) - A participating Provider, such as Hospital, clinic or Physician that has entered into an agreement to provide health services to persons insured by the Insurer. The Insurer maintains an international network of medical Providers and facilities with which it has arranged direct billing procedures. Please refer to **www.mshchina.com** to access a list of Providers.

Premium(s) - Means the consideration owed by the Policyholder to the Insurer in order to secure benefits for its Eligible Employees and Dependents under this Policy.

Prescription Drugs - Prescription Drugs are Medical Necessary medications which are prescribed by a Physician.

Proof of Good Health - Means, for the purpose of evaluating Late Entrants, satisfactory evidence that an individual is in good health, based on medical information, as the Insurer may require.

Provider - Means the organization or person performing or supplying treatment, services, supplies or drugs.

Rehabilitation - Therapeutic services designed to improve a patient's medical condition within a predetermined time period through establishing a maintenance program designed to maintain the patient's current condition, prevent it from deteriorating and assist in recovery. Inpatient Rehabilitation is only covered during the acute and sub-acute recovery phase of treatment and only when authorized by Us.

Repatriation or Local Burial - These are the reasonable and necessary expenses of preparation and the air transportation of the mortal remains of the Insured Person from the place of death to his/her Home Country, or the reasonable and necessary expenses for preparation and local burial of the mortal remains of an Insured Person who dies outside his/her Home Country.

Residence - The following rules apply to the location and physical address of all Insured Persons.

- The Residence of all Insured Persons is assumed to be the location of the Policyholder. If the residency of any Insured Person is otherwise, the Insurer must be notified in writing of their full-time Residence immediately. Any changes to residency must also be immediately reported to the Insurer.
- If any Insured Persons are living full-time in specified areas, the Premiums will be adjusted according to an applicable location surcharge.
- The residence of all Insured Persons under this Policy is presumed to be the location of the Policyholder during the Policy Year. Any deviation must be reported immediately to the Insurer who reserves the right to change rates to reflect normal residency.

Respite Care - Respite Care is Inpatient care for a chronically or terminally ill patient, for the sole purpose of relieving the patient's primary caregiver. Respite Care is not covered under this Policy.

Schedule of Benefits - Means the summary description of the available benefits, payment levels and Maximum Benefits, provided under this Policy. The Schedule of Benefits is included with and is part of this Policy.

Sub-Acute Care - Medical care which is somewhat acute, falling between acute and chronic care, but with some acute features.

Usual and Customary Charge - Means the lower of:
a) the Provider's usual charge for furnishing the treatment, service or supply; or
b) the charge determined by the Insurer to be the general rate charged by the others who render or furnish such treatments, services or supplies to persons:
(1) who reside in the same area (zip code); and
(2) whose Injury or Illness is comparable in nature and severity.

The Usual and Customary Charge for a treatment, service or supply that is unusual, or not often provided in the area, or that is provided by only a small number of Providers in the area, will be determined by the Insurer. The Insurer will consider such factors as:
(1) complexity;
(2) degree of skill needed;
(3) type of specialist required;
(4) range of services or supplies provided by a facility; and
(5) the prevailing charge in other areas.

The term "area" means a city, a county or any greater area, which is necessary to obtain a representative cross section of similar institutions or similar treatment, based upon the formal international recognized standards.

Terrorism - Terrorist activity means an act, or acts, of any person, or group(s) of persons, committed for political,

religious, ideological or similar purposes with the intention to influence any government and/or to put the public, or any section of the public, in fear. Terrorist activity can include, but is not limited to, the actual use of force or violence and/or the threat of such use.
Furthermore, the perpetrators of terrorist activity can either be acting alone, or on behalf of, or in connection with any organization(s) or government(s).

Utilization Review Measures - The Insurer retains the right to determine the Medical Necessity of a planned treatment. The appropriateness of care and the treatment plan will be reviewed in consultation with the attending Physician and alternative care options may be recommended.

Waiting Period - Means a length of time during which no benefit is payable.

Pre-authorization Requirements and Procedures

Pre-authorization is required before certain medical procedures or treatments are undertaken. Failure to comply with this requirement may result in the application of a penalty in the form of a significant reduction in the resulting claims payment.

Pre-authorization is a process by which an Insured Person obtains approval for certain medical procedures or treatments from Us prior to the commencement of the proposed medical treatment. The Insured Person must submit a completed Pre-authorization Form to Us.This completed Pre-authorization Form must be received by Us a minimum of 5 business days prior to the scheduled procedure or treatment date. We will review the matter and respond to the Insured Person. Written approval from Us must be received by the Insured Person, prior to the commencement of the proposed medical treatment.
Please note: some treatment requests may require longer than 5 business days for the review process to be completed.

Notwithstanding the requirement to obtain Pre-authorization:
- Pre-authorization approval does not guarantee payment of a claim in full, as additional co-payments and out-of-pocket expenses may apply.
- Benefits payable under the Policy are still subject to eligibility at the time charges are actually incurred, and to all other terms, limitations, and Exclusions of the Policy.
- In the event of an emergency that requires medical evacuation, contact the Emergency Assistance Company in advance in order to approve and arrange such Emergency Medical Evacuation. The Emergency Assistance Company, on behalf of the Insurer, retains the right to decide the medical facility to which the Insured Person shall be transported.

  Approved medical evacuations will only be to the nearest medical facility capable of providing the necessary medical treatment. The Emergency Assistance Company contact information can be located on the Insurance Card.
- In the event of an emergency, Pre-authorization is required for International Plus Plan and AsiaPacific Plus Plan members who require treatment in the areas in which only emergency coverage is provided.

The following services require Pre-authorization:
- Hospitalization, including babydeliveries.
- Outpatient surgery requiring general anesthesia; Chemotherapy and radiation treatments; Hemodialysis & Peritoneal dialysis treatment.
- Emergency Medical Evacuation.
- Emergency Dental Treatment (pre-authorization is not required for immediate pain relief).
- Purchase or rental of Durable Medical Equipment (DME), including but not limited to insulin pumps and supplies.
- Medications or immunizations in excess of USD 1,200 per refill.

Non-Emergency Pre-authorizations must be received 5 business days in advance of the Admission or procedure.

Medical Emergency Pre-authorizations must be received within 48 hours of the Admission or procedure. In instances of an emergency, the Insured Person should go to the nearest Hospital or Provider for assistance even if that Hospital or Provider is not part of the PPO Network.

To obtain Pre-authorization and verification of network utilization, the Insured Person, the Provider or the Insured Person's representative must call the number listed on the back of the Insurance Card. Representativesare available 24 hours a day, every day. Network lookup information can also be found at **www.mshchina.com.**

The fact that certain medical services have been Pre-authorized as Medically Necessary does not mean that they will be covered by this Policy. All medical services are subject to the terms of the Policy, including its conditions, limitations, maximums and Exclusions.

Pre-authorization ensures that prior to incurring liability for medical treatment, surgeries and other procedures, the prospective claimant is eligible under the Policy and will be reimbursed up to the applicable limit by the Insurer.

All services (except for Emergency Medical Evacuation) requiring Pre-authorization by Us will be subject to an Insured Person co-payment liability of 40%, with no out-of-pocket limit, if services are performed without the Insured Person first having our letter of authorization in hand, prior to the performance of those services Emergency Medical Evacuation performed without Pre-authorization by Us will be subject to an Insured Person co-payment liability of 100%, with no out-ofpocket limit.

In order to appeal the application of the 40% co-payment, Insured Persons will need to provide proof of Pre-authorization.

