AXA TIANPING INDIVIDUAL COMPREHENSIVE MEDICAL INSURANCE POLICY WORDING (C 2021 Edition)

Registration ID: C00007832512021070605391

Chapter I General Conditions

Article 1 Entire Policy

This Insurance Policy (hereinafter referred to as "this Policy") consists of Policy Wording, **Application Form** (Interpretation 1), **Schedule** (Interpretation 2) or **Endorsement** (Interpretation 3). Any agreement concerning this Policy shall be made in writing.

Article 2 Formation of the Policy

This Policy is formed upon the application by the **Policyholder** (Interpretation 4) for this insurance and acceptance by the **Company** (Interpretation 5) of such application.

Article 3 Policyholder

The Policyholder hereof shall be the Insured having full capacity for civil conduct or other persons having an insurable interest in the Insured.

Article 4 Insured Person(s)

Any natural person who is physically healthy and is able to work and live normally and meets the following requirements is, with the consent of the Company, eligible for the coverage under this Policy as Insured. The Insured hereof includes **Main Insured** (Interpretation 6) and Dependant Insureds. The **Spouse** (Interpretation 7) and **Child/Children** (Interpretation 8) of the Main Insured are eligible for the coverage under this Policy as Dependant Insureds. Except specifically stated, the references to the Insured Person in the following clauses are fully applicable to the Main Insured and Dependant Insureds.

(1) The initial enrollment **Age** (Interpretation 9) of the Main Insured shall be 18 to 74 years old. Where the spouse and the child/children are Dependent Insureds, the initial enrollment age of the spouse shall be 18 to 74 years and that of the child/children shall be 15 days after birth to 18 years old (Age Last Birthday).

(2) At the time of placement of policy, the **Usual Country of Residence** (Interpretation 10) of the Insured Person shall be Mainland China, viz. the Insured Person has resided in Mainland China for more than 185 days in one year. Where the Insured Person is not Chinese, the Insured Person shall hold the work permit issued by the Chinese government or the residence permit or the right of permanent residence in China and provide a permanent residential address in China.

Article 5 Beneficiary

The beneficiary of benefits hereunder is the Insured Person, except as otherwise provided by law or otherwise stated in this Policy.

Article 6 Period of Insurance

The period of insurance of this Policy is up to one year with the commencement date and expiry date as set forth in the Schedule or Endorsement.

Article 7 Sum Insured

The sum insured is the maximum limit of the benefits payable by the Company. The sum insured hereof is agreed by the Policyholder and the Company and specified in the Schedule. The sum insured shall not, once determined, be altered during the Period of Insurance.

Article 8 Deductible and Co-payment

Deductible is the amount to be borne or paid by the Insured Person and for which the Company is not liable to pay the corresponding claims under the Policy. The deductible of this Policy shall be agreed by the Policyholder and the Company, and shall be specified in the Schedule or Endorsement.

Co-payment is the percentage of the medical costs to be borne or paid by the Insured Person after application of the deductible.

Article 9 Payment of Premium

The amount of premium is calculated based on each Insured Person's age at the commencement of the period of insurance, the applicable rates adopted by the Company at the commencement of the relevant period of insurance and the factors with potential substantial influence on the risk covered.

Subject to the terms and conditions of this Policy, the Policyholder shall pay the premiums in full to the Company prior to the effective date of this Policy stated in the Schedule or the Endorsement.

In the event that Policyholder fails to pay the premiums as stipulated in this Policy, this Policy shall not take effect. The Company shall not be liable for the insured event that occurs before entry into force of this Policy, except where with the consent of the Company, the premium needs to be paid later than the payment date specified in this Policy due to the regulation governing foreign currency payment.

Article 10 Renewal

(1) **This Policy is a non-guaranteed renewal contract. The period of insurance is a year (or less than a year). Upon expiration of the Period of Insurance, the Policyholder needs to file a new application to the Company, pay premiums, and obtain a new insurance policy after the Company approves the renewal.**

The Policyholder may apply for renewal to the Company and pay the renewal premium at or before the expiration of the Period of Insurance of this Policy to indicate renewal. If the Company approves the renewal and issues the insurance policy and has received the renewal premium, the new insurance policy shall be formed and take effect.

(2) At the time of renewal, the Policyholder may alter the coverage or covered territory of the insurance policy.

(3) In the event of any **Illness** (Interpretation 11) or **Accidental Injury** (Interpretation 12) occurring, confirmed or lasting during the period of insurance of the renewed policy, which is directly or indirectly caused by the **Disability** (Interpretation 13) or accident confirmed or lasting during the previous period of insurance, **the sum insured for the Disability shall be subject to the sum insured of the previous policy or the sum insured of the renewed policy, whichever is the lower.**

(4) **Under any of the following circumstances, the Company shall not accept renewal:**

1. This insurance product is uniformly discontinued;
2. The Insured fails to perform the obligation of truthful disclosure with respect to the inquiries made by the Company about the Policyholder or the Insured;
3. The insurance policy before renewal has been terminated before the expiration of the Period of Insurance;
4. Death of the Insured, change of the Insured's Usual Country of Residence, the age of the Insured exceeds the age range as stipulated herein and other circumstances which do not meet the terms and standards of acceptance of this product.

Article 11 Waiting period

The period commencing from the effective date of this Policy or the first day when the Insured is eligible for coverage hereof (whichever is later) as agreed by the Policyholder and the Company, and set forth in the Schedule or the Endorsement, up to 180 days. If the Insured suffers from illness during this period, the Company shall not be liable for the payment of insurance benefits. If the period of insurance of the renewed insurance policy and that of the insurance policy of the previous year is uninterrupted in time, the waiting period will not be recounted for the renewed insurance policy; otherwise, the waiting period will be recounted.

Article 12 Cooling-off Period

The Policyholder has **a cooling-off period of fourteen (14) workings days** as of receipt of this Policy to review this Policy. If the Policyholder determines that this Policy does not suit his/her needs, the Policyholder may request to cancel the Policy by giving the clear, written instructions to the Company and returning the policy, the membership card and related materials issued by the Company to the Company by mailing. **The Company shall refund the premiums in full without interest within thirty (30) days upon receipt of the notice of termination, whereupon this Policy shall become invalid and the Company shall cease to bear any insurance liability. This cooling-off period shall not apply to the addition of other Dependant Insureds by the Policyholder during the Period of Insurance of the Main Insured.**

Chapter II Coverage

Article 13 Covered Territory

The Company offers the following three covered territories: global, international and China programs, which are determined by the Insured and the Company at the time of placement through negotiation and stated in the Policy.

