International Healthcare Plan

Benefits Schedule

$ - Essential

Effective 1 April, 2012

In the table below, we have displayed the benefits applicable to your cover.

To help you understand your cover, the words and phrases that are in bold in your policy documentation have specific meanings, and are defined in the IHP member handbook.

The following benefits are covered under this policy up to the maximum aggregate limit subject to the benefit limits in this schedule, the applicable medical underwriting, the member’s certificate of insurance and our general conditions and exclusions.

General exclusions include: alcohol, drug or solvent abuse, chronic medical conditions that pre-date the member’s original date of entry, cosmetic treatment, sexually transmitted diseases, sterilisation and elective medical checkups.

All benefits shown are per insured person, per period of cover (unless specifically stated), and the selected policy excess applies to all benefits on a per medical condition basis (unless specifically stated).
<table>
<thead>
<tr>
<th>Essential</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maximum Annual Aggregate Limit</strong></td>
</tr>
<tr>
<td><strong>Inpatient, Day Patient, Emergency Care and Diagnostics</strong></td>
</tr>
<tr>
<td>Inpatient Care</td>
</tr>
<tr>
<td>Reconstructive Surgery and Rehabilitation</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Accident &amp; Emergency Treatment Outside Area of Cover</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>CT PET and MRI Scans</td>
</tr>
<tr>
<td>Organ Transplant</td>
</tr>
<tr>
<td>Inpatient Psychiatric Treatment</td>
</tr>
<tr>
<td>Accidental Damage to Teeth</td>
</tr>
<tr>
<td>Hospital Cash</td>
</tr>
<tr>
<td>Parental Accommodation</td>
</tr>
<tr>
<td><strong>Disease and Chronic Conditions Management</strong></td>
</tr>
<tr>
<td>Oncology</td>
</tr>
<tr>
<td>Chronic Conditions</td>
</tr>
<tr>
<td>Congenital Anomalies</td>
</tr>
<tr>
<td>Durable Medical Equipment, Prosthetic and Orthotic Supplies (DMEPOS)</td>
</tr>
<tr>
<td>AIDS</td>
</tr>
<tr>
<td>Hospice Care</td>
</tr>
<tr>
<td>Hormone Replacement Therapy</td>
</tr>
<tr>
<td><strong>Outpatient and Alternative Treatments</strong></td>
</tr>
<tr>
<td>Outpatient Care</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
</tr>
<tr>
<td>Outpatient Psychiatric Treatment</td>
</tr>
<tr>
<td>Alternative Treatment</td>
</tr>
<tr>
<td>Vaccinations and Injections</td>
</tr>
<tr>
<td>Home Nursing</td>
</tr>
<tr>
<td><strong>Evacuation and Transportation</strong></td>
</tr>
<tr>
<td>Emergency Transportation</td>
</tr>
<tr>
<td>Essential</td>
</tr>
<tr>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>Evacuation &amp; Additional Travel Expense</td>
</tr>
<tr>
<td>i) Travel</td>
</tr>
<tr>
<td>ii) Non-hospital accommodation</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Compassionate Emergency Travel</td>
</tr>
<tr>
<td>No cover</td>
</tr>
<tr>
<td>Mortal Remains</td>