Preferred Provider Network in the U.S.

The Insurer maintains a Preferred Provider Network both inside and outside the United States. Outside of the U.S., the Insurer maintains the right to require the use of a Network Provider where available. Please visit www.mshchina.com for a complete list of Providers.

In the United States, Provider choices and assessment will be based upon three tiers of Provider network types (coverage is assessed after the Deductible and Policy Co-payment):

1. Preferred Provider Network - 100% coverage This Tier consists of all First Health providers as well as other Preferred Providers designated by the Insurer and listed on the website.

2. Out-Of-Network - 80% coverage (When network Provider was available within 30-mile (50 km) radius of where you are staying in the U.S.) No out-of-pocket maximum and benefits payable are limited to the Usual and Customary Charges for the services received. If a discount is negotiated with the

Provider, the savings thus realized will be passed on to the Insured Person.

3. Out-of-Market Area - 100% coverage No network Providers located within a 30-mile (50 km) radius of where you are staying in the U.S.

For information on the Providers and facilities within the Preferred Provider Network, consult **www.mshchina. com.**

For non-emergency treatment within the U.S., outside of the Preferred Provider Network, where an appropriate network Provider is available, members will be reimbursed up to the Usual and Customary Charges of the Preferred Provider Network. Amounts in excess of these charges shall be the sole responsibility of the Insured Person. Amounts in excess of the Usual and Customary Charges will not count toward the Deductible or Policy Year Out-Of-Pocket Co-payment Maximum.

All Inpatient treatment and Outpatient surgeries received are required to be Pre-authorized to avoid additional co-payments. (See Pre-authorization section for more details of services that require Pre-authorization.)

Health Care – Coverage and Benefits

Scope of Coverage

The Policy covers the Insured Persons for Allowable Charges for medical services provided in the areas of coverage for the plans selected as stated on the Schedule of Benefits and Policy Rider. This includes Allowance Charges for hospitalization, surgery, medical treatment and medical supplies incurred while such Insured Person is enrolled under the Policy. Such services must be recommended or approved by a licensed medical professional. They must also be essential and Medically Necessary, in the Insurer's judgment, for the treatment of an Insured Person's Injury or Illness for which insurance is provided under the Policy. When the Policyholder has chosen Optional benefits, insurance is extended to cover the costs of expenses on the same basis as described above.

Areas of Coverage

The Insurer offers three areas of coverage: Worldwide Plan, International Plus Plan, and Asia Pacific Plus Plan. Your Insurance Card will state the areas of coverage for your Policy next to Policy Type. Insured Dependents must use the same area of coverage as the Primary Insured.

A. Worldwide Plan

The Worldwide Plan has no geographic restrictions and provides coverage in any country in the world.

B. International Plus Plan

The International Plan provides coverage for medical treatment throughout the world, with the exceptions of the United States. In addition, the International Plus Plan provides emergency coverage in the United States.

In order for emergency coverage in the United States to be eligible for reimbursement, it must first be approved by the Emergency Assistance Company. The Emergency Assistance Company contact information can be found on the Insurance Card. If the situation is determined to be a medical emergency, then the Emergency Assistance Company will direct the Insured Person to the nearest network facility. **(If the Emergency Assistance Company is not contacted prior to treatment then coverage will be denied).**

C. Asia-Pacific Plus Plan

The Asia-Pacific Plus Plan provides coverage for medical treatment within Asia-Pacific Area. In addition, the Asia Pacific Plus Plan provides emergency coverage outside of the Asia Pacific region. In order for emergency coverage outside of the Asia-Pacific region to be eligible for reimbursement, it must first be approved by the Emergency Assistance Company. The Emergency Assistance Company contact information can be found on the Insurance Card. If the situation is determined to be a medical emergency then the Emergency Assistance Company will direct the Insured Person to the nearest network facility. **(If the Emergency Assitance Company is not contacted prior to treatment then coverage will be denied).**

The following specifically applies to the International Plus Plan and the Asia-Pacific Plus Plan:

In situations in which it is not possible to contact the Emergency Assistance Company prior to treatment, the member must then contact the Emergency Assistance Company within 48 hours after the occurrence of the emergency.

For a claim to be payable under the emergency coverage provided under the International Plus Plan or Asia Pacific Plus Plan, it must be a sudden or unexpected onset of a condition requiring medical or surgical care which the Insured Person secures after the onset of such condition (or as soon thereafter as care can be made available, but in any case not any later than twenty-four (24) hours after the onset), and in the absence of which an Insured Person would be expected to suffer severe life-long injury or premature death. An Insured Person's journey to an area where only emergency coverage is provided must not have been against what could be deemed to have been against medical advice, and not be directly or indirectly an intention to seek care or treatment.

Emergency coverage absolutely excludes:

- Routine medical treatment.
- Treatment that could have been postponed until return from the area in which only emergency coverage is provided.
- Treatment that has been planned in advance.
- Treatment arising from circumstances that could have been reasonably anticipated by the Insured Person.
- Maternity treatment (delivery and complications).

The following additional rules apply to Insured Persons under the International Plus Plan and Asia-Pacific Plus Plan:

- The Insurer retains the right to limit or prohibit the use of Providers, which significantly exceed Usual and Customary Charges.
- In the event the Insurer develops a Preferred Provider Network within your geographic location, the Insurer will retain the right to limit treatment to the Preferred Providers.

Schedule of Benefits

All benefits of this Policy are payable in accordance with the Schedule of Benefits in effect at the time the services are rendered. The Schedule of Benefits, which contains payment levels, benefit limitations, benefit maximums and other applicable information, is included and forms part of this Policy. The Insurer reserves the right to modify the Schedule of Benefits from time to time. Receipt of the current Schedule

of Benefits by the Policyholder shall constitute delivery to the Primary Insured. Payment of benefits as set forth in the Schedule of Benefits is subject to the Deductible and Policy Co-payment.

Deductibles and Policy Co-payments The Deductible is the amount paid by each of the Insured Persons for eligible medical treatment expenses on an Annual (per Policy Year) or Per Claim basis. Deductibles are indicated on the Insurance Card and on the Schedule of Benefits.

The Policy Year Out-Of-Pocket Co-payment Maximum is the maximum amount the Insured Person will pay in Policy Co-payments for Covered Expenses during any one Policy Year. The Policy Co-payment is the percentage amount that the Insured Person will pay of Covered Expenses after the Deductible is met. Once the Policy Year Out-Of-Pocket Co-payment Maximum set forth in the Schedule of Benefits is reached, the Policy shall pay 100% of eligible Covered Expenses for the remainder of the Policy Year.

The Policy Year Out-Of-Pocket Co-payment Maximum does not apply to any of the expenses covered under the optional Dental benefits.

- For Asia-Pacific Plus Plan, the Per Claim Deductible can be USD0, USD50, USD100 or USD250.
- For Asia-Pacific Plus Plan, the Annual Deductible can be USD0, USD100, USD500, USD750 or USD1,000
- Family Deductible is always 3 times the individual amount.
- The Insurer currently offers four general Policy Co-payment plans: 0%, 10%, 20% and 30%.
- The Policy Co-payment plans and the respective Policy Year Out-Of-Pocket Co-payment Maximum apply to the first USD15,000 of covered treatment. The Policy Year Out-Of-Pocket Co-payment Maximum for 10%, 20%, and 30% Policy Co-payment plans would be USD1,500, USD3,000, and USD4,500 respectively. The Policyholder may also elect to have no Policy Year Out-of-Pocket Co-payment Maximum. See the Schedule of Benefits.
- You may change your Policy Co-payment plan when you renew your Policy.
- In addition to the Policy Co-payment, there may beadditional co-payments associated with specific benefits, such as Prescription Drug coverage in United States.