(1) Global program

The covered territory is any country or region in the world.

(2) International program

The covered territory is any country or region in the world other than the United States.

(3) China program

The covered territory is within the territory of the People's Republic of China (including Hong Kong, Taiwan and Macau).

The covered territory for the Dependant Insureds shall be equal to or less than that of the Main Insured.

Article 14 Insuring Agreement

During the Period of Insurance hereof, if the Insured Person sustains any accidental injury or contracts any illness and seeks treatment from the **Hospital** (Interpretation 14) as stipulated herein in the covered territory, the Company shall be, subject to the terms and conditions of this Policy, liable for the **Reasonable and Necessary** (Interpretation 15)medical charges actually incurred and paid by the Insured Person, up to the sum insured, after deducting the deductible and co-payment as set forth in the Schedule, unless otherwise specified herein.

(I) Inpatient and day surgery/daycare treatment

The reasonable and necessary medical charges incurred by the Insured Person as **Inpatient** (Interpretation 16), patient receiving **Day Surgery** (Interpretation 17) or **Daycare Treatment** (Interpretation 18) are covered by the Company pursuant to Item 1-15 below.

1. Inpatient bed fees and meal charges

The accommodation charges for **Standard Private Room** (Interpretation 19), meal and routine nursing service charges.

2. Intensive care unit charges

Charges for admission to **Intensive Care Unit** (Interpretation 20), cardiac care unit and other similar units or wards.

3. Miscellaneous hospital charges

(1) Prescription drug costs

The costs of the drugs prescribed by a **Physician** (Interpretation 21) during inpatient treatment and on the date of discharge, with the dosage up to one hundred twenty (120) days as of the date of discharge.

(2) Inpatient laboratory examination costs

The laboratory examination costs incurred by the Insured Person during inpatient treatment.

(3) Nursing, operation materials and miscellaneous expenses

The expenses of routine nursing, operation materials and miscellaneous expenses incurred during

inpatient treatment.

(4) Operating room fees

The charges for using the operating room during the **Surgery** (Interpretation 22) or day surgery.

4. Ambulance charges

The charges for medically necessary ambulance services received by the Insured Person in traveling to and from the hospital in the event of inpatient treatment due to illness or accidental injury.

5. Inpatient physiotherapy charges

Inpatient physiotherapy charges arising from or in connection with illness or accidental injury on the part of the Insured Person.

6. Operation-related charges

The charges of surgical operation or day surgery carried out by a **Surgeon** (Interpretation 23) including operation fee, surgical instruments, blood and plasma, implants.

7. Anesthesia charges

The charges for anesthesia carried out by the **Anesthetist** (Interpretation 24) in surgical operation or day surgery.

8. Inpatient attending physician charges

The charge for daily rounds by the attending physician during inpatient treatment of the Insured Person, limited to one (1) round per day by each physician.

9. Home nursing charges

The expenses incurred by the Insured Person when receiving home nursing provided by a **Registered Nurse** (Interpretation 25) and meeting the following conditions:

(1) The home nursing is indeed **Medically Necessary** (Interpretation 26) as proved by the attending physician;
(2) The Insured Person needs to continue to stay in hospital without home nursing;
(3) The home nursing is carried out at the Insured Person's home;
(4) The home nursing is carried out immediately after the Insured Person is discharged from the hospital.

This cover is limited to ninety (90) days of nursing for each disability.

10. Immediate family accommodation charges

The accommodation charges incurred by a member of **Immediate Family** (Interpretation 27) of the Insured Person at the hospital and meeting the following conditions:

(1) At the time of admission, the Insured Person is under 12 years of age or over 60 years of age;

(2) The Insured Person need to be hospitalized for more than 6 days due to illness or accidental injury;
(3) Immediate family accommodation is necessary as proved by the attending physician in writing;
(4) The accommodation charge standard is the cost of placing an extra bed for a member of immediate family in the one and same room.

This cover is limited to ninety (90) days of nursing for each disability.

11. Inpatient rehabilitation (Interpretation 28) **cost**

The costs incurred by the Insured Person receiving rehabilitation treatment and meeting the following conditions, **the maximum number of days of payment for each insurance year is subject to the limit set forth in the Schedule:**

(1) The illness or physical injury giving rise to rehabilitation is covered by this Policy and is medically necessary as part of the treatment as certified in writing by the specialist;
(2) Performed by a professional rehabilitation physician;
(3) The written consent of the Company has been obtained before the Insured Person begins to receive rehabilitation treatment.

12. Consultation charges before admission or day surgery

The charges of seeking consultation(including medication) from a physician with respect to the hospitalization or day surgery disease/injury within ninety (90) days before hospitalization or day surgery.

This cover is limited to one consultation for each disability before admission or day surgery.

13. Laboratory examination charges before admission or day surgery

The charges of examination and test as recommended by the physician in writing with respect to the hospitalization or day surgery disease/injury within ninety (90) days prior to hospitalization or daytime surgery.

This cover is limited to one laboratory examination for each disability before admission or day surgery.

14. Post-discharge or post-day surgery treatment charges

The cost of follow-up diagnosis and treatment provided by the physician within ninety (90) days from the date of discharge or the end of the day surgery of the Insurer Person, the cost of the drugs is subject to the dosage for one hundred twenty (120) days (as of the date of discharge).

15. Inpatient psychiatric treatment (Interpretation 29) charges

Medical expenses of inpatient treatment received by the Insured Person from a **Psychiatrist** (Interpretation 30) for mental illness after the waiting period. The maximum number of days of payment in each insurance year is subject to the limit set forth in the Schedule.

This cover shall be agreed upon by the Policyholder and the Company at the time of

placement and set forth in the Schedule. Otherwise, the Company shall not be liable for payment of benefit.

If the expenses set forth in Item 1-15 above are incurred by the Insured Person for seeking medical treatment outside the covered territory, the Company will only bear the medical expenses of emergency treatment as required for Accidental Injury or Emergency Condition (Interpretation 31).

(II) Organ transplantation

The charges of **kidney, heart, liver, lung or bone marrow transplantation** required by the Insured Person for illness or accidental injury.

(III) Prosthesis/artificial body

The charges of the medically necessary surgically implanted, non-cosmetic crystals, stents (**excluding braces**), pacemakers, prostheses or similar orthopedic appliances and implants recommended by the attending specialist.

