MassMutual FINANCIAL GROUP℠

Notes on Group Medical Claims for Insured Member's Reference

Notice and Proof of Claim

All claims must be submitted to MassMutual Asia Ltd. within 90 (ninety) days after the completion of the events for which the claim is being made.

MassMutual Asia Ltd. will not be liable in any event until proof satisfactory to MassMutual Asia Ltd. is furnished to MassMutual Asia Ltd. and the claimant at his own expense has furnished such information, assistance, documents, medical evidence and reports signed by an Acceptable Doctor and in such form and of such nature as MassMutual Asia Ltd. may prescribe.

MassMutual Asia Ltd. shall have the right at MassMutual Asia Ltd.'s expense to examine the Insured Member, as appropriate, when and as often as may reasonably be required whilst a claim under the Policy is pending.

Payment of Claim

All benefits that pertain to an Insured Member shall be paid by cheque to the order of the Insured Member or by direct reimbursement to the Insured Member's bank account, unless the Policy Owner for reasons acceptable to MassMutual Asia Ltd. requests otherwise, or MassMutual Asia Ltd., at its discretion, considers it preferable to make the payment in another manner.

Out-Patient Benefit

Where the Insured Member is covered for less than a full Policy Year, all benefits provided on the basis of a fixed number of visits or a fixed amount in any year shall be pro-rated on a daily basis accordingly.

Physiotherapy or treatment by a chiropractor recommended by a Registered Medical Practitioner in writing shall be payable under the Clinical Visit terms. No benefit shall be paid for physiotherapy or treatment by a chiropractor without a valid referral letter from a Registered Medical Practitioner.

For Chinese Medicine's Treatment, original copy of the official receipt and prescription sheet issued by the Chinese Medicine Practitioner are required.

For the benefits provided on the basis of a fixed number of visits, reimbursement shall be limited to no more than one visit per day, and to the maximum number of visits stated in the Policy Schedule in one Policy Year.

If using medical card for doctor consultation, any special expensive, extra medication or long-term medication as determined by the appointed panel doctors will not be covered under the Policy.

Validity of a written referral letter

Validity of a written referral letter by a Registered Medical Practitioner is limited to 90 days. Treatment for the referred Injury or Sickness 90 days after the last treatment was made shall be considered separately and a new referral by a Registered Medical Practitioner shall be required for the Benefit to be payable.

Return Claim Document

If an Insured Member needs us to return the claim document to him/her after processing, please state the request on the front page of the claim form together with the Insured Member's signature. Please note that claims documents will not be returned after 3 months from the submission date.

The above information is for reference only. The insurance coverage shall be subject to the terms and conditions contained in the Policy.

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Minimum Period of Confinement

Each hospital confinement must be for a minimum period of certain consecutive hours as specified under the Policy before any benefits hereunder are payable, except that no minimum period of hospital confinement is required if such confinement is in connection with a surgical operation.

Reasonable and Customary Charges

No benefit shall be paid for charges in excess of the general level of charges levied by other providers of similar standing in the locality where the charges are incurred, when providing like or comparable treatment, services or supplies for a similar Sickness or Injury.

Limitations

When an Insured Member is entitled to benefits payable under Employees' Compensation Law, any government or public program of medical benefits, or other group or individual insurance, the benefits payable under this Policy shall be limited to the balance of the expenses not covered by benefits payable under the Law and other insurance and shall be computed in accordance with the Policy Schedule of this Policy.

Supplementary Major Medical Benefit

Subject to the conditions contained in the Policy, if, while the Supplementary Major Medical Benefit is in force, an Insured Member is confined to a Hospital as a result of an Injury or Sickness for which benefits are payable under the Daily Room and Board benefit of the Policy and incurs In-hospital Expenses in the direct treatment of the Insured Member's Injury or Sickness, which exceeds the amount of coverage under the Basic Benefit as shown in the Policy Schedule ("the Eligible Expenses"), the Company shall reimburse the Insured Member for the Eligible Expenses in accordance with the following calculation :

{Eligible Expenses x Adjustment Factor (if applicable) – Deductible Amount for Any One Disability} x Coinsurance

The maximum payable amount of Supplementary Major Medical Benefit in Any One Disability shall not exceed the maximum benefit per disability as specified in Supplementary Major Medical Benefit section of the Policy Schedule.

The Daily Room and Board benefit under this Supplementary Major Medical Benefit will be payable starting on the day when the maximum number of days per disability of the Daily Room and Board benefit as specified in the Policy Schedule is exceeded.

The Supplementary Major Medical Benefit shall be subject to the same Limitations & Exclusions as specified in the Policy.

Definitions:

a. "Adjustment Factor" shall only apply if the average Daily Room and Board charges incurred during such hospitalization is more than the Daily Room and Board benefit as set in the Policy Schedule. The Adjustment Factor shall be calculated as follows:

$$\frac{\text{Maximum Daily Room and Board benefit set forth in the Policy Schedule}}{\text{Average Daily Room and Board charges incurred during hospitalization}}$$

b. "Coinsurance" shall mean the reimbursement percentage of Any One Disability as specified in Supplementary Major Medical Benefit section of the Policy Schedule.

c. "Deductible Amount" shall mean the amount of Any One Disability as specified in Supplementary Major Medical Benefit section of the Policy Schedule.

d. "Basic Benefit" shall include the benefits of Daily Room and Board, Hospital Services Expenses, In-Hospital Doctor's Call, In-Hospital Specialist's Fee, Surgical Benefit, Anaesthetist's Fee, Operating Theatre Fee and Intensive Care Benefit (if applicable) under the Hospitalization & Surgical Benefit of the Policy.

e. "In-hospital Expenses" shall mean the expenses actually charged by the Hospital and the Registered Medical Practitioners for the services rendered as covered under the Basic Benefit during such Hospital confinement.