Each Insurance Card will show what type of Deductible and Policy Co-payment options have been selected.

Application of Deductibles and Policy Co-payments

The Insurer adjudicates claims in the order in which they are received. When claims are presented to the Insurer, the Allowable Charges will be applied towards the selected Deductible amount and will then be calculated and reimbursed at the percentage listed on the Schedule of Benefits until the Policy Year Out-OfPocket Co-payment Maximum is met by the Insured Person. Once the Deductible and Policy Year Out-OfPocket Co-payment Maximum has been satisfied, all Allowable Charges will be paid at 100% up to the listed maximum amounts outlined in the Schedule of Benefits. Adjudication and reimbursements can only be completed once the Insurer receives a fully completed Claim Form and associated documents. The original receipts (tax invoice if within of Mainland China) and itemized bill(s) showing the date of service and services provided must accompany the Claim Form. The bill(s) must be on the Provider's legal billing receipt and clearly display the Provider's name, address, phone number and Tax ID, when appropriate.

Lifetime Maximum

Certain payment of benefits are subject to a lifetime aggregate maximum per Insured Person as indicated in the Schedule of Benefits, as long as the Policy remains in force. The Lifetime Maximum includes all benefit maximums specified in this Policy, including those specified in the Schedule of Benefits and in any Policy Endorsement.

Pre-existing Conditions

Pre-existing Conditions must be disclosed on a Member Health Statement when requested by the Insurer for health insurance coverage. Pre-existing Conditions may be individually excluded from coverage on either a temporary or permanent basis as a result of the Insurer's underwriting of this Policy. To the extent that a Pre-existing Condition is not excluded during the underwriting process, the following Pre-existing Condition limitations will nonetheless apply:

Newly Hired Employees:

At any time during the Policy Year, newly hired Employees may be insured within 30 days of becoming eligible for coverage and subject to notification from the Policyholder to the Insurer. Such new Employees may be added to the plan with limited or full coverage for Pre-existing Conditions upon presentation of documented Credible Coverage. In the absence of documented prior Credible Coverage, the new Employee will be medically underwritten and may be subject to Waiting Periods for coverage of Pre-existing Conditions and other limitations. See the Pre-existing Conditions section of the Schedule of Benefits for details on your Policy.

The addition of such new Employees may be subject to verification of hire date and employment status and/or any additional documents requested by the Insurer's Enrollment Department.

Existing Employees and Dependents Employers

requesting coverage for an existing Employee after his/her original eligibility date, or after the renewal enrollment period, must submit a Member Health Statement for approval or denial of coverage. The circumstances of the late request will also be taken into consideration. Employees who were eligible during a renewal enrollment period, but who decided not to enroll at that time, cannot be added for coverage until the next renewal period.

Group Migrating To More Or Less Stringent Categories

For groups that reduce in number and move into a category with more stringent limitations on Pre-existing Conditions, the more stringent limitations will apply for new Insured Persons immediately. Should the group grow in size to a category with less stringent limitations on Pre-existing Conditions, the less stringent limitations will apply for all Insured Persons upon renewal of the Policy.

Congenital Conditions

Coverage for Congenital Conditions is for treatment of any Congenital Conditions or birth anomalies and is covered up to the amount stated on the Schedule of Benefits.

Chronic Conditions

All treatment costs for Chronic Conditions are covered up to the amount stated on the Schedule of Benefits. Treatment costs include, but are not limited to:consultations, medication, and Hospital fees.

Catastrophic Illnesses

All treatment costs for Catastrophic Illnesses (as defined in the Definitions section of this Policy) are covered up to the amount stated on the Schedule of Benefits.

Hospitalization and Inpatient Benefits

Hospitalization services include, but are not limited to, semi-private room and board (standard private room if in Cambodia and Mainland China), Inpatient consultation by a Physician and/or specialist, general nursing care and the following additional facilities: services and supplies as Medically Necessary and approved and covered by the Policy, meals and special diets (only for the patient), use of operating room and related facilities, use of intensive care and cardiac units, and related services to include x-ray, laboratory and other diagnostic tests, drugs, medications, biological anesthesia and oxygen services, radiation therapy, inhalation therapy, chemotherapy and administration of blood products. Emergency room services are also covered when Medically Necessary. All Inpatient ancillary benefits are paid in accordance with the Schedule of Benefits.

Surgical Services

The Insurer will provide benefits for covered surgical services received in a Hospital or other approved facility. Surgical services include operative and cutting-procedures, treatment of fractures and dislocations. When Medically Necessary, assistant surgical fees will be paid.

Anesthesia Services

Benefits are provided for the service of an anesthesiologist, including the operating surgeon or his/her assistant, who administers anesthesia for a covered surgical procedure.

Inpatient Care Duration

Inpatient Hospital confinements, where an overnight accommodation, ward, or bed fee is charged, will only be covered for as long as the patient meets the following criteria:

- Admission to the Hospital was Pre-authorized by Us, or was deemed to be an eligible medical emergency by Us;
- The patient's medical status continues to require either acute or sub-acute levels of curative medical treatment, skilled nursing, physical therapy, or Rehabilitation services. We are responsible for this determination of the patient's medical status.

Inpatient Hospital confinements primarily for purposes of receiving non-acute, long term Custodial Care, chronic maintenance care, or assistance with Activities of Daily Living (ADL), are not eligible expenses.

Medical Emergency Services

Medical Emergency Services means services provided in connection with an "Emergency", defined as an injury or illness that is acute, poses an immediate risk to a person's life or long term health and requires immediate medical intervention which the Insured Person secures after the onset of such condition (or as soon thereafter as care can be made available, but in any case not any later than twenty-four (24) hours after the onset).

Inpatient Services

Benefits are provided per the Schedule of Benefits for Medically Necessary Inpatient Hospital care.

1. Accommodations: Coverage is provided for room and board, special diets and general nursing care. All charges in excess of the Allowable semi-private room rate (standard private room if in Cambodia and Mainland China) are the responsibility of the Insured Person.
2. Intensive Care Units: Benefits will be provided based on the Allowable Charge for Medically Necessary Intensive Care services.
3. Companion Bed: A companion bed for a parent accompanying a hospitalized insured child under eighteen (18) years of age and for a baby under sixteen (16) weeks old accompanying a hospitalized female Insured Person is included in coverage.

Inpatient Ancillary Hospital Services

If Medically Necessary for the diagnosis and treatment of the Illness or Injury for which an Insured Person is hospitalized, the following services are also covered:

- Use of operation room and recovery room;
- All medicines;
- Blood transfusions, blood plasma, blood plasma expanders, and all related testing, components, equipment and services;
- Surgical dressings;
- Laboratory testing;
- Durable Medical Equipment;
- Diagnostic x-ray examinations;
- Radiation therapy rendered by a radiologist for proven malignancy or neoplastic diseases;
- Respiratory therapy rendered by a Physician or registered respiratory therapist;
- Chemotherapy rendered by a Physician or Nurse under the direction of a Physician;
- Physical and Occupational therapy (if covered) must be rendered by a Physician or registered physical or occupational therapist and relate specifically to the Physician's written treatment plan.
  Therapy must:
  - Produce significant improvement in the Insured Person's condition in a reasonable and predictable period of time, and
  - Be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed only by a Physician or a registered physical or occupational therapist.
- A Medically Necessary Video Laryngoscope for the diagnosis of a swallowing dysfunction may be per formed by a registered speech therapist.