(IV) Cancer treatment and non-inpatient kidney dialysis treatment

1. Cancer treatment

The medical charges for inpatient (including operation), outpatient, chemoradiotherapy and other related follow-up treatment arising from **Cancer** (Interpretation 32) treatment for the Insured Person.

2. Non-inpatient kidney dialysis treatment

The charges for medically necessary non-inpatient **Kidney Dialysis** (Interpretation 33) received by the Insured Person as recommended by a specialist.

(V) Emergency outpatient dental treatment

1. The charges for medically necessary dental emergency treatment for natural tooth or gum injury caused by an **Accident** (Interpretation 34) and carried out in twenty-four (24) hours after the occurrence of the accident.
2. The charges for follow-up consultation within thirty (30) days after the occurrence of the accident (including the costs of prescribed medical supplies and drugs).

This cover is not subject to the restriction of covered territory.

(VI) Emergency outpatient treatment

(1) The charges for emergency treatment of the injury arising as a result of an accident occurring to the Insured Person within twenty-four (24) hours after the occurrence of the accident.

(2) The charges for follow-up consultation within thirty (30) days after the occurrence of the accident (including the costs of prescribed medical supplies and drugs).

This cover is not subject to the restriction of covered territory.

(VII) 24-hour emergency assistance service

If an Insured Person suffers from serious accidental injury or emergency condition or needs emergency medical assistance due to travel from his Residence, provided that the journey is not against the medical advice or is not designed to seek any overseas medical treatment or surgical operation, the Company shall designate Emergency Assistance Center to provide services and directly settle the charges with Emergency Assistance Center up to the annual limit set forth in the Schedule. The Insured Person or his/her authorized representative may call the 24-hour-service hotline of Assistance Center to obtain the following emergency assistance services.

This cover is not subject to the restriction of covered territory.

1. Emergency medical care, telephone medical advice, evaluation and referral appointment.

The Insured Person may call the hotline of Emergency Assistance Center to obtain the medical advice and online physician's assessment, if needed. The Insured Person shall deem it as advice rather than diagnosis. If medically necessary, the Insured Person shall seek personal diagnosis from other physicians or medical experts, and Emergency Assistance Center will assist the Insured Person in making the medical appointment.

2. Emergency medical evacuation

If an Insured Person suffers from accidental injury or emergency condition and needs to be hospitalized in a medical institution or be transferred to a medical institution for hospitalization as recommended by the medical team and attending physician of the emergency service center designated by the Company for receiving appropriate treatment, the Company will arrange the transfer of the Insured Person to the nearest hospital meeting the requirements and pay for medically reasonable and necessary charges:

(1) transfer the Insured Person to the hospital which is more capable of treating his/her injury or emergency condition by using necessary medical evacuation equipment (including but not limited to air rescue plan, civil flight and road ambulance) under the supervision of the medical staff; or

(2) If medically permitted, directly transfer the Insured Person to the suitable hospital or other health care institution in the neighborhood of his/her permanent residence via the ambulance transport airport and civil flight under the supervision of the medical staff. The medical team and attending physician will jointly decide on necessary arrangements depending on the circumstances.

3. Medical escort after treatment

After the aforesaid emergency medical evacuation, if medically necessary, Emergency Assistance Center will arrange and pay for the economy class of the civil flight or other appropriate means of transport (if the return ticket held by the Insured Person cannot be used), and pay any airport transport costs, to help the Insured Person return to the medical institution in the People's Republic of China or its home country. The Insured Person shall submit the unused portion of the air ticket to Emergency Assistance Center for disposal. Any decision on the return of the Insured Person after treatment shall be made jointly by the attending physician and Emergency Assistance Center under ongoing medical supervision.

4. Repatriation of remains or cremains

Regardless of whether an Insured Person travels from his Residence, if he/she is deceased outside

his/her country of nationality, the emergency rescue center designated by the Company will arrange all matters in accordance with local procedures and pay:

(1) the expenses of repatriation of the remains or cremains of the Insured Person to the People's Republic of China or the country of nationality of the Insured Person or the country where the Insured Person has permanent residency, or

(2) the expenses of local burial at the request of the heir or family members of the Insured Person; **provided that the local burial expenses shall not exceed the expenses required for repatriation of remains or cremains and not include the coffin cost.**

Special Notice: the emergency services provided by the Company do neither include the services of transferring the Insured Person out of vessels, oil rig platform or similar offshore venues nor the services beyond the scope of the foregoing clauses.

(VIII) Outpatient treatment

1. Clinical consultation

The charges for medical treatment rendered by a registered Physician.

2. Specialist consultation

The charges for treatment rendered by a Specialist.

3. Physical therapy and spinal massage treatment costs

The charges for physiotherapy treatment or chiropractic treatment as referred by a physician or a specialist.

4. Chinese herbalist, bonesetter and acupuncture treatment

The charges for herbal medicine prescribed by a registered Chinese Herbalist, bonesetting treatment rendered by a registered bonesetter or acupuncture treatment rendered by a registered acupuncturist.

5. X-Ray and other laboratory examinations

The medical charges for X-ray and laboratory examinations received by the Insured Person.

6. Prescription drug costs

The costs of medically necessary drugs prescribed by the attending Physician in writing.

7. Routine physical examination, health check-up, vaccination and vision care charges

Medical charges for preventive routine physical examinations, health check-ups and vaccination and vision examinations, medical costs arising from glasses or contact lenses prescribed by an ophthalmologist or optometrist.

This benefit cannot be enjoyed separately, but only in conjunction with benefits of Item (I) through (VII). This cover shall be agreed upon by the Policyholder and the Company and stated in the Schedule. Otherwise, the Company shall not be liable under this Policy for the above expenses.

Limit to one visit per day per disability.

(IX) Dental treatment

The medical expenses of the following treatments received by the Insured Person and performed by a **Registered Dentist** (Interpretation 35) during the Period of Insurance.

1. Dental treatment charges

Treatment of natural teeth or gums, periodontal disease, including packing, filling, extraction (**except for wisdom teeth**), X-ray, root surface leveling, root canal treatment.

2. Oral examination and dental cleaning charges

Oral examination and tooth cleaning treatment (including scaling, polishing), fluoridization, pit and fissure sealing, **limited to the number of medical visits during each Period of Insurance specified in the Schedule.**

3. Dentures charges

Replacement of the missing natural tooth with artificial materials, including the repair of the replaced natural tooth.