</tr>
<tr>
<td>Up to $8,500 per insured person</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Mother and Child</td>
</tr>
<tr>
<td>Complications of Pregnancy</td>
</tr>
<tr>
<td>Covered in full</td>
</tr>
<tr>
<td>New Born Care</td>
</tr>
<tr>
<td>Up to $100,000 per insured person per period of cover and to a maximum of 90 days hospital stay</td>
</tr>
<tr>
<td>New Born Accommodation</td>
</tr>
<tr>
<td>Covered in full</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Options to Reduce Costs</td>
</tr>
<tr>
<td>Outpatient Consultation Copay per Visit</td>
</tr>
<tr>
<td>This benefit is available where nil excess has been selected.</td>
</tr>
<tr>
<td>AED 50 ($13.59) Co-pay per Visit or deductible.</td>
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<tr>
<td>Or</td>
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<tr>
<td>AED 75 ($20.38) Co-pay per Visit or deductible.</td>
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<tr>
<td>Or</td>
</tr>
<tr>
<td>AED 100 ($27.18) Co-pay per Visit or deductible.</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Options to Upgrade Cover</td>
</tr>
<tr>
<td>Alternative Treatment without Medical Referral</td>
</tr>
<tr>
<td>Up to $1,000 per insured person per period of cover OR Up to $2,000 per insured person per period of cover</td>
</tr>
<tr>
<td>Chronic Conditions</td>
</tr>
<tr>
<td>No additional options available – see above standard chronic conditions benefit</td>
</tr>
<tr>
<td>Complications of Pregnancy – no wait period</td>
</tr>
<tr>
<td>Covered in full</td>
</tr>
<tr>
<td>Compassionate Emergency Travel</td>
</tr>
<tr>
<td>No cover</td>
</tr>
<tr>
<td>Congenital Anomalies - Including Pre-existing Congenital Anomalies</td>
</tr>
<tr>
<td>Covered in full</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>Up to $100,000 per medical condition OR Up to $250,000 per medical condition</td>
</tr>
<tr>
<td>Dental 1 - Routine Dental Treatment</td>
</tr>
<tr>
<td>Up to $250 per period of cover and subject to 25% coinsurance OR Up to $250 per period of cover and no coinsurance OR Up to $500 per period of cover and subject to 25% coinsurance OR</td>
</tr>
</tbody>
</table>
| Essential | \begin{tabular}{|l|}
| Up to $500 per period of cover and no coinsurance OR Up to $750 per period of cover and subject to 25% coinsurance OR Up to $750 per period of cover and no coinsurance OR Up to $1,000 per period of cover and subject to 25% coinsurance OR Up to $1,000 per period of cover and no coinsurance OR Up to $1,500 per period of cover and subject to 25% coinsurance OR Up to $2,000 per period of cover and subject to 25% cover and subject to 25% coinsurance OR Up to $2,500 per period of cover and subject to 25% coinsurance OR Up to $1,500 per period of cover and no coinsurance OR Up to $2,000 per period of cover and no coinsurance OR Up to $2,500 per period of cover and no coinsurance |
|----------|-------------------|
\end{tabular} |