All Inpatient Ancillary benefits are paid in accordance with the Schedule of Benefits.

Day-care Treatment

Benefits are provided as per Hospitalization and Inpatient benefits when treatment is received as a Day-care patient.

Extended Care Facility Services, Skilled Nursing and Inpatient Rehabilitation

Benefits are available for up to the number of days as outlined in the Schedule of Benefits for a confinement and services provided in an approved Extended Care Facility following, or in lieu of, an Admission to a Hospital as a result of a covered Illness, disability or Injury. Care provided must be at a skilled level and is payable in accordance with the Schedule of Benefits. Intermediate, custodial, rest and homelike care services will not be considered skilled and are not covered.

Coverage for confinement is subject to the Insurer's approval. Covered services include:

- Skilled nursing and related services on an Inpatient basis for patients who require medical or nursing care for a covered Illness.

- Rehabilitation for patients who require suchb care because of a covered Illness, disability or Injury.

Transplant Services

- Medically Necessary blood, organ, bone marrow, or cell transplants will be covered for the recipient medical expenses only on a case-by-case basis.
- All transplant services must be Pre-authorized by Us.
- This coverage applies only when the transplant recipient is an Insured Person under this Policy.
- Donor search and transplant tissue storage fees are not covered.

Mental Health Benefits – Inpatient Services

Benefits are provided for psychotherapeutic treatment and psychiatric counseling and treatment for an approved psychiatric diagnosis and are payable as follows and in accordance with the Schedule of Benefits. Inpatient mental health treatment is covered up to the Policy Year Maximum stated on the Schedule of Benefits. Inpatient Rehabilitation treatment for alcohol and drug abuse is also covered under this Policy, up to the amount stated in the Schedule of Benefits. All Rehabilitation treatment programs must be Pre-authorized.

1. Benefits are provided for Inpatient mental health treatment in a Hospital or approved facility. A Physician or a licensed clinical psychologist must provide all mental health care services.
2. Services include treatment for bulimia, anorexia, Bereavement, non-medical causes of insomnia, Attention Deficit Disorder (ADD), and Attention Deficit Hyperactivity Disorder (ADHD).
3. The following services are excluded:

- Aptitude testing, educational testing and services;
- Services for conditions not determined by the Insurer to be emotional or personality Illnesses;
- Psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation;
- Services for mental disorders or Illnesses which are not amenable to favorable modification;
- Marriage and family counseling.

Hospice Care

Hospice Care is a program approved by the Insurer to provide a centrally administered program of palliative and supportive services to terminally ill persons and their families. Terminally ill means the patient has a prognosis of two-hundred-forty (240) days or less. Services are provided by a medically supervised interdisciplinary team of professionals and volunteers.

Covered services are available in Inpatient settings up to the amount listed on the Schedule of Benefits. Admission to a Hospice program is made on the basis of patient and family need. The Hospice Care:

- Must relate to a medical condition that has been the subject of a prior valid claim with the Claims Administrator, with a diagnosis of terminal Illness from a Physician; and
- Benefit is payable only in relation to care received by a recognized Hospice.

Durable Medical Equipment

The Insurer provides benefits for prosthetic devices (artificial devices replacing body parts), orthopedic braces and Durable Medical Equipment (including wheelchairs and Hospital beds). The Policy will pay the Usual and Customary Charges for artificial devices and prosthetics listed, provided such Durable Medical Equipment (DME) is:

1. Prescribed by a Physician; and
2. Customarily and generally useful to a person only during an Illness or Injury; and
3. Determined by the Insurer to be Medically Necessary and appropriate.

Prosthetics may include, but are not limited to leg, arm, back, and neck braces, artificial legs, arms and eyes. The amount payable is based on the Usual and Customary Charge for the equipment, which meets the Insured Person's basic medical needs.

The Insurer will allow for two breast prosthesis for cancer patients who have a Mastectomy while covered under this Policy. Bras will be a Covered Expense.

Rental fees must not exceed the Allowable purchase price of the Durable Medical Equipment. Benefits are payable in accordance with the Schedule of Benefits.

Charges for repairs or replacement of artificial devices, prosthetics or other Durable Medical Equipment originally obtained under this Policy will be paid at 50% of the Usual and Customary Charge.

Durable Medical Equipment does not include: motor driven wheelchairs or bed; hearing aids; comfort items such as telephone arms and over bed tables; items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); disposable supplies; exercise bikes, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment; and similar items.

Emergency Medical Evacuation

Utilization of the medical evacuation provision requires prior approval from Us. In the event of an emergency that may require medical evacuation, contact the Emergency Assistance Company in advance in order to approve and arrange such Emergency Medical Evacuation. The Emergency Assistance Company, on behalf of the Insurer, retains the right to decide the medical facility to which the Insured Person shall be transported. The Emergency Assistance Company contact information can be located on the Insurance Card.

"Medical Emergency", defined as an injury or illness that is acute, poses an immediate risk to a person's life or long term health and requires immediate medical intervention.

The Insured Person is required to contact the Emergency Assistance Company for Pre-authorization before an Insured Person incurs any evacuation and assistance costs of any transportation. If the Insured Person fails to follow these conditions, he or she will be liable for the full costs of any transportation. The Emergency Assistance Company contact information appears on the back of the Insurance Card.

Certain costs for an accompanying person during an approved Emergency Medical Evacuation are also covered. Hotel fees are covered for the accompanying person up to a maximum amount per night, not to exceed the maximum number of nights per Policy Year as stated on the Schedule of Benefits. The accompanying person must use Economy-class air tickets, in the case of initial transportation to the location of the Insured Person. The cost of Economy-class air tickets to return to the place of Residence is also covered for the Insured Person and the accompanying person.

Outpatient Benefits

When an Insured Person is treated as an Outpatient of a Hospital or other approved facility or Provider, benefits will be paid for facility charges and ancillary services according to the Schedule of Benefits for the following:

1. Treatment of Accidental Injury within forty-eight (48) hours of the Accident, and treatment for a covered Illness;
2. Minor surgical procedures;
3. Medically Necessary covered emergency services, as defined herein.

When Medically Necessary, covered Outpatient costs include, but are not limited to: Outpatient Physician visit, consultation by a specialist, echocardiography, ultrasound, CAT scan, PET scan or MRI, endoscopy (e.g., gastroscopy, colonoscopy, cystoscopy), x-rays, laboratory, chemotherapy, radiotherapy, radiation therapy and respiratory therapy.

Emergency Room

Emergency room services are also covered when Medical Necessary. For non-emergency use of the emergency room, reimbursement is 50% with an out-of-pocket maximum for the Insured Person per incident as stated on the Schedule of Benefits. This out-of-pocket maximum does not count towards the Policy Year Out-Of-Pocket Co-payment Maximum.

Surgical Services

The Insurer will provide benefits for covered surgical services received in a Physician's office or other approved facility. Surgical services include operative and cutting-procedures, treatment of fractures and dislocations. When Medically Necessary, assistant surgical fees will be paid.

Anesthesia Services

Benefits are provided for the service of an anesthesiologist, including the operating surgeon or his/her assistant, who administers anesthesia for a covered surgical procedure.

Medical Emergency Services

Medical Emergency Services means services provided in connection with an "Emergency", defined as an injury or illness that is acute, poses an immediate risk to a person's life or long term health and requires immediate medical intervention.