After this cover remains valid for the Company for one year, the following special provisions for the **Pre-existing Dental Conditions** (Interpretation 36) shall apply:

1. If the dental coverage for the Insured Person has been in effect for a whole year, during the second and third year of insurance maintained at the Company **(there shall be no interruption between insurance periods in different years)**, the Company shall be **liable for the treatment expenses** of filling and extraction **(except for wisdom teeth)**. **However, the amount of benefits shall in no event exceed the sum insured under the dental coverage as set forth in the Schedule applicable at the time of renewal and be subject to the limit of RMB6,000 per year.**

2. If the dental coverage for the Insured Person have been in effect for three years from the first year of insurance, during the fourth and fifth year of insurance maintained at the Company**(there shall be no interruption between insurance periods in different years)**, the Company shall be liable for the following treatment charges: packing, filling, post, core, tooth extraction**(except for wisdom teeth)**, porcelain-fused-to-metal crown, onlay, inlay, temporary denture, artificial teeth, periodontal deep scratch, root planing, root canal therapy, periodontal treatment, missing teeth replacement, preservation therapy as well as repair of used denture crown, denture bridge, removable denture repair. **However, the amount of benefits shall in no event exceed the sum insured under the dental coverage as set forth in the Schedule applicable at the time of renewal and shall be subject to the limit of RMB6,000 per year.**

3. If the dental coverage for the Insured Person have been in effect for five years from the first year of insurance, from the sixth year of continuous insurance and thereafter **(there shall be no interruption between insurance periods in different years),** the Company shall be liable for all dental treatment charges directly or solely incurred by the pre-existing dental conditions or injury on the part of the Insured Person. **However, the amount of benefits shall in no event exceed the sum insured under the dental coverage set forth in the Schedule applicable at the time of renewal.**

This benefit cannot be enjoyed separately, but only in conjunction with benefits of Item (I) through (VIII). This cover shall be agreed upon between the Policyholder and the Company and stated in the Schedule. Otherwise, the Company shall not be liable under this Policy for the above

expenses.

(X) Maternity benefit

The following medical expenses incurred as a result of the Insured Person becoming pregnant after the waiting period. **If it is estimated that the Insured Person is pregnant during the waiting period based on the gestational age certificate issued by a specialist, the Company will not be liable under this Policy even if the medical expenses are actually incurred after the waiting period.**

1. The actual cost of childbirth, antenatal complications and complications during childbirth, the cost of medically necessary ambulance, and the costs of medically necessary artificial termination of pregnancy, miscarrage, including the costs of all antenatal and 42-day postnatal examinations. Antenatal complications refer to: cervical insufficiency, ectopic pregnancy, gestational diabetes, hypertension during pregnancy, hydatidiform mole, hyperemesis gravidarum, cholestasis during pregnancy, threatened abortion, placenta previa, placental abruption, fetal distress.
2. Medical charges incurred within 15 days after the birth of the baby, including neonatal medical examination fees, hospitalization expenses, nursing and other medically necessary expenses, **but excluding the medical expenses of any congenital diseases, congenital malformations or defects.**

This benefit cannot be enjoyed separately, but only in conjunction with benefits of Item (I) through (VIII). This cover shall be agreed upon between the Policyholder and the Company and stated in the Schedule. Otherwise, the Company shall not be liable under this Policy for the above expenses.

(XI) High Cost Providers

Reasonable and necessary medical expenses incurred by the Insured Person at **High Cost Providers** (Interpretation 37), which are subject to those set forth in the Schedule.

This cover shall be agreed upon by the Policyholder and the Company at the time of placement and set forth in the Policy. Otherwise, the Company shall not be liable to pay the benefit for the above expenses.

Article 15 Exclusions

(I) The Company shall not be liable under this Policy for the medical expenses incurred by the Insured Person arising from the following circumstances:

1. Seeking medical consultation and treatment outside the covered territory. However, (V) Emergency Outpatient Dental Treatment, (VI) Emergency Outpatient Treatment and (VIII) 24-hour Emergency Assistance Service under Article 14 Insuring Agreement hereof are not subject to the restriction of covered territory.

2. Seeking medical consultation and treatment at Restricted Providers (Interpretation 38), which are subject to those set forth in the Schedule.
3. Suicide or attempted suicide, self-inflicted injuries or any attempt thereat whether sane or insane.Fight, the Insured Person being attacked or murdered caused by deliberate act or provocation of the Insured Person.
4. War, military conflict, riot or armed rebellion, nuclear explosion, nuclear radiation or nuclear contamination, terrorist act; Biological or chemical pollution.
5. The Insured Person violates the law or attempts to violate the law or resists criminal

coercive measures taken in accordance with the law.

(II) The Company shall not be liable under this Policy for the following expenses:

1. Pre-existing Condition (Interpretation 39) or any related or subsequent illness, except as disclosed by the Insured Person to the Company in the application form and approved in writing by the Company.

2. Non-medical administrative costs of purchasing personal supplies and using telephone, television, radio, newspapers, catering, report fees, printing costs, etc.

3. Pregnancy, childbirth, miscarriage, artificial termination of pregnancy, ectopic pregnancy, infertility and all complications arising therefrom or any costs arising therefrom, except as agreed by the Policyholder and the Company and expressly stated in the Schedule.

4. Birth control measures, assisted reproduction, sterilization or any costs arising therefrom or in connection therewith.

5. Circumcision, impotence or erectile dysfunction and any costs arising therefrom or in connection therewith.

6. Any treatment or examination of venereal disease (Interpretation 40), human immunodeficiency virus (HIV)-related diseases (including AIDS and AIDS-related syndromes (ARC) and any mutations, derivations or mutations thereof).

7. Transsexual surgery and any related treatment costs.

8. Any congenital condition (Interpretation 41), congenital malformation or defect and any related treatment.

9. Non-hospital nursing care, rest cures or sanitaria care that does not meet the agreement on home nursing under this Policy, treatment arising from any psychogeriatrics, or psychiatric, psychological, mental or psychiatric disorder and any physical or mental causes or manifestations thereof, except for the mental illness treatment covered under this Policy as expressly stated in the Schedule.

10. The costs of vision testing, any treatment for refractive defects (including myopia, hyperopia, and astigmatism); the costs of glasses, monocles, contact lenses, contact lens care solution，sunglasses, laser-assisted refractive corneal stratification, laser eye surgery, or similar products or corrective surgery, except as agreed upon by the Policyholder and the Company and expressly stated in the Schedule.

11. The costs of medical aids, facilities or durable medical equipment, including but not limited to insulin pumps, blood glucose monitors and test strips, orthopedic arch supports, pressure socks, hearing aids, speaking aids (electronic laryngeal), wheelchairs, crutches, medical splints and medical orthopedic stents.