| Dental 2 - Major Restorative Dental Treatment | \begin{tabular}{|l|}
| Up to $500 per period of cover and subject to 25% coinsurance OR Up to $500 per period of cover and no coinsurance OR Up to $750 per period of cover and subject to 25% coinsurance OR Up to $750 per period of cover and no coinsurance OR Up to $1,000 per period of cover and subject to 25% coinsurance OR Up to $1,000 per period of cover and no coinsurance OR Up to $1,500 per period of cover and subject to 25% coinsurance |
|----------|-------------------|
\end{tabular} |
<table>
<thead>
<tr>
<th>Plan</th>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
</table>
| Essential | OR | Up to $2,000 per **period of cover** and subject to 25% **coinsurance**  
| | OR | Up to $2,500 per **period of cover** and subject to 25% **coinsurance**  
| | OR | Up to $1,500 per **period of cover** and no **coinsurance**  
| | OR | Up to $2,000 per **period of cover** and no **coinsurance**  
| | OR | Up to $2,500 per **period of cover** and no **coinsurance**  
| Dental 3 - Orthodontic Dental Treatment | | Up to $500 per **period of cover** and subject to 50% **coinsurance**  
| | | Up to $1000 per **period of cover** and subject to 50% **coinsurance**  
| | | Up to $1,500 per **period of cover** and subject to 50% **coinsurance**  
| | | Up to $1,500 per **period of cover** and no **coinsurance**  
| | | Up to $500 per **period of cover** and no **coinsurance**  
| | | Up to $1000 per **period of cover** and no **coinsurance**  
| Dental 5 - Combined Routine & Restorative Dental | | Up to $1,500 per **period of cover** and no **coinsurance**  
| | | Up to $1,500 per **period of cover** and subject to 25% **coinsurance**  
| Dental 6 - Combined Routine & Restorative Dental with Orthodontics | | Up to $2,500 per **period of cover** and no **coinsurance**  
| | | Up to $2,500 per **period of cover** and subject to 25% **coinsurance**  
| Dental 7 - Combined Routine & Restorative Dental with Orthodontics and Dental Implants | | Up to $3,000 per **period of cover** and no **coinsurance**  
| | | Up to $3,000 per **period of cover** and subject to 25% **coinsurance**  
| Outpatient Direct Settlement Network - nil excess | | This benefit is available where a Nil, $50 OR $100 **policy excess** has been selected.  
| | | Outpatient consultations are available on a nil excess basis where treatment is received in network.  
| | | Where outpatient consultations take place outside the direct settlement network the policy excess applies.  
<p>| Extended Evacuation | | Covered in full |</p>
<table>
<thead>
<tr>
<th>Essential (to the country of choice)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out of Country Transportation</strong></td>
</tr>
<tr>
<td><em>For medically necessary non-emergency treatment as an inpatient or day patient</em></td>
</tr>
<tr>
<td>i) Travel</td>
</tr>
<tr>
<td>ii) Non-hospital accommodation</td>
</tr>
<tr>
<td>i) Covered in full</td>
</tr>
<tr>
<td>ii) Up to $150 per person per day and $5,000 per person, per evacuation OR Up to $250 per person per day and $10,000 per person, per evacuation</td>
</tr>
<tr>
<td><strong>Infertility Treatment</strong></td>
</tr>
<tr>
<td>(minimum of 10 Employees required)</td>
</tr>
<tr>
<td>No cover</td>
</tr>
<tr>
<td><strong>Routine Pregnancy</strong></td>
</tr>
<tr>
<td>Up to $5,000 or per pregnancy and subject to 20% coinsurance OR Up to $5,000 per pregnancy and no coinsurance OR Up to $10,000 per pregnancy and subject to 20% coinsurance OR Up to $10,000 per pregnancy and no coinsurance OR Up to $20,000 per pregnancy and subject to 20% coinsurance per pregnancy OR Up to $20,000 per pregnancy and no coinsurance OR Covered in full per pregnancy but subject to 20% coinsurance OR Covered in full per pregnancy with no coinsurance</td>
</tr>
<tr>
<td><strong>Traditional Chinese or Ayurvedic Medicine</strong></td>
</tr>
<tr>
<td>$30 per session to a maximum of 10 sessions OR $30 per session to a maximum of 20 sessions OR £30 or €35 or $50 per session to a maximum of 30 sessions OR Up to $500 per period of cover OR Up to $750 per period of cover</td>
</tr>
<tr>
<td><strong>USA Elective Treatment</strong></td>
</tr>
<tr>
<td>i) Inpatient or day patient treatment received inside the direct settlement network</td>
</tr>
<tr>
<td>ii) Inpatient or day patient treatment received outside the direct settlement network</td>
</tr>
<tr>
<td>iii) Outpatient treatment</td>
</tr>
<tr>
<td>i) Covered in full</td>
</tr>
<tr>
<td>ii) Up to $1,000,000 per member per period of cover and subject to 50% coinsurance</td>
</tr>
<tr>
<td>iii) Covered in full</td>
</tr>
</tbody>
</table>
The International Healthcare Plan (IHP) does not comply with the Patient Protection and Affordable Care Act (U.S. healthcare reform), and cannot be used to satisfy any requirements for health insurance cover mandated therein.

| Vision Care | One eye exam and a maximum benefit of up to $250 per period of cover OR One eye exam and a maximum benefit of $500 per period of cover OR One eye exam and a maximum benefit of $750 per period of cover |
| Wellness Option 1 | Routine medical checkups & well-baby checks Up to £160 or €200 or $250 per insured person per period of cover |
| Wellness Option 2 | Bilateral mammogram/breast examination and routine gynaecological tests including PAP tests Testicular/prostate examination/PSA/DRE tests Routine medical checkups Well-baby checks Up to $500 per insured person per period of cover OR Up to $750 per insured person per period of cover OR Up to $1,000 per insured person per period of cover OR Up to $1,500 per insured person per period of cover |
| Wellness Option 3 Preventive Screening | Preventive screening for members who are deemed at high risk Up to $1,000 per insured person per period of cover OR Up to $1,500 per insured person per period of cover |