Outpatient Prescription Drugs

- Prescription Drugs are acovered benefit under this Policy.
- The Deductible and Policy Co-payment apply to this benefit, except in the U.S.
- The maximum length of a supply of a prescription that can be filled at any one time outside of the U.S. is stated on the Schedule of Benefits.

If you choose to purchase a brand-name Prescription Drug when a generic equivalent is available, you will have to pay the difference between the cost of the brand-name Prescription Drug and the generic drug in addition to the Policy Co-payment. This penalty does not apply to prescriptions that your Physician has indicated must be dispensed as written.

In the U.S.:

- A preferred pharmacy network is available in the United States for certain members. Failure to use a network pharmacy will result in additional co-payments. Please refer to **www.mshchina.com** to download a list of participating pharmacies.
- Prescription Drugs filled in the U.S. at a non-network pharmacy are subject to a 20% co-payment, in addition to the Formulary Co-payment, if a preferred pharmacy network is available to you.
- The maximum length of the supply of a prescription that can be dispensed per filling in the U.S. is stated on the Schedule of Benefits.
- There is no maximum out-of-pocket limit for co-payments on Prescriptions Drugs in the U.S.
- The Deductible and Policy Co-payment does not apply to Prescription Drugs in the U.S.

Formulary Co-payments:

Formulary Co-payments are applicable to all Prescription Drugs in the U.S. and are based on the length of the supply as well as the Tier the Prescription Drug falls under. See the Schedule of Benefits for the applicable Formulary Co-payments. The Drug Guide can be found at **www.mshchina.com.**

Prescribed Traditional Chinese Medicine

For Prescribed Traditional Chinese Medicine, the following applies:

- a maximum of USD 50 per visit and 20 visits per Policy Year.

Therapeutic Services

The Insurer will provide benefits for Medically Necessary therapeutic services rendered to an Insured Person as an Outpatient of a Hospital, Provider's office, or approved independent facility. Benefits for facility and professional services for therapeutic services are payable in accordance with the Schedule of Benefits.

Physical therapy, physiotherapy, chiropractic therapy, vocational therapy, speech therapy, and occupational therapy must be provided by a Physician or registered therapist to be covered. Services must be pursuant to a Physician's written treatment plan, which contains short and long term treatment goals and is provided to the Insurer for review. Benefits are payable in accordance with the Schedule of Benefits.
Services must either:

- Produce significant improvement in the Insured Person's condition in a reasonable and predictable period of time; or
- Be of such a level of complexity and sophistication, and/or the condition of the patient must be such that the required therapy can safely and effectively be performed.

A Medically Necessary Video Laryngoscope may be performed by a registered speech therapist for the diagnosis of a swallowing dysfunction.

Alternative Medicine

- Acupuncture and Homeopathy is covered where such is provided as treatment for a covered Illness;
- Treatment is covered only at certified Acupuncture and Homeopathy specialists;
- Benefits are limited to the maximum amount stated on the Schedule of Benefits.

Sleep Studies, Tests and Treatments

Sleep studies, tests and treatments for the suspected conditions of Narcolepsy or Obstructive Sleep Apnea must be Pre-authorized by Us. If approved as Medically Necessary, they will be covered, on a case-by-case basis.

Mental Health Benefits - Outpatient Services

Benefits are provided for psychotherapeutic treatment and psychiatric counseling and treatment for an approved psychiatric diagnosis and are payable as follows and in accordance with the maximum stated on the Schedule of Benefits. Outpatient Rehabilitation treatment for alcohol and drug abuse is also covered under this Policy, up to the amount stated in the Schedule of Benefits. All Rehabilitation treatment programs must be Pre-authorized.

1. Benefits are provided for Outpatient mental health treatment. A Physician or a licensed clinical psychologist must provide all mental health care services.
2. Services of a clinical psychologist must be rendered in the Provider's office or in the Outpatient department of a Hospital.
3. Services include treatment for bulimia, anorexia, Bereavement, non-medical causes of insomnia, Attention Deficit Disorder (ADD), and Attention Deficit Hyperactivity Disorder (ADHD).
4. The following services are excluded:
   • Aptitude testing, educational testing and services;
   • Services for conditions not determined by the Insurer to be emotional or personality Illnesses;
   • Psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation;
   • Services for mental disorders or Illnesses which are not amenable to favorable modification;
   • Marriage and family counseling.

Hospice Care

Hospice Care is a program approved by the Insurer to provide a centrally administered program of palliative and supportive services to terminally ill persons and their families. Terminally ill means the patient has a prognosis of two-hundred-forty (240) days or less. Services are provided by a medically supervised interdisciplinary team of professionals and volunteers.

Covered services are available in home and Outpatient settings up to the amount listed on the Schedule of Benefits. Admission to a Hospice program is made on the basis of patient and family need. The Hospice Care:

- Must relate to a medical condition that has been the subject of a prior valid claim with the Claims Administrator, with a diagnosis of terminal Illness from a Physician; and
- Benefit is payable only in relation to care received by a recognized Hospice.

Private Duty Nursing, Skilled Nursing, Visiting Nurse, Home Health Nursing

Skilled nursing care is a covered benefit for those who require a minimum of four consecutive hours of continuous skilled nursing care per day. Skilled nursing care is defined as prescribed care that can only be provided by a licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) which is Medically Necessary to treat or ameliorate identified medical conditions on a temporary, limited basis.

Pre-authorization by Us is required. These service need to meet specified medical and circumstantial criteria to be covered. Thorough case manager review is required.

Home health care benefits are provided for the following:
- Home nursing by skilled Nurses immediately following treatment as an Inpatient on Physician recommendation; and
- Up to the maximum number of days stated on the Schedule of Benefits; and
- Benefits are only available where treatment by a Physician is taking place, exceptionally and out of necessity, in the Insured Person's home; and
- It is payable only when all charges are reasonable and necessary and are exclusively for exercising nursing skills of which only skilled Nurses are capable.

The Insurer considers private duty home nursing Medically Necessary as set forth below.

1. Subject to applicable Policy terms and limitations, the Insurer considers home nursing care Medically Necessary when recommended by the Insured Person's primary care and/or treating Physician and both of the following circumstances are met:
   • The Insured Person has skilled needs; and
   • Placement of the Nurse in the home isdone to meet the skilled needs of the Insured Person only. It is not for the convenience of the family caregiver.
2. In most cases, more than twelve (12) hours per day of skilled nursing care is not considered Medically Necessary. However, more than twelve (12) hours per day of skilled nursing care may be considered Medically Necessary in any of the following circumstances:
   • The Insured Person is being transitioned from an Inpatient setting to his/her home; or
   •The Insured Person becomes acutely ill and the additional skilled nursing care will prevent a Hospital Admission; or
   •TheInsuredPersonmeets the clinicalcriteria for confinement in a skilled nursing facility (SNF), but a SNF bed is not available. In this situation, additional skilled nursing may be provided until a SNF bed becomes available.

Ongoing skilled home nursing care is not considered Medically Necessary for Insured Persons who are on bolus nasogastric (NG) or gastrostomy tube (GT) feeds and do not have other skilled needs. Home nursing care may be considered Medically Necessary for these members only as a transition from an Inpatient setting to the home.

Durable Medical Equipment

The Insurer provides benefits for prosthetic devices (artificial devices replacing body parts), orthopedic braces and Durable Medical Equipment (including wheelchairs and Hospital beds). The Policy will pay the Usual and Customary Charges for artificial devices and prosthetics listed, provided such Durable Medical Equipment (DME) is:
1. Prescribed by a Physician; and
2. Customarily and generally useful to a person only during an Illness or Injury; and
3. Determined by the Insurer to be Medically Necessary and appropriate.