12. Medical expenses arising from accidental injury or illness caused by the following sports: professional sports or professional competitions, fixed-point skydiving, cliff diving, riding or learning to fly without a flight permit, diving at a depth of twenty (20)meters or more, walking to an altitude of three thousand five hundred (3,500)meters or above, riding a hot air balloon, climbing with bare hands, climbing with or without ropes, bungee jumping, canyoning, gliding, paragliding, driving and maneuvering paragliding, skydiving or cave exploration;

Medical expenses arising from accidental injury or illness caused by the following sports: martial arts, scuba diving at a depth of no less than ten (10) meters but less than twenty (20) meters, hiking to an altitude of no less than two thousand five hundred (2,500) meters but less than three thousand five hundred (3,500) meters, skiing outside the ski slopes or any other winter sport, unless the event meets the following conditions at the same time:

(1) The Insured Person does not act alone;

(2) The Insured Person is accompanied by a qualified tour guide or coach who has obtained local certification, or the Insured Person has qualification and acts to the extent as

permitted by relevant authorities or organizations;

(3) The Insured Person does not act against the doctor's advice;

(4) The Insured Person does not act against the strict warning or persuasion of the local government;

(5) The Insured Person has taken all reasonable defense measures and used appropriate equipment while carrying out the activity.

13. The treatment costs incurred by accidents occurring to the Insured Person while onboarding any aircraft or airborne vehicle (except for taking the civil or commercial flight in the capacity of passenger).

14. The costs of use of any drugs not licensed by the governmental authorities of the country in which the drug is given, or the use of any drugs against the physician's advice or instructions and any Treatment arising therefrom; any vitamins and nutraceuticals, any nourishing Chinese medicine, including but not limited to herbal paste (Gao Fang), ginseng, Ejiao (colla corii asini), Deerhorn glue, Guilu Erxian Jiao (glue of the two ingredients tortoise plastron and antler), Gui Ban Jiao (glue of tortoise plastron), turtle carapace glue, horse bezoar, Shan Hu (Japanese coral), Dai Mao (carapax eretmochelyos), cordyceps sinensis, saffron, antelope, Xi Jiao (rhinoceros horn), bezoar, musk, velvet antler, iron maple.

15. The costs of any experimental medical investigation and treatment, any investigation and treatment that has not been proven safe and effective by a public authority.

16. The costs of treatment, evaluation and rating of physical and mental retardation, precocious puberty, learning disabilities, and behavioral problems in children.

17. The costs of related treatments for hair loss, beauty, cosmetic (aesthetic) or plastic Surgery or Treatment, or any Treatment which relates to or is needed because of previous beauty, cosmetic or plastic Surgery or Treatment, except for the Surgery or Treatment which is done at a medically appropriate stage after the accident or surgery and is carried out to restore function or appearance as approved by the Company before the operation.

18. Any cost incurred by the removal of fat or surplus tissue from any part of the body whether or not it is needed for medical or psychological reasons, treatment of obesity, weight reduction or weight improvement.

19. The costs required for acquisition of organ (including but not limited to transportation costs) or any costs incurred by the donor.

20. The cost of purchasing any kidney dialysis equipment, instruments, material, machines and supplies.

21. Any expenses incurred as a result of drug or addictive substance abuse or dependence (including but not limited to drugs and alcohol).

22. The costs of fatigue or weakness; The cost of treatment for sleep disorder, including but not limited to snoring, insomnia, sleep apnea hyperpnoea syndrome and sleep test.

23. Any expenses incurred due to accidental tooth damage caused by eating.

24. The cost of hospitalization for permanent neurological injury or persistent vegetative state for more than ninety (90) days. The persistent vegetative state is: no response to the surrounding environment, complete loss of cognitive ability to itself and the surrounding, even if the patient is able to open eyes and spontaneously breath, the state lasts for more than four (4) weeks and there is no signs of improvement or recovery.

25. The cost of treatments to alleviate physical or physiological changes due to non-disease symptoms such as aging, menopause, adolescence.

26. The costs of any preventive or predictive genetic testing.

27. Any expenses incurred as a result of dental treatment except for Emergency outpatient dental treatment, except as agreed by the Policyholder and the Company and expressly stated in the Schedule.

Chapter III Obligations of the Policyholder and the Insured Persons

Article 16 Obligations of the Policyholder and the Insured Persons

(1) Obligation of paying premium

Subject to the terms and conditions of the policy, the Policyholder shall pay the premiums in full to the Company prior to the effective date of the policy stated in the Schedule or the Endorsement.

(2) Obligation of truthful disclosure

When concluding an insurance policy, if the Company inquires about the Policyholder or the Insured Person, the Policyholder shall give truthful disclosure.

In the event that the Policyholder fails to perform the obligation of truthful disclosure due to intentional or gross negligence, to the extent of materially affecting the Company's decision as to whether or not to accept insurance or to increase the premium rate, the Company shall have the right to rescind this Policy. Such right shall be extinguished if it is not exercised more than thirty (30) days from the date on which the Company knows any cause of rescission.

In the event that the Policyholder deliberately fails to perform the obligation of truthful disclosure, the Company shall not be liable to pay the insurance benefit for the insured event occurring prior to the rescission of the Policy and shall not refund the premium.

In the event that the Policyholder fails to perform his/her obligation of truthful disclosure due to gross negligence, which has significant relevant bearing on the occurrence of an insured event, the Company shall not be liable for the insured event occurring prior to the rescission of this Policy, but shall refund the premium.

(3) Obligation of notification of insured event

The Policyholder, the Insured Person or the beneficiary shall notify the Company as soon as they become aware of the occurrence of the insured event. **Where they fail to inform the Company in time due to intentional or gross negligence, making it difficult to determine the nature, cause and degree of damage and other circumstances of the insured event, the Company shall not be liable for payment of the insurance benefit for the portion that cannot be determined,** unless the Company is aware of or ought to be aware of the occurrence of such insured event in due time through other ways. The agreement above does not include the delays caused by force majeure.

(4) Obligation of notification of changes in information of the Policyholder and the Insured Persons

Under any of the following circumstances, the Policyholder shall promptly notify the Company in writing:

1. Change of the Insured Person's occupation/business.
2. Change of the Policyholder's address. If the Policyholder does not inform in time, the notices sent by the Company according to the latest address given shall be deemed to have been served to the Policyholder.
3. Change of Usual Country of Residence of the Insured Persons. Usual Country of Residence in Mainland China is an important condition for the Company to decide whether to insure the applicant. **If the Usual Country of Residence of any Insured Person has changed, the Policyholder or the Insured Person shall timely notify the Company. For such Insured Person, the Company reserves**

the right to change underwriting terms, decline to provide coverage or not to renew the insurance.