Prosthetics may include, but are not limited to leg, arm, back, and neck braces, artificial legs, arms and eyes. The amount payable is based on the Usual and Customary Charge for the equipment, which meets the Insured Person's basic medical needs.

The Insurer will allow for two breast prosthesis for cancer patients who have a Mastectomy while covered under this Policy. Bras will be a Covered Expense.

Insulin pumps and supplies, glucose test strips, and other Medically Necessary diabetic supplies are also included in coverage.

Rental fees must not exceed the Allowable purchase price of the Durable Medical Equipment. Benefits are payable in accordance with the Schedule of Benefits.

Charges for repairs or replacement of artificial devices, prosthetics or other Durable Medical Equipment originally obtained under this Policy will be paid at 50% of the Usual and Customary Charge.

Durable Medical Equipment does not include: motor driven wheelchairs or bed; hearing aids; comfort items such as telephone arms and over bed tables; items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); disposable supplies;

exercise bikes, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment; and similar items.

Emergency Ground Ambulance

Benefits are provided for Medically Necessary emergency ground ambulance transportation to the nearest Hospital able to provide the required level of care and are payable in accordance with the Schedule of Benefits.

If the Insured Person could have been transported in a private car, whether or not one was available, then costs for ground ambulance transportation are not covered.

Emergency Dental

- Emergency Dental Treatment necessary to restore or replace sound natural teeth damaged in an Accident is covered under this Policy. Sound teeth do not include teeth with previous crowns, fillings, or cracks.
- Damage to teeth caused by chewing foods does not qualify for coverage under this benefit.
- Benefits are limited to the amount stated on the Schedule of Benefits.
- Routine dental treatment is not covered unlesspurchased as an Optional benefit.

Maternity Related Benefits

1. The following maternity benefits are covered as outlined in the Schedule of Benefits and are applicable to any condition related to pregnancy, including but not limited to childbirth, anesthesia, prenatal care, miscarriage, Medically Necessary C-section, Complications of Pregnancy, and premature birth. These benefits are only available to the Primary Insured or insured spouse (or domestic partner). Maternity benefits for an Insured Dependent daughter are not included under this Policy.

- Pre-natal vitamins are covered during the term of the pregnancy only, if prescribed by a Physician;
- Ultrasounds are covered.

Obstetrical services are covered and are limited to:

- Hospital services rendered in a licensed Hospital or approved Birth Center (including anesthesia, delivery, pre-natal and post-natal check-up) for any condition related to pregnancy, including but not limited to childbirth and miscarriage.
- Obstetrical services (including prenatal, delivery and post-natal care) and anesthesia services by Physicians.

2. Newborn Infant Care Services:

- Newborn infants of a covered pregnancy are automatically covered without notification for the first fourteen (14) days up to the amount stated on the Schedule of Benefits. Charges for Hospital nursery services and professional services for the newborn infant are covered separately from the insured mother's Maternity benefits and are subject to the satisfaction of the Deductible and Policy Co-payment amounts in accordance with the Policy and the Schedule of Benefits.
- Hospital nursery servicesand medical care provided by the attending Physician for newborn infants in the Hospital are not subject to the maximum stated on the Schedule of Benefits if the notification to enroll the baby is received by the Insurer within thirty (30) days of birth.

3. Well Baby Care - includes child immunizations and routine medical exams up to the number of visits and during the time period stated on the Schedule of Benefits and is subject to the Deductible and Policy Co-payment.

- Included well child routine medical exams and child preventive care services: health history, development assessments, physical examinations, and age related diagnostic tests.
- Child immunizations include: diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, haemophilus influenza B, hepatitis A and other Medically Necessary pediatric immunizations.

Repatriation of Mortal Remains

The necessary clearances for the return of an Insured Person's mortal remains by air transport to the Home Country will be coordinated by the Emergency Assistance Company.

A benefit up to the amount stated on the Schedule of Benefits for either repatriation of mortal remains or local burial is included under this Policy.

Group Optional Benefits

War and Terrorism Benefit – Optional

This Policy covers bodily Injury directly or indirectly caused by certain acts of War and Terrorism subject to the terms and conditions described below.

The following limited War and Terrorism coverage is included if stated on the Schedule of Benefits, and up to the amounts stated on the Schedule of Benefits:

This benefit is subject to all Policy Exclusions, limitations and conditions, including any applicable Deductibles and Policy Co-payments. Notwithstanding any provision to the contrary within this Policy, or any Policy Rider attached thereto, it is agreed that coverage under this Policy is extended to include bodily Injury directly or indirectly caused by, resulting from, or in connection with any of the following;

1. War, hostilities or warlike operations (whether war be declared or not);
2. Invasion;
3. Act of an enemy foreign to the nationality of the Insured Person or the country in, or over, which the act occurs;
4. Civil war;
5. Riot;
6. Rebellion;
7. Insurrection;
8. Revolution;
9. Overthrow of the legally constituted government;
10. Civil commotion assuming the proportions of, or amounting to, an uprising;
11. Military or usurped power;
12. Explosions of war weapons;
13. Murder or assault subsequently proved beyond reasonable doubt to have been the act of agents of a state foreign to the nationality of the Insured Person whether war be declared with that state or not;
14. Terrorist activity.

Exclusions

Benefits will not be available for the following:

1. The Insured Person's active participation in or training for any, or all, of items (1) to (14) described above;

2. When the circumstances of items (1) to (14) as described above are the result of the utilization of nuclear, chemical or biological weapons of mass destruction howsoever these may be distributed or combined.

Wellness Benefits - Optionalal

If the Policyholder purchases the optional Wellness benefits, these benefits will be included:

- The Policy Year maximum per Insured Person is stated on the Schedule of Benefits, as selected by the Policyholder.
- The costs of a full physical examination and the tests and procedures associated with such examination, are covered per Policy Year, not to exceed the Policy Year maximum for the Wellness benefit.
- Immunizations, routine tests and exams.
- The Deductible and Policy Co-payment does not apply to treatment received as part of the optional Wellness benefits.

Dental Benefits - Optional

The benefits described in this section apply only if the Policyholder has elected to include optional Dental benefits. Dental benefits are not subject to the Deductible or Policy Co-payment of the health plan.

The expenses described in the three classes below are reimbursed subject to an annual maximum indicated in the Schedule of Benefits.

Class I Dental Services - Preventive

The Policy pays the percentage of Usual and Customary Charges indicated in the Schedule of Benefits for necessary diagnostic examinations and preventive treatment. Covered Expenses include:

- Routine examinations;
- Dental health instruction;
- Fluoride treatment;
- Scale and polish (prophylaxis);
- Cleaning of teeth (oral prophylaxis) up to two (2) times per Policy Year.

Class II Dental Services - Basic Restorative

The Policy pays the percentage of Usual and Customary Charges indicated in the Schedule of Benefits for Medically Necessary basic restoration, endodontic, periodontal treatments and oral surgery. Covered Expenses include:

- Amalgam or composite fillings;
- Simple extractions;
- Periodontal scaling;
- Root planing.

Class III Dental Services - Major Restorative

The Policy pays the percentage of Usual and Customary Charges indicated in the Schedule of Benefits for Major Restorative treatment including:

- Root fillings;
- Crowns and inlays;
- Bridges (including laboratory and anesthetic fees);
- Wisdom teeth extractions;
- Orthodontic treatment - study models (including pan oral x-rays), impressions, removable string appliances (braces), fixed appliances (including adjustments), extractions, re-cementing of brackets.

Dental Exclusions

- Cosmetic surgery or supplies or procedures;
- False teeth;
- Dental Implants;
- Onlays;
- Veneers and all associated costs.

Vision Benefits - Optional

If the Policyholder purchases the optional Vision benefits, the following benefits will be included. Maximum amounts are stated in the Schedule of Benefits. Benefits are not subject to the Deductible or Policy Co-payment of the health plan.

- Examination (one per Policy Year)
- Insured Persons are eligible for either one (1) pair of glasses, or contact lenses. For disposable contact lenses, multiple pairs may be reimbursed, in aggregate not to exceed the maximum amount stated in the Schedule of Benefits.

Exclusions:

Sunglasses and/or related accessories.

Individual Optional Benefits

Supplemental Benefits Package - Optional

If the Policyholder purchases the optional Supplemental Benefits Package, the following benefits will be included.

Wellness Benefits

- USD250 per Policy Year maximum.
- The costs of a full physical examination and the tests and procedures associated with such examination, are covered per policy Year, not to exceed the Policy Year maximum for the Wellness benefit.
- Immunizations, routine tests and exams.
- The Deductible and Policy Co-payment does not apply to treatment received as part of this benefit.

Dental Benefits

Insured Persons will receive 50% reimbursement on all dental treatment described below, up to USD320 per Policy Year. Coverage:

Preventive Treatment

includes routine examination, dental health instruction, fluoride treatment,scale and polish (prophylaxis). Two routine cleanings per Policy Year are included in coverage.

Basic Restorative

includes amalgam or composite fillings, simple extractions, periodontal scaling, and root planing.

Major Restorative

includes root fillings, crowns and inlays, bridges (including laboratory and anesthetic fees), wisdom teeth extractions.

Dental Exclusions

Cosmetic Treatment (not Medically Necessary), orthodontic treatment, false teeth, dental implants, on-lays, veneers and all associated costs.

Exclusions and Limitations

The following services, conditions and other items are excluded from coverage under this Policy:

1. Treatment of excluded Illnesses and related conditions by the Insurer, and non-declared Pre-existing Conditions of the Insured Persons requested by the Insurer to submit a Member Health Statement.

2. Services, treatments or supplies for conditions subject to designated “Waiting Periods” as set forth in the Policy and on the Schedule of Benefits or Policy Rider.

3. Services and supplies, which are deemed by the Insurer to be Experimental or Investigational.

4. Any services or benefits provided by or available under any Workers' Compensation law, Occupational Disease law or similar law concerning job related conditions of any country; Treatment, services, benefits, supplies, drugs and/or Emergency Medical Evacuation services payable by another insurance company, charity or government.

5. Services, supplies or treatment provided by the Insured Person, a family member of the Insured Person, or any enterprise owned partially or completely by the aforementioned persons.

6. Reimbursement for photocopies and any other non-medical non-covered expenses; Telephonic consultations or missed appointments; Any services not ordered by a Physician or not necessary for medical care, as well as medical and dental services that do not meet professionally recognized standards or are determined by the Insurer to be unnecessary for proper treatment; Treatment, services, benefits, supplies, drugs and/or Emergency Medical Evacuation services that are not Medically Necessary, not recommended or approved by a doctor or not recommended/approved by a doctor or not rendered within the scope of a doctor's license; Charges in excess of the Usual and Customary Charges for any covered procedure.

7. Injuries and/or Illnesses resulting or arising from or occurring during the commission or perpetration of a violation of law by an Insured Person; All self-inflicted Illnesses or Injuries, suicide or attempted suicide, while sane or insane, or Emergency Medical Evacuation services for the same.

8. Personal comfort and convenience items, including but not limited to: television, private rooms and suites, housekeeping services, guest meals and accommodations, telephone charges, take home supplies, travel expenses, ambulance services, nurse hired during hospitalization for personal care, and all other services and supplies that are not Medically Necessary, other than those provided for by benefits under this Policy.

9. Claims and costs for medical treatment occurring after the expiration date of the Policy, resulting from Accidents, Illnesses, or Maternity Care during the Policy Year period, unless the Policy has been renewed, including any portion of a covered prescription to be used after 90 days beyond the expiration date for the Worldwide Plan and 30 days for other Plans.

10. Health check-ups, vaccinations/immunizations, visits, and tests necessary for administrative purposes (e.g., determining insurability, employment, school or sport-related physical examinations), other than provided for under the Well Baby Care benefit or optional Wellness benefit; Travel and hotel expenses related to medical or dental care, unless provided for under a specific benefit in this Policy.

11. Over-the-counter (OTC) drugs or supplies not required by a Physician prescription, smoking cessation drugs, appetite suppressants, hair regenerative drugs, anti-photo aging drugs, cosmetic and beauty aids, megavitamins, vitamins (other than prenatal as described under Maternity Related benefits); Traditional Chinese Medicine for general health improvement; Chinese herbal paste; Any herb processing charge related to powder making, pill, capsule, paste, mastic and other preparation making.

12. Radiation therapy, chemotherapy, physical therapy, American chiropractic treatment, occupational therapy or speech therapy without the recommendation of a Physician, except for emergency cases and when Physicians are fully aware of the Insured Person's need of such treatment.

13. Services and supplies related to visual therapy, radial keratotomy procedures, lasik, or eye surgery to correct refractive error or deficiencies; Services or treatment for myopia or presbyopia.

14. Rest cures, Respite Care, Custodial Care or homelike care, whether or not prescribed by a Physician; Care in a nursing home or home for the aged; Milieu therapy for rest and/or observation; Services or treatment in any long term care facility, spa, hydro clinic, Rehabilitation institution, sanatorium or home for the aged that is not a Hospital as defined in this Policy; Hospital costs if the Hospital effectively becomes, or could be treated as, being the Insured Person's home or permanent abode; Hospital costs where Admission to the Hospital is arranged wholly or partly for domestic reasons.

15. Elective surgery and procedures, treatment and/or surgery, that is not Medically Necessary, as defined by a qualified, licensed medical practitioner; Treatment that is provided for the sole purpose of improving or enhancing the quality of an existing condition and does not meet the definition of Medically Necessary treatment.

16. Services or supplies for aesthetic treatment and cosmetic treatment whether or not for psychological purpose, including dental treatment.

17. Treatment or removal of benign skin lesions not demonstrating evidence of suspicious cellular activity such as, but not limited to, recent changes in size, shape or color; Treatment of Vitiligo; Treatment of, or surgery for, superficial varicose veins that are not Medically Necessary, spider veins, non-keloid scars, tattoo removal, or other skin discolorations.

18. Charges for breast reduction or augmentation and any complications arising from such procedures.

19. Treatment of hair loss including, but not limited to: hairplasty for male pattern alopecia or any alopecia; the temporary or permanent removal of hair by laser, electrolysis, waxing, or any other means; hair transplants to correct permanent hair loss that is clearly caused by disease or Injury, for male pattern baldness, or age related thinning in women.

20. Smoking cessation treatments whether or not recommended by a Physician; Weight reduction and the cost of any and all treatments for weight reduction or weight reduction programs; Medical fast diets, weight loss programs and educational dietary counseling related to weight loss efforts; Health care services and associated expenses related to or associated with treatment of morbid or non-morbid obesity, including, but not limited to: gastric bypass, gastric balloons, gastric stapling, jejunal ileal bypass, and any other procedures or complications arising therefrom.