Change of Usual Country of Residence means Insured Person's ceasing to maintain a residence in his/her current Usual Country of Residence (Mainland China) for a period in excess of three consecutive months.

4. Change of the Insured Person's name or certificate.
5. Change of the Policyholder's name or certificate.

Article 17 Determination of Age and Misstatement of Age

The age of an Insured Person shall be subject to the age of the Insured Person's last birthday registered in the statutory identity certificate. The Policyholder shall fill in the Insured Person's last birthday at the time of application. In case of any misstatement, it shall be handled as follows.

(1) If the age of the Insured Person stated by the Policyholder is untrue, and his/her actual age does not comply with the requirements on entry age, the Company shall have the right to cancel this Policy. Such right shall be extinguished if not being exercised by the Insurer thirty (30) days beyond the date when the Company becomes aware of the cause of cancellation. The Company shall not be liable for paying benefit for the insured event occurring before the cancellation of this Policy, but shall refund the premium for the remaining days of the Period of Insurance calculated on a daily basis.

(2) If the age of any Insured Person has been misstated and the actual premium paid as a result thereof is less than the due premium, the Company shall have the right to correct it and require the Policyholder to make up for the insufficiency.

(3) If the age of any Insured Person has been misstated and the actual premium paid as a result thereof is more than the due premium, the Company will refund the excess to the Policyholder without interest.

Chapter IV Request for and Payment of Insurance Benefits

Article 18 Calculation Method of Insurance Benefits

(1) **The medical cost reimbursement principle applies to this Policy**. If the Insured Person has been reimbursed or indemnified for the medical costs from other sources (including social medical insurance, public medical care, the employer and any commercial medical insurance agencies including the Company, etc.), **the Company shall pay the insurance benefit pursuant to this Policy based on the balance of the medical costs actually incurred by the Insured Person after deduction of the reimbursement or indemnity amount received from other sources, viz. the sum of all reimbursement or indemnity amounts paid through all channels including this Policy shall not exceed the medical costs actually incurred by the Insured Person.** The medical treatment benefits obtained by the Insured Person from social medical insurance, public medical care, the employer and any commercial medical insurance agencies including the Company can offset the deductibles set forth in the Schedule.

(2) During the Period of Insurance, the amount of medical insurance benefit paid by the Company as requested by the Insured Person is calculated as per the following formula:

1. If the reimbursed or indemnified medical cost received by the Insured Person from various sources is more than the deductible stated in the Policy:

Insurance benefit paid = (the sum of medical costs individually paid - the reimbursed or indemnified medical cost received from various sources - deductible) × (1 - percentage of co-payment)

2. If the reimbursed or indemnified medical cost received by the Insured Person from various sources is less than or equal to the deductible stated in the Policy:

Insurance benefit paid = (the sum of medical costs individually paid - deductible) × (1 - percentage of co-payment)

(3) Where otherwise agreed by the Policyholder and the Company, the medical costs actually incurred by the Insured Person shall be paid by the Company according to the agreement and the terms and conditions set forth in the Policy.

Article 19 Request for Insurance Benefits

(1) The Insured Person shall file the claim or entrust another person to file the claim to the Company within thirty (30) days from the date of occurrence of the insured event.

(2) The Company provides the claim form, the Insured Person shall fill in and submit to the Company the claim form together with all necessary certificates showing the identity of the Insured Person, all bills, information and evidence supporting the claim within sixty (60) days from the date of occurrence of the insurance accident, including but not limited to the original certificate issued by the hospital, the medical certificate, pathological examination, laboratory examination reports, outpatient and inpatient medical costs and other original documents, charges, billing details and prescriptions. The benefit applicant is responsible for submitting all certificates, receipts, information and evidence necessary for proving the claim.

(3) The benefit applicant refers to the Insureds, the beneficiaries or the heirs of the Insured or other natural persons who have the right to claim insurance benefits in accordance with law.

If the heir requests insurance benefits as benefit applicant, the heir shall also provide relevant rights documents that can prove his/her legitimate right of inheritance. If the heir is a person without civil capacity or a person with limited capacity for civil conduct, his legal guardian shall apply for insurance benefits on his behalf, and the legal guardian shall also provide the proof evidencing the heir is a person without civil capacity or a person with limited capacity for civil conduct and the proof evidencing the guardian has legal guardianship.

Article 20 Payment of Insurance Benefits

(1) The Company has the right to conduct medical examination of the Insured Person making a claim to the reasonable extent in the process of claims examination. Besides, the Company has the right to request autopsy to the extent permitted by law at its own cost.

(2) The Company shall, after receiving any claim for payment of insurance benefits from the

benefit applicant, promptly carry out the review of such claim; where the circumstances are complicated, the result of the review shall be made within thirty (30) days, unless otherwise stipulated in the Policy.

After making the assessment according to the stipulations, the Company shall inform the Policyholder of the result. Where insurance liability exists, the Insurer shall perform its obligation to make payment of insurance benefits within ten (10) days after reaching an agreement with the benefit applicant. If it is beyond the scope of the insurance liability, the Company shall issue a written notice of rejection of insurance benefit to the benefit applicant and explain the reason thereof within three (3) days from the date of assessment.

(3) The benefits shall be settled in the currency as set forth in the Schedule in which the premiums were paid by the Policyholder and according to relevant regulations of the State on foreign exchange and RMB management. The charges paid in any other currency shall be settled in RMB as per the exchange rate on the date when the medical service charges were incurred.

(4) The Company may designate an independent management agency to handle the claims settlement on behalf of the Company. The benefit incurred under VII "Global Emergency Medical Assistance" under Article 14 Insuring Agreement hereof shall be directly paid to the emergency service agency designated by the Company.

(5) The Insurer's direct payment of medical charges and other relevant expenses payable by the Insured Person to the medical institutions shall be deemed as the Company's fulfillment of the obligation of benefit payment to the Insured Person.

Chapter V Alteration, Cancellation and Termination of the Policy

Article 21 Alteration of the Policy

During the Period of Insurance of this Policy, if the Policyholder needs to alter this Policy, it shall file an application in writing to the Company. The Company shall issue an endorsement upon approval of the application.