21. Organ transplants and related procedures except as specified in the Transplant Services section of this Policy; All donor expenses, donor search and transplant tissue storage fees are excluded; All expenses of any cryopreservation and the implantation or reimplantation of living cells, or in conjunction with infertility or reproductive treatments, are not covered by the Policy; Medically Necessary organ, blood, or cell transplants will be covered on a case-by-case basis when Pre-authorized by Us.

22. Any fertility/infertility services, tests, treatments and/or procedures of any kind, including, but not limited to: fertility/ infertility drugs, artificial inseminations, in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), surrogate mother and all other procedures and services related to fertility and infertility; Any pregnancy resulting from such treatments, complications of that pregnancy, delivery and postpartum care are also excluded; Resulting children born due to such procedures/treatment are subject to full underwriting with no automatic enrollment.

23. Genetic counseling, screening, testing or treatment.

24. Infertility, other than for reasonable costs of investigations into the causes of infertility or repeated miscarriage where the Insured Person:
• Has been continuously covered by the Insurer for at least two years at the time of incurring such costs; and
• Has been unaware of the existence of infertility at the date of enrollment and has not received any form of assisted reproduction.

25. Elective abortions and complications thereof.

26. Male and female birth control; Vasectomies and sterilization or any expenses for their reversal; Sex changes or implantations; Treatment for sexual transformation, sexual dysfunctions or inadequacies; Circumcisions and related fees; Maternity/delivery preparation classes; Elective C-sections; “Viagra” or other sexual enhancement drugs and their respective generic equivalents.

27. Pregnancy and related conditions for a Dependent child.

28. Alcoholism, solvent abuse, drug abuse or addictive conditions of any kind, and treatment of any Illness or Injury arising directly or indirectly from alcohol or drug abuse or addiction.

29. Treatment for any Injuries and Illnesses caused by, contributed to or resulting from the Insured Person’s use of alcohol, illegal drugs, or any drugs or medicines that are not taken in the dosage or for the purpose prescribed by the Insured Person’s Physician.

30. Eyeglasses and contact lenses, except under the optional Vision benefits.

31. Unless optional Dental benefits have been purchased, dental coverage is limited to Accidental Injury of sound, natural teeth sustained while covered under this Policy. Accidental Injury does not include damage to teeth incurred while chewing food or foreign objects.

32. Instructions for the use and care of Durable Medical Equipment; Customizing any vehicle, bathroom facility or residential facility; Costs of all over-the-counter medical devices; Motor driven wheelchairs or bed; Hearing aids; Comfort items such as telephone arms and over bed tables; Items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners); Disposable supplies; Exercise bikes, sun or heat lamps, heating pads, bidets, toilet seats, bathtub seats, sauna baths, elevators, whirlpool baths, exercise equipment; and similar items.

33. Prosthesis and corrective devices which are not medically required intra-operatively or equivalent appliances, except prosthesis or Durable Medical Equipment used as an integral part of treatment prescribed by a Physician.

34. Orthopedic shoes or other supportive devices for the feet, such as, but not limited to, arch supports and orthotic devices or any other preventative services and supplies; any devices resulting from the diagnosis of weak, strained, unstable or flat feet or fallen arches; or any tarsalgaia, metatarsalgia; or specified lesions of the feet, such as calluses, and hyperkeratosis, except for operations which involve the exposure of bones, tendons, or ligaments.

35. Routine podiatry or other foot treatment not resulting from an Illness or Injury.

36. All services, supplies, Emergency Medical Evacuation services and/or treatments, under the direction of public authorities, related to epidemics.

37. Growth hormones, unless Medically Necessary and Pre-authorized by Us.

38. Health care services associated with conditions as a result of traveling against medical advice.

39. Exceptional Risks

• Treatment as a consequence of Injury sustained while participating in or training for any professional sport.
• Treatment as a consequence of Injury sustained as a consequence of: war (declared or not), acts of Terrorism, acts of foreign enemy hostilities, civil war, rebellion, revolution or insurrection, except as described under the optional War and Terrorism benefit.
• Contamination by radioactivity from any nuclear material or from the combustion of nuclear fuel.
• Treatment for any loss or expense of whatsoever nature directly or indirectly arising out of, contributed to, caused by, resulting from, or in connection with needless self-exposure to peril or bodily Injury, except in an endeavor to save human life.

40. Under Inpatient and Outpatient Mental Health benefits, the following services are not covered:
• Aptitude testing, educational testing andservices;
• Services for conditions not determined by the Insurer to be emotional or personality Illnesses;
• Psychiatric services extending beyond the period necessary for evaluation and diagnosis of mental deficiency or retardation;
• Services for mental disorders or Illnesses which are not amenable to favorable modification;
• Marriage and family counseling.

How to File a Claim

Claims Procedure

1. Claims Procedure

The Claim Form is used only when a Provider does not bill the Insurer directly, and when the Insured Person has out-of-pocket expenses to submit for reimbursement.

Claim Forms are downloadable from **www.mshchina.com**. The company can also send Claim Forms by fax or e-mail, upon request. Please ensure that the Claim Form is fully completed by the Insured Person and the treating physician. All Claim Forms must have itemized bills and original receipts (tax invoices if within Lao P.D.R.) attached, and should include the following information:

- Name of patient.
- Printed invoice number.
- Name and entity of medical practitioner or institution.
- Description of services rendered.
- Prescriptions must accompany all pharmacy bills.

Submit all claim documents to the designated address. The Insurer must receive completed forms within 180 days of treatment to be eligible for reimbursement of Covered Expenses. Such original documents will belong to the Insurer.

The Insurer shall have the right and opportunity to ask the Insured Person to take a physical check-up. The Insured Person shall provide all medical reports and records, and where required, shall sign all authorization form necessary to give the Insurer authority to get a full and complete medical history. The Insurer shall have the right and the opportunity to require an autopsy in the case of death, unless forbidden by law of religious beliefs.

2. Fraudulent Claims If any claim under this Policy is in any respect fraudulent of unfounded, all benefits paid and/or payable in relation that claim shall be forfeited and, if appropriate, recoverable. The Company reserves the right to cancel any Policy or terminate a Primary Insured's (and/or eligible Dependent's) membership or subject his/her coverage to different terms if the Insured Person agreed to attempt by a third party to obtain an unreasonable pecuniary advantage to our detriment.

Claim Payment

Once the Company receives a fully completed Claim Form and associated documents, it will adjudicate the claim in 5 business days. In complicated conditions, the adjudication will be done in 30 business days.

If the Deductible and Policy Year Out-Of Pocket Co-payment Maximum has been satisfied, all Allowable Charges will be paid in 10 days. If the claim is not processed on time, the Insured Person will be compensated for the loss and the Allowable Charges.

If the expenses are not covered under the Policy, the Company will send an explanation of denied claim in 3 business days after the adjudication.

The benefit will be paid within 60 days from the receipt of a fully completed claim form and the associated documents. For incomplete conditions, the balance will be paid after the final adjudication.

Status of Claims

Insured Persons wishing to request the status of a claim or have a question about a reimbursement received, please e-mail us at **mediplus@mshchina.com.**
Inquiries regarding the status of past claims must be received within 12 months of the date of service to be considered for review.

Claims Appeals

If at any time you do not agree with the outcome of a processed claim, you may submit a written appeal with supporting documents attached to **ClaimAppeal@mshchina.com.** Appeals should be submitted within 60 days of receiving the result of your processed claim. Upon appeal, the Insured Person will pay any fees associated with the request of medical records. The Appeals Committee will review your information and provide a response.

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ASSURANCE

MSH CHINA