Article 22 Automatic Termination of Cover

Cover under this Policy for the respective Insured Person shall automatically terminate on the earliest occurrence of any of the following events without otherwise giving notice:

1. **Expiration of the Period of Insurance;**
2. **Death of the Insured Person;**
3. **The aggregate insurance benefits paid during the Period of Insurance reaches the sum insured.**

Article 23 Cancellation of the Policy

(1) Before the commencement of cover, the Policyholder has the right to cancel this Policy by giving written notice to the Company. The validity of this Policy shall terminate as of 24:00 on the date of receipt of such notice by the Company or the time of termination as stated in the notice, whichever is later. The Company shall refund the insurance premium in full within thirty (30) days from the date of receipt of the notice of cancellation without charging any handling fee.

(2) During the Period of Insurance, the Policyholder has the right to cancel this Policy by giving written notice to the Company. The validity of this Policy shall terminate as of 24:00 on the date of receipt of the notice of cancellation by the Company or the time of termination as stated in the notice, whichever is later. If the Insured Person has made claims during the Period of Insurance, the Company shall refund no premium to the Insured Person. If the Insured Person has not made any claim during the Period of Insurance, the Company shall refund the premium according to the following formula within thirty (30) days upon receipt of the notice of cancellation:

Amount of premiums refunded = premiums paid × (original period of insurance - period of insurance lapsed)/original period of insurance. The period of insurance is calculated on a daily basis.

(3) If the Policyholder fails to perform the obligation of truthful notification as stated in Article 16 above, to the extent of affecting the Company's decision as to whether to accept insurance or raise the premium rate, the Company shall have the right to terminate this Policy by giving written notice to the Policyholder. This Policy shall terminate as of 24:00 on the date of receipt of such notice by the Policyholder or the time of termination as stated in the notice, whichever is later. If the Policyholder deliberately fails to perform the obligation of truthful notification, the Company will not refund the insurance premium to the Insured; if the Policyholder fails to perform the obligation of truthful notification due to gross negligence, which has a serious impact on the occurrence of the insured event, the Company shall refund the premium.

Chapter VI Dispute Resolution and Miscellaneous

Article 24 Right of Recovery

Where the Company directly pays or authorizes the partners to directly pay the medical costs incurred hereunder to the benefit applicant or the medical institution, if the costs paid are not covered or beyond the corresponding coverage, the Company shall have the right of recourse.

Article 25 Governing Law

The formation, validity, interpretation, performance of this Policy and settlement of disputes in connection herewith shall be governed by the laws of People's Republic of China ("China").

Article 26 Dispute Resolution

Any dispute between the Policyholder, the Insured Person, the beneficiary and the Company arising from the Policy or relating to the Policy, if the negotiation fails, shall be resolved in one of the following ways:

1. Arbitration by China International Economic and Trade Arbitration Commission in accordance with the Commission's arbitration rules in effect at the time of applying for arbitration provided that such arbitration shall be governed by the law of China. The arbitral award is final and binding upon both parties;
2. Judgment by the courts in China having competent jurisdiction.

The dispute resolution shall be settled and agreed between the Policyholder and the Company when the insurance policy is executed. The second one is the implied dispute resolution if there is

no special agreement.

Article 27 Language

Certain documents in this Policy may be available in both Chinese and English. In case of any discrepancies between the two versions, the Chinese version shall prevail. If necessary, the English version shall be used as the first reference in interpretation of individual words in the Chinese version.

Chapter VII Interpretation

1. Application Form: The form completed by the Policyholder to request for Coverage from the Insurer and the information, documents and declarations provided by the Insured Person in applying for this Policy, including any medical examination reports and forms, written representations and statements made by the Insured Person and any supplementary questionnaires completed by the Insured Person, all of which contain information which the Insurer rely or have relied on in deciding whether or not to insure the respective Insured Person.

2. Schedule: Any Schedule to this Policy containing the particulars of the Policyholder and the Insured Person, the benefits available to the Insured Person under this Policy, limit of liability for all benefits including sum insured, premium amount and any other details as may be applicable under this Policy.

3. Endorsement: A written statement or notice issued by the Insurer to confirm and record any amendments made to this Policy, including any change in the wording of or Cover offered under this Policy or qualification of wording if the Policy is accepted on restricted terms.

4. Policyholder: Refers to the person who has the right to enter into the Policy with the Company and has the obligation to pay the premium for the Policy.

5. The Company: AXA Tianping Property & Casualty Insurance Co., Ltd.

6. Main Insured: Refers to the person who is shown as the Main Insured in the Application form.

7. Spouse: Your husband or wife under a marriage recognized by law and whose Age Last Birthday is from 18 to 99 years old.

8. Child/Children: The natural or step or legally adopted Child of the main insured.

9. Age: The Age Last Birthday registered in the valid identity certificates (e.g. resident ID card, passport, household register, certificate of birth, etc.).

10. Usual Country of Residence: A country in which the Insured Person lives more than 185 days in one year. The Usual Country of Residence and residential address of the Insured Person will be set forth in the Schedule.

11. Illness: A physical condition marked by a pathological deviation from the normal healthy state.

12. Accidental Injury: An external and visible bodily Injury sustained by an Insured Person and caused solely and directly by an Accident and **does not include any Illness or naturally occurring medical conditions or degenerative process.**

13. Disability: Refers to an illness or injury or any symptom, sequela or complication caused thereby.

14. Hospital: An establishment duly constituted and licensed in the covered territory in which it is located as a medical and surgical Hospital for the care and Treatment of sick or injured persons as inpatient or outpatient, and which provides a full range of facilities for diagnosis, treatment and surgery, is supervised by a full-time staff of physicians at all times; **and is not primarily a infirmary, a mental Hospital or institution, a custodial care centre or facility for alcoholics or drug addicts, a spa, or hydropathic or a nursing home or convalescent home or rehabilitation hospital or a home for the aged, or such similar establishments.**

A reference to a Hospital in this Policy shall be construed to refer to either a Public Hospital or Private Hospital.

15. Reasonable and necessary: Means customary and medically necessary. The medical service received by the Insured Person is customary if:

1) The service is intended to meet the medical needs and complies with the prevailing treatment practice in the place of treatment, and adopts the common treatment methods in the place of treatment;

2) The medical expenses do not exceed the usual costs of treating similar circumstances in the local area. Similar circumstances refer to similar treatments or services for the same disease or physical injury suffered by people of the same sex and similar age in the same area.

16. Inpatient: Admission and confinement of an Insured Person in a Hospital for Treatment of an Illness or Injury as a registered bed-paying patient for which the Hospital levies a daily room and board charge.

17. Day Surgery: Surgery on an Insured Person for the Treatment of an Illness or Injury and which is pre-planned and carried out by a Surgeon, at a Hospital or Clinic, but not on an Inpatient basis.

18. Daycare Treatment: Treatment at a Hospital where an Insured Person is admitted and occupies a bed due to day surgery, but does not remain overnight, **excluding Kidney Dialysis and Cancer Treatment**.

19. Standard Private Room: The standard accommodation covered under this Policy shall mean the grade or class of room (offering, where available, a private room with single occupancy as a minimum) for which the Hospital levies the lowest charges for room and board.

20. Intensive Care Unit: A section within a Hospital which is designated as an Intensive Care Unit by the Hospital and which is operating on a twenty-four (24) hour basis solely for the Treatment of patients in critical medical condition and which is equipped to provide specialized nursing and medical services not available elsewhere in the Hospital. This definition also includes a Coronary Care Unit which has facilities not less comprehensive than those described above.

21. Physician: A person qualified as a medical practitioner (other than an Insured Person or a member of his/her Immediate Family or his/her business associates including business partners, employers or employees) who has obtained a medical license from the medical and health authorities of the country in which he/she practices and, in rendering Treatment, is practicing within the scope of his/her licensing and training.

A reference to a "Physician" in this Policy shall be construed to mean, wherever appropriate, a General Practitioner and/or a Specialist.

22. Surgery: A medical Treatment of surgical intervention.

23. Surgeon: A Specialist who is qualified to perform Surgery.

24. Anesthetist: A person trained in anesthesiology and duly registered to perform anesthesia.

25. Registered Nurse: A person qualified as a nurse (other than an Insured Person or a member of his Immediate Family or his/her business associates including any business partners, employers or employees) and duly licensed the medical authority of the country in which he/she is practicing.

26. Medically Necessary: A Treatment, service, supply, or drug, is medically necessary if it is prescribed by a Physician and is appropriate and essential to diagnose or treat the patient's Illness or Injury;

1) does not exceed, in scope, duration, or intensity, the level of care which is needed to provide safe, adequate, and appropriate diagnosis or Treatment;
2) is consistent with widely accepted professional standards of medical practice in the jurisdiction where Treatment is rendered;
3) **is not primarily for the personal comfort or convenience of the patient, the patient's family, the Physician, or other provider of care;**
4) **is not a part of or associated with the scholastic education or vocational training of the patient;**
5) **is not experimental or investigative;**
6) in the case of Inpatient care, cannot be provided safely on an Outpatient basis.

27. Immediate Family: Any of the following people, related to an Insured Person by blood, marriage or adoption:

1) parents and parents-in-law;
2) siblings and brothers-in-law and sisters-in-law;
3) spouse;
4) children;
5) grandparents, maternal grandparents, grandchildren, maternal grandchildren.

28. Rehabilitation Treatment: to improve the patient's physical condition through designed maintenance programs within the prescribed course of treatment, so as not to worsen and assist in rehabilitation. **Where the Insured Person is hospitalized for rehabilitation treatment, the Company shall only be liable for the hospitalization of patients in the acute or subacute stage, subject to approval of the Company.**

29. Psychiatric Treatment: A Physician who has experience in the diagnosis and treatment of mental illnesses and holds a recognized degree in psychiatry or other equivalent qualification.

30. Psychiatrist: A Physician who has experience in the diagnosis and treatment of mental illnesses and holds a recognized degree in psychiatry or other equivalent qualification.

31. Emergency Condition: A sudden change in an Insured Person's health which requires

immediate and urgent medical Treatment to avoid death or impairment to the Insured Person's immediate health.

32. Cancer: A malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. This diagnosis must be supported by histological evidence of malignancy and confirmed by an oncologist or pathologist.

33. Kidney Dialysis: Means hemodialysis (removal of the wastes and excessive water in blood through blood circulation in vitro machine), or peritoneal dialysis (dialysate flows through the abdominal cavity of the Insured Person, removes the wastes and excessive water in blood via the lining of the abdomen) carried out at the lawfully registered dialysis center.

34. Accident: Any adventitious, fortuitous, sudden, unexpected or unforeseen objective event not attributed to illness, which directly and solely results in physical injury.

35. Registered Dentist: A legally qualified dentist who is permitted to provide dental services in his or her practice area.

36. Pre-existing Dental Condition: Pre-existing dental condition includes but not limited to the following dental conditions:

1) missing teeth before the effective date of the Policy;
2) teeth that have been removed or damaged before the effective date of the Policy;
3) Any treatment caused by accidents before the effective date of the Policy, or the lesions that started before the effective date of the Policy, e.g. fillings, porcelain-fused-to-metal crown, denture bridge, removable prosthesis, post, onlay, inlay, preservation treatment, even if the state of the lesion does not appear on the effective date of the Policy;
4) Any condition requiring deep cleaning, root planing, periodontal care, and treatment that occurs before the effective date of the Policy, even if the condition does not appear on the effective date of the Policy;
5) Any treatment requiring dental or dental surgery resulting from an accident occurring prior to the effective date of the Policy or the lesion starting prior to the effective date of the Policy, even if the condition of the lesion does not appear on the effective date of the Policy.

37. High Cost Providers: The High Cost Providers as set forth in the Schedule.

38. Restricted Providers: The medical institutions set forth in the Schedule which seriously deviate from the peers in terms of the level of diagnosis and treatment and medical expenses. **The Insurer shall not be liable for any expenses incurred by the Insured Person in Restricted Providers.**

39. Pre-existing Condition: Accidental injury or illness that existed before the first effective date of the Policy. Regardless of whether the Insured Person has sought or received medical advice, diagnosis, or treatment, anything which meets any of the following conditions is considered a pre-existing condition:

1) the existing accidental injury or illness, or existing symptom or sign of the Insured Person based on the widely accepted pathological development;
2) that is known or should have been known by the Insured Person;

40. Venereal Disease: Means an Illness which has been transmitted by sexual contact, or any of the following Illnesses whether sexually transmitted or not: syphilis, gonorrhea, venereal warts, genital

herpes, granuloma inguinale, chancroid, trichomona, pubic lice (phthirus pubis) infestation, chlamydia and mycoplasma infection.

41. Congenital Condition: A medical condition that is present at birth or is believed to have been present since birth, whether it is inherited or caused by an environmental factor.

(There is no